We must have this plan if we are to ensure that all North Carolinians have the same chances . . .

One North Carolina.

A state where all residents and citizens have the same chances no matter where they live or what their ethnicity.

- *Mary Easley*
First Lady of
North Carolina

NC Latino Health, 2003

A report from the Latino Health Task Force
North Carolina Institute of medicine
in collaboration with El Pueblo, Inc.

This report would not have been possible without the generous support of The Kate B. Reynolds Charitable Trust and The Duke Endowment.

health policy
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El Pueblo is North Carolina's statewide Latino advocacy and public policy organization, dedicated to strengthening the Latino community through programs in Legislative Monitoring, Health, Educational Campaigns, Culture, Outreach & Training, and Civic Participation.

The full text of this report is available online at www.nciom.org

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February 7, 2003

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Executive Summary

Overview

Latinos are the fastest growing ethnic group in North Carolina. Between 1990 and 2000, their number grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. Latinos now comprise approximately 5% of the state's population.

Latinos move to North Carolina for employment; they are more likely to be employed and in the workforce than any other population in the state. Latinos are often employed in the state's most hazardous industries—agriculture or construction—or in low paying jobs that are less attractive to native North Carolinians. Because of their willingness to work in these industries, some North Carolina businesses actively recruit Latinos from Mexico and other Central American countries. Latinos are major contributors to the North Carolina economy, contributing more than $2.3 billion in purchases in 1999.

The Latino community is one of tremendous diversity. North Carolina Latinos come from many different geographic backgrounds. Some are united as an ethnic group by a common heritage derived from Spanish language and culture, while others identify more with cultural heritages unique to their countries of origin. Most Latinos in the state are of Mexican origin, but many come from Puerto Rico or other Caribbean, Central American, or South American countries.

The growing Latino population has created new health care challenges for the state. Most North Carolina Latinos are recent immigrants: nearly two-thirds are foreign-born. Because many Latinos are coming directly from Mexico or other foreign countries, they still have language barriers. In addition, persons coming from other countries are accustomed to different health care systems. The rapid growth of this new population has overwhelmed many public agencies, and the underlying issues of lack of insurance coverage, language barriers, different cul-

tural and health care beliefs, and general unfamiliarity with the US health care system have not been adequately addressed.

NC IOM Latino Health Task Force

Because the large influx of Latinos in North Carolina is so recent, there have been limited opportunities to examine the health status or health care needs of this population. The North Carolina Institute of Medicine (NC IOM), in collaboration with El Pueblo, Inc., helped create a Task Force to study these issues. The Task Force was led by the Honorable Mary Easley, the First Lady of North Carolina, the Honorable Carmen Hooker Odom, Secretary of the NC Department of Health and Human Services, and Felix S. Sabates, Chairman of FSS Holdings in Charlotte, one of the state's most prominent Latino business leaders. The Task Force was comprised of 48 members who were chosen to represent public and private health care sectors, state and local governmental health and human services agencies, legislators, Latino service and advocacy organizations, representatives of private industry, non-profits, and the faith-based community. The work of the Task Force was supported by a generous grant from The Duke Endowment and The Kate B. Reynolds Charitable Trust.

Guiding Principles

At the outset of its efforts, the Latino Health Task Force reached a clear consensus on some of the principles that would guide its work. The most important of these are:

- ***Latinos residing in North Carolina are making a substantial contribution to the economic, social and cultural enrichment of our state.*** Regardless of immigration status, the health and well-being of this population should be considered of vital importance to the present and future of North Carolina.

- ***Language barriers to needed health, behavioral health, or social services should no longer be acceptable in our state.*** The most effective way to increase access to health, mental health and substance abuse, dental, and social services is to hire bilingual and bicultural providers who can provide appropriate services to both the English-speaking and Spanish-speaking populations. In the short term, it may be necessary to hire interpreters to bridge the language gap; but the goal should be to recruit and employ bilingual, bicultural staff. The additional costs incurred in hiring interpreters and/or bilingual staff need to be recognized and reimbursed.

  Inasmuch as federal law (Title VI of the Civil Rights Act) mandates that states take positive steps to ensure that persons are not discriminated against on the basis of race, ethnicity, or language, NC should seek to comply fully with guidelines of the US Office of Civil Rights pertaining to this legislation, not merely try to avoid a federal non-compliance judgment. Compliance is “the right thing to do” and we should seek to “serve” clients in a linguistically and culturally appropriate manner.

- ***Care should be compatible with patients' cultural health beliefs and practices.*** Staff at health care organizations, including their leadership and governing boards, should be diverse and representative of the communities

they serve. Staff at all levels should receive ongoing education and training in culturally appropriate service delivery.

- ***Public and private health, behavioral health, dental, and social services providers, non-profits, foundations, and churches can play an important role in meeting the health care needs of the growing Latino population in the state.*** Private employers and industries that recruit Latinos from other countries have a special responsibility to ensure that the health care needs of this vulnerable population are met while in their employment.

Major Health Issues Facing the Latino Community

The Task Force met for more than nine months with the goal of developing a consensus on the major health and health care problems facing the NC Latino community, and to identify public and private sector initiatives that can be undertaken to address these concerns.

Over the course of its deliberations, the Task Force identified eight key issues:

1. **Latinos are disproportionately likely to live in poverty and are more likely to go without health care. Despite these problems, Latinos in the state, especially recent immigrants, are relatively healthy as compared to whites or African Americans. But as Latinos acculturate to the US lifestyle, their health status worsens. Thus, the future health issues confronting the Latino population are likely to be more similar to those of the majority population of our state.**

   North Carolina Latinos, especially recent immigrants, are generally healthy. Latinos have better birth outcomes and have lower age-adjusted death rates that whites or African Americans. There are several possible explanations for this. Latinos are a younger population than the state as a whole. North Carolina Latinos are also likely to be recent immigrants: studies have shown that first-generation immigrants may be healthier than those who have lived in the country for longer periods of time. Strong family support systems, coupled with low rates of smoking and traditional diets that emphasize vegetables and grains rather than high-fat foods, may explain, at least in part, why recent immigrants as a group are relatively healthy.

   Nonetheless, there are some health problems of immediate concern. Latinos are more likely to die from alcohol-related motor vehicle crashes and to suffer occupational injuries. Latinos are more likely to be born with certain developmental disabilities; Latino children are more likely to have dental disease and untreated dental caries. Further, Latinos are also more likely to contract immunization-preventable communicable diseases such as rubella. While first-generation Latinos generally are healthy, if they follow the pattern of other Latinos across the country, their overall health status is likely to worsen as they acculturate to the United States. Already, we are seeing signs that Latino youth are acquiring some of the poor health behaviors that lead to chronic health problems. Latino youth look much like their white and African-American peers in the percentage that report being overweight or at risk of being overweight and leading sedentary lifestyles. One-fourth of Latino high school students report smoking; 10% report their health sta-

tus as poor. This is a higher percentage than white or African-American high school students. Absent culturally appropriate, effective interventions aimed at promoting healthful behaviors among the growing Latino population, Latinos are likely to suffer the same adverse health outcomes as other population groups.

2. **Immigrants coming to this country are accustomed to different health care systems and may have different health care beliefs. This can create barriers to the effective use of the US health care system. Health, behavioral health, dental, and social services providers must be aware of these different cultural beliefs.**

   Health care systems differ from one country to another, as do ways of accessing health services. For example, injections are commonly used to treat a wide variety of infections and other illnesses in Mexico and other countries. Waiting until after tests results are available to determine the course of treatment may not make sense to a person who is accustomed to getting immediate treatment, including antibiotics. Rather than wait, some Latinos may feel more comfortable seeking immediate treatment with vitamins and medicines that are familiar to them from a trusted community source. In addition, many Latinos have understandings of the cause of illness that are different than what is customarily believed in the United States. Because of the influence of certain cultural beliefs and practices, many Latinos may simultaneously seek the help of both formal medical care and folk healers for either acute or chronic conditions. North Carolina health care practitioners need to understand these different cultural expectations in order to be able to communicate effectively with their Latino patients and establish a trusting relationship.

3. **Because many North Carolina Latinos are recent immigrants, many face language difficulties. This creates barriers when seeking health, behavioral health, or social services, in addition to barriers caused by poverty, isolation, cultural differences, and lack of health insurance.**

   According to the US Census, approximately half of North Carolina Latinos have limited English proficiency (LEP) or are unable to speak English very well. These language barriers can impair a Latino's ability to access needed programs and services. Title VI of the Civil Rights Act prohibits public and private providers who accept federal funds (including Medicaid, NC Health Choice, or Medicare reimbursement) from discriminating on the basis of race, color, or national origin. The failure to make services and programs linguistically accessible has been interpreted to violate Title VI provisions. In October and November of 2001, the Office of Civil Rights (OCR) of the US Department of Health and Human Services conducted a review of the NC Department of Health and Human Services and five of the local public health and DSS agencies. OCR found North Carolina to be out of compliance with Title VI by failing to provide adequate language assistance to groups who speak a primary language other than English. According to OCR, individuals with limited English proficiency were sometimes turned away because no interpreters were available, or were required to use their

family members, including minor children, as interpreters. Not only does this violate the provisions of Title VI, it compromises the confidentiality and accuracy of communication between the clients and the agency personnel. The best way to ensure that services are linguistically and culturally accessible is to hire bilingual, bicultural staff, but in the absence of sufficient bilingual personnel, agencies and health care providers must ensure the availability of trained interpreters.

4. **Lack of "health literacy" causes additional communication barriers between Latinos and their health care providers.**

   Health literacy assumes a basic understanding of medical terms, a basic ability to read medical instructions, and an understanding of health care technology which is essential to ensure that the patient can be a full participant in managing his or her medical care. Nationally, 40% of Americans are unable to understand the information and any warnings contained on a common prescription bottle. The increasing complexity of health care information and the shift of a greater responsibility onto patients to participate in health care decision making and manage their own diseases have made health literacy problems much more daunting. While the problem of health literacy is not unique to the Latino population, it is particularly acute for many Latinos because of their communication barriers, different understandings of the underlying factors that affect health, and lack of awareness of the US health care system.

5. **Latinos are disproportionately likely to be uninsured compared with other racial and ethnic groups. Latinos are more likely to work for small employers or industries that do not offer health insurance coverage to their employees. Because many Latinos are recent immigrants, they are unable to qualify for publicly-funded insurance, such as Medicaid and NC Health Choice. Some Latino adults are afraid of seeking assistance for their eligible citizen children because of their fear that this would affect their ability to remain in the United States or obtain lawful permanent residence status.**

   North Carolina Latinos are more likely to be uninsured than other groups. More than half (54%) of all Latino adults in North Carolina are uninsured, compared to 11% of non-Latino whites and 22% of African Americans. Nationally, a smaller percentage of Latinos are uninsured (37%) than in North Carolina. Similarly, Latino children in North Carolina are more likely to be uninsured (29%), compared to non-Latino whites (8%) or African Americans (15%). Latinos are more likely to be uninsured for a number of reasons: they are more likely to work for employers or in industries that do not provide coverage, and are less likely to qualify for publicly-funded insurance, despite their relative poverty.

   Federal laws in 1996 made eligibility for publicly-funded programs more restrictive for most immigrants. While federal law restricts coverage for many immigrants, the citizen children of these immigrants born in the United States may be eligible for assistance. However, many immigrants are afraid of applying for their children because they fear they or their children

may be labeled "public charges," making it more difficult for the parents to qualify later for lawful permanent resident status, or that they may be deported if they seek assistance from a governmental agency.

6. **Migrant farmworkers face additional barriers in accessing health services and are generally thought to be in worse health than the general Latino population. In addition, many migrant and seasonal farmworkers are ineligible for workers' compensation if they are injured on the job.**

   Migrants suffer all the same barriers faced by other Latinos in accessing the health care system—including different health care expectations, a lack of understanding of the US health system, language barriers, inability to take off work, and transportation problems. Further, migrants are even more likely to be uninsured than the general Latino population, and have particular problems accessing publicly-funded health insurance programs. Because of the transitory nature of their work, migrant farmworkers may have little understanding of the local health care systems. Migrants are often isolated, living in remote rural areas, and may lack telephones and transportation.

   Migrant and seasonal farmworkers and their families have different and more complex problems, many of which can be attributed to a mobile lifestyle and the environmental and occupational hazards of farmwork. Because of state laws, migrant and seasonal farmworkers, unlike most other employees, lack workers' compensation coverage. Thus, while they are working in a hazardous industry—agriculture—they have no form of recourse if they are injured on the job. Migrants, as a whole, are more likely to contract infectious and other parasitic diseases. They are also likely to have a higher incidence of tuberculosis. Nationally, studies suggest that migrant farmworker women have poorer health outcomes: the infant mortality rate for farmworkers is 25-30% higher than the national average. Because of the isolation of many migrant and seasonal farmworkers, special outreach efforts are needed by trusted members of the community.

7. **There are insufficient resources available to address the health, behavioral health and dental health needs of Latinos.**

   Because of financial and non-financial barriers, health, behavioral health, and dental health services are generally more limited for the North Carolina Latino population than for other North Carolinians. As a result, the Latino population relies more heavily on publicly-funded programs or safety-net providers; that is, providers who are willing to treat low-income patients for free or on a sliding-fee scale basis. However, these resources are not available throughout the state, and even when available, they may be insufficient to serve all in need. Nationally, almost four fifths of all the people in the United States saw a doctor in the past year. However, the available data—albeit limited—suggest that there are many counties in the state where less than 20% of Latinos visited a primary care provider in the past year. Further, Latinos have particular problems accessing behavioral health services. Despite the evidence that Latinos are more likely to be born with developmental disabilities and that Latino males may have a higher inci-

dence of alcohol abuse, Latino use of publicly-funded mental health, developmental disabilities, and substance abuse services is low. While the state and many other public and private health care providers have implemented special outreach efforts to the Latino community, these are generally isolated initiatives. There have been limited state or local funds available to cover the costs of treating uninsured Latinos.

There are new federal funds available that can be used to provide primary care, dental, and behavioral health services to Latinos and other underserved populations in the state. However, special efforts are needed to encourage and assist communities in seeking these funds. Additional state and local funding is needed to help replicate successful pilot programs aimed at providing culturally appropriate and linguistically accessible primary care, immunization efforts, family planning, maternity services, behavioral health, and dental services across the state.

8. **The lack of health data specific to North Carolina Latinos makes it more difficult to measure health disparities and use of health services.**

   In the past, health data were not collected by race and ethnicity. More recently, some agencies and programs have started to collect this information, but it is difficult to establish baseline data or to make accurate comparisons across different Latino subcultures. In addition, private health care providers do not collect this information routinely, so it is difficult to measure the use of health services among North Carolina Latinos. State and local agencies, and other health, behavioral health, dental, and human services providers should collect health, behavioral health, dental, and social services related data (including but not limited to utilization and health outcomes) by race and ethnicity. Data should be used to determine if Latinos are able to access needed health, behavioral health, dental, and social services and whether there are specific health disparities facing the Latino community.

Recommendations

The Latino Health Task Force made a total of 33 recommendations to improve the health status of Latinos and increase access to culturally and linguistically appropriate health, behavioral health, dental, and social services. Task Force members understand that governmental and private funding available to address these needs is limited. Therefore, the Task Force developed **13 priorities** that, if implemented, would have a significant positive impact on the ability of Latinos to access needed health, behavioral health, dental, and social services which would ultimately lead to improved health status. Because of the immediate need of bridging the language and cultural gap, most of the priority recommendations are aimed at expanding the availability of bilingual and bicultural providers. In addition, the Task Force made recommendations to expand the availability of primary, behavioral health, and dental resources; remove barriers that deter families from applying for Medicaid, NC Health Choice, and other publicly funded programs; provide meaningful workers' compensation for migrant and seasonal farmworkers; develop leadership within the Latino community to address health issues; address the problems of health literacy, includ-

ing the lack of understanding of the US health system; and ensure that the state has adequate data to monitor health disparities and health access of the Latinos living and working in the state.

To expand the availability of bilingual and bicultural providers, the Task Force recommended that:

1. The NC Department of Health and Human Services help local communities in their efforts to recruit and retain bilingual and bilcultural providers and to hire and train interpreters. The Department should take responsibility for identifying possible grant sources for these efforts, and should assist local communities in seeking these funds. In addition, the Department should develop systems to maximize federal funds to reimburse providers and agencies for interpreter services. The NC General Assembly should appropriate funding to the NC Department of Health and Human Services to assist in recruiting bilingual and, if available, bicultural professionals and in paying for interpreter services.

2. The NC General Assembly appropriate additional funds to the Office of Minority Health and Health Disparities (OMHHD) to expand the capacity of OMHHD to focus on Latino health issues. Specifically, the OMHHD should expand its technical assistance; communicate with communities about funding opportunities; provide cultural diversity and interpreter training to local agencies, non-profits, and community groups; and conduct research into the major health issues facing Latinos.

    - As part of this effort, the OMHHD Hispanic Health Task Force should be expanded to include a broader collaboration of state agencies and other organizations to develop policies and programs to address the health care needs of Latinos. The collaboration should help support the development or expansion of local coalitions to address the health needs of Latinos.

    - If no new funds are immediately available, the Department of Health and Human Services should explore state, federal, and private grant sources to obtain additional revenues to support the work of OMHHD.

3. The Governor's Office and the NC Department of Health and Human Services explore the issues around certification, credentialing, and licensing of foreign graduates and research what other states are doing to develop systems to enhance recruitment of bilingual and bicultural health, behavioral health, and human services providers.

    - Because of the immediate need for bilingual and bicultural mental health and substance abuse counselors, the NC Department of Health and Human Services should work with the NC Social Work licensure board, the NC Certification Board for Substance Abuse Counselors, and the Office of State Personnel to facilitate the certification, credentialing, licensure and employment of bilingual, bicultural social workers and substance abuse counselors.

- The General Assembly should appropriate funds to the University and Community College system to provide course work tailored to foreign graduates to assist them in preparing for certification, credentialing, and licensure in social work, substance abuse, nursing, and other allied health and human services professions to increase the recruitment of bilingual, bicultural providers.

4. The NC General Assembly appropriate funding to maintain and expand the AHEC Spanish Language and Cultural Training Initiative and the Office of Minority Health and Health Disparities interpreter training and cultural diversity training courses.

To expand the availability of health, behavioral health and dental services, the Task Force recommended that:

5. The NC Primary Health Care Association, in conjunction with the NC Office of Research, Demonstrations and Rural Health Development and other state agencies, encourage and assist communities in seeking new federal Community and Migrant Health funds to expand the availability of primary care, dental, and behavioral health services. The NC General Assembly should appropriate funds to Community and Migrant Health Centers (C/MHC) to be used to support the federal grants.

6. The NC General Assembly establish a health program that would address the health needs of uninsured, low-income Latinos who would otherwise qualify for public insurance, but who cannot because of federal immigration restrictions. Priority should be given to: coverage of children; prenatal care; and health conditions or diseases that are significant problems for Latino populations, as determined by the State Health Director.

To help remove barriers that deter families from applying for Medicaid, NC Health Choice, and other publicly-funded services, the Task Force recommended that:

7. The NC Division of Medical Assistance and Division of Social Services re-examine the Medicaid, NC Health Choice and other DSS applications, notices, and policies to make services more accessible to the Latino population.

    - As part of this effort, the NC Department of Health and Human Services should help train Latino service organizations and other organizations to assist applicants in filling out Medicaid, NC Health Choice, and other public assistance applications. Funding from private foundations would assist in supporting this work.

8. The NC Division of Medical Assistance explore methods to improve migrant families' access to Medicaid and NC Health Choice.

To ensure that migrant and seasonal farmworkers are covered by workers' compensation, the Task Force recommended that:

9. The NC General Assembly extend workers' compensation to agricultural workers if they work for an employer who employs three or more full-time workers at least 13 weeks in a year. The NC General Assembly should also change existing workers' compensation laws to give the Industrial Commission the right to impose monetary or other sanctions on workers' compensation carriers for a pattern or practice of bad faith denials.

    - The Industrial Commission should be directed to conduct an educational campaign, through the Latino media, partnering organizations and existing outreach sources and programs, to explain how the workers' compensation system works, who is covered, how to apply for benefits, and where to go for assistance.

To develop leadership within the Latino population to improve Latino health, the Task Force recommended that:

10. El Pueblo, in conjunction with AHEC and other organizations, create a Latino Health Institute dedicated to improving the health of North Carolina Latinos.

To address the problems of health literacy, including the lack of understanding of the US health system among many Latinos, the Task Force recommended that:

11. The NC Department of Health and Human Services take the lead in convening a group of organizations that have developed and implemented lay health advisor programs. This group will help coordinate and strengthen lay health advisor programs, develop training for lay health advisors, and provide technical assistance to other organizations seeking to implement similar programs. The group should help identify possible funding sources from North Carolina and national philanthropies, with priority given to communities and counties with a large concentration of Latino residents.

12. The NC Community College system (Adult Literacy) take positive steps to address the problems of low literacy, including health literacy, among its Latino population. There is a need for a statewide initiative to address this problem across all population groups (not limited to Latinos).

To ensure that the state has adequate data to monitor health disparities and health access of the Latinos living and working in the state, the Task Force recommended that:

13. The NC Department of Health and Human Services and other health, behavioral health, dental, and human services providers should collect health, behavioral health, dental, and social services-related data (including but not limited to utilization and health outcomes) by race and ethnicity to determine if Latinos are able to access needed health, behavioral health, dental, and social services, and whether there are specific health disparities facing the North Carolina Latino community.

1 Introduction

North Carolina has one of the fastest growing Latino populations in the country, with much of the growth among new immigrants. Latinos are less likely to have health insurance than other population groups, and are more likely to experience language barriers. The growing Latino population has created new health care challenges for the state. The number of Latinos has overwhelmed many public agencies, and the underlying issues of lack of insurance coverage, transportation, and translation have not been adequately addressed.

In the spring of 2001, the North Carolina Institute of Medicine (NC IOM) began to consider the feasibility of studying the health and health care issues affecting the state's growing Latino population. The Institute approached El Pueblo, Inc., about the possibility of creating a statewide Task Force to study these issues. El Pueblo is a non-profit statewide advocacy and policy organization dedicated to strengthening the Latino community. The NC Institute of Medicine, with the involvement and support of El Pueblo, the NC Area Health Education Centers Program, the NC Hospital Association, and other health-related organizations, approached The Duke Endowment and The Kate B. Reynolds Charitable Trust about the possibility of obtaining funding to support the work of such a Task Force. By late fall of 2001, the Institute received word from both philanthropies that support for the work of the Task Force would be forthcoming. Work was to begin in early 2002 with a final report ready in January 2003. The Institute of Medicine greatly appreciates the support and encouragement of The Duke Endowment and The Kate B. Reynolds Charitable Trust associated with this effort.

As discussed throughout the report, North Carolina has a Latino population largely comprised of recent immigrants, and therefore there have been limited opportunities to assess the health status of this group. Some initial studies and reports have been undertaken and published, but until the inception of the Task

Force, only one had attempted to analyze data and develop policy recommendations from a statewide perspective.[1] The work of this Task Force is a first, as it not only analyzes and considers existing research and assessments, but does so through a Task Force made up of a diverse and inclusive group.

Charge to the Task Force

Once the decision was reached to launch the Latino Health Task Force, NC IOM and El Pueblo arrived at a consensus specification of the charge to be addressed. It was agreed that the Task Force would undertake four specific functions:

1. To develop a consensus definition of the major health and health care problems facing the NC Latino community. The Task Force would be asked to study, among other things, access to publicly-funded health services (including public health clinics, rural community and migrant health centers, and the area mental health programs in the state), public and private health insurance coverage, cultural and language barriers, dental services, occupational health issues, and specific health problems that disproportionately affect Latinos.

2. To identify whether regional variations exist in the capacity of local communities to address Latino health issues.

3. To identify and disseminate "best practices" for meeting the health and health care needs of Latinos in North Carolina, e.g., local or statewide initiatives that have been successful in improving health for NC's Latino population.

4. To identify public and private sector initiatives that can be undertaken to address these concerns.

Membership of the Task Force

Members of the Latino Health Task Force were chosen for their special knowledge and expertise with regard to particular health or health care issues pertinent to the Latino population of our state. Among the members of the Task Force are persons representing the public and private health care sectors, state and local governmental health, behavioral health and human services agencies, legislators, Latino service and advocacy organizations, representatives of private industry, non-profits, and the faith-based community. The list of Task Force members is included in the front section of this report, beginning on page i. The Task Force met for full-day meetings once each month, beginning in April 2002.

Leadership and Staffing of the Task Force Effort

The First Lady of North Carolina, the Honorable Mary Easley, served as Honorary Chair of the Task Force and actively participated in the deliberations. Her involvement in this role helped underscore the importance of the issues being addressed by the Task Force, as well as enabling the Task Force to take advantage of her own technical knowledge of some of the issues pertinent to the health of Latinos in our state.

On a day-to-day basis, the operational co-chairs of the Task Force were Felix S. Sabates, Chairman of FSS Holdings in Charlotte, one of the state's most promi-

nent Latino business leaders, and the Honorable Carmen Hooker Odom, Secretary of the North Carolina Department of Health and Human Services. Although it was not possible for Mr. Sabates to attend every meeting of the Task Force, Secretary Hooker Odom was at each meeting and steered the group through its many subsets of issue exploration and analysis.

Primary staff direction for the work of the Task Force was the responsibility of Pam Silberman, JD, DrPH, Vice President of the NC Institute of Medicine, Gordon H. DeFriese, PhD, President and CEO of the NC Institute of Medicine, and Andrea Bazan-Manson, MSW, MPH, Executive Director of El Pueblo, a statewide Latino advocacy and public-policy organization based in Raleigh.

The Task Force was supported by a multi-disciplinary Steering Committee composed of key professional staff from several agencies of NC state government, the University of North Carolina at Chapel Hill, El Pueblo, the North Carolina Institute of Medicine, and statewide non-profits. The Steering Committee, whose members are listed in "Acknowledgments," met on a monthly basis about two weeks prior to the scheduled meetings of the full Task Force. The Steering Committee assumed responsibility for planning the Task Force meetings, arranging for speakers who presented key data and information pertinent to the issues being discussed, and helping organize the workgroups in which Task Force members had the opportunity to examine issues in greater detail.

Four workgroups met for several months at different times during the life of the Task Force. These workgroups were:

1. Systems of Care
2. Access to Care
3. Insurance and Workers' Compensation
4. Health Promotion and Health Literacy

The analyses undertaken by each of these workgroups constitute the materials presented in the principal chapters of this report.

Principles Guiding the Task Force Effort

Latinos are major contributors to the North Carolina economy. The Selig Center for Growth at the University of Georgia estimated that in 1999, Latinos contributed more than $2.3 billion in purchases in North Carolina.[2] East Carolina University estimated that Latinos who work in eastern North Carolina contributed at least $1.15 billion directly to the economy of 18 counties in eastern North Carolina, which in turn created 16,650 new jobs in 1998.[3] Indirectly, Latinos contributed $875 million to the economy, generating 20,358 jobs. Latinos move to North Carolina in order to work. Latino adults are more likely to be employed and in the workforce than any other population in the state. In fact, some industries actively recruit Latino workers from Mexico and other Central American countries. Latinos are often employed in the state's most hazardous industries--agriculture and construction--or are employed in low paying jobs that are less attractive to native North Carolinians. The Task Force recognized early in its deliberations the important contribution that Latinos make in

North Carolina, producing our foods, building our roads, working in the service industries—and the critical role that Latinos play in the state's economy.

At the outset of its efforts, the Latino Health Task Force reached clear consensus on some of the principles that would guide its work. The most important of these are:

- **Latinos residing in North Carolina are making a substantial contribution to the economic, social, and cultural enrichment of our state.** Regardless of their immigration status, the health and well-being of this population should be considered of vital importance to the present and future of North Carolina.

- **Language barriers that limit access to needed health, behavioral health, dental, or social services should no longer be acceptable in our state.** The most effective way to increase access to health, mental health, dental, and social services is to hire bilingual and bicultural providers who can provide appropriate services to both the English-speaking and Spanish-speaking populations. In the short term, it may be necessary to hire interpreters to bridge the language gap; but the goal should be to recruit and employ bilingual, bicultural staff. The additional costs incurred in hiring interpreters and/or bilingual staff need to be recognized and reimbursed.

  Inasmuch as federal law (Title VI of the Civil Rights Act) mandates that states take positive steps to assure that persons are not discriminated against on the basis of race, ethnicity or language, NC should seek to fully comply with guidelines of the US Office of Civil Rights pertaining to this legislation, not merely try to avoid a federal non-compliance judgment. Compliance is "the right thing to do" and we should seek to "serve" clients in a linguistically and culturally appropriate way.

- **Care should be compatible with patients' cultural health beliefs and practices.** Staff at health care organizations, including the leadership and governing board, should be diverse and representative of the community they serve. Staff at all levels should receive ongoing education and training in culturally appropriate service delivery.

- **Public and private health, behavioral health, dental, and social services providers, non-profits, foundations and churches can play an important role in meeting the health care needs of the growing Latino population in the state.** Private employers and industries that recruit Latinos from other countries have a special responsibility in ensuring that the health care needs of this vulnerable population are met while in their employment.

Organization of This Report

This report contains nine chapters. Chapters 2-4 offer important background information (demographics, cultural beliefs and health status of NC's Latino population) relevant to the discussion of health issues affecting the Latino population of our state. Chapters 5-8 present summaries of the key findings and recommendations emerging from the work of the four principal workgroups through which the detailed analyses of the Task Force took place. Chapter 9

includes a summary of the work of the Task Force, along with priority recommendations that could lead to a substantial improvement in the health status and health prospects for this important population in our state.

The fact that this is one of the first comprehensive examinations of the health status and unmet health needs of the Latino population across the state should not suggest that communities, government, health care providers, philanthropies, non-profit and faith-based organizations, and private industry have done nothing to address these needs. To the contrary, many efforts have occurred in the public and private sectors at both the state and local levels. Throughout this report we have tried to highlight some of the innovative and exemplary efforts, e.g., a listing of "best practices." These best practices are not exhaustive, but can serve as models for other groups seeking to address the health care needs of the growing Latino population.

Conclusion

In the context of these discussions, it has become clear that further steps beyond the work of the Task Force will be necessary. The problems identified, many of which are already apparent and pressing, will necessitate further public and private sector action and it would make sense to plan for the development of the organizational and collaborative efforts needed for those purposes now, even though the specific substantive foci of those efforts cannot be precisely defined.

We are certain that the North Carolina General Assembly, the state's leading private philanthropies, the business and industry community, and the many organizations now functioning to improve the health and welfare of North Carolina's Latino population will find in these recommendations many issues worthy of further discussion and debate. The North Carolina Institute of Medicine stands ready to assist in these deliberations. We hope that this report will lend some factual basis to the issues needing attention as well as partially illuminate the path forward as we all work toward the betterment of health for all North Carolinians.

Notes

1. Scharer J. Hispanic/Latino Health in North Carolina. NC Center for Public Policy Research, Raleigh, NC: August 1999.

2. Georgia Business and Economic Conditions. Volume 62, No. 2. www.selig.uga.edu Selig Center for Economic Growth (University of GA). North Carolina is expected to experience a 912% increase in Latino purchasing power between 1990 and 2002, the highest growth rate in the country.

3. Simpson MT, Brockett SR, Arena K, Hofmann E. Hispanic Economic Impact Study: An Eastern North Carolina Analysis. East Carolina University Regional Development Institute. Greenville NC: January 1999.

2 North Carolina Latinos[1]

Introduction

North Carolina has the fastest growing Latino population in the country. According to the US Census, the Latino population in North Carolina has grown 394%, from 76,726 in 1990 to 378,963 in 2000.[2] Latinos now make up 4.7% of the North Carolina population in comparison to 1.04% in 1990.[3] Other sources estimate the population to be even larger, with numbers closer to 530,328 in 2002.[4] In contrast, 12.5% of the US population is Latino. Census projections estimate that by 2050, Latinos will constitute roughly one fourth of the US population.[5] Most Latinos migrate to the United States for economic opportunities.[6]

Country of Origin and Citizenship

Most of the Latinos in North Carolina are of Mexican origin (65.1%).[7] Puerto Ricans (who are US citizens) comprise 8.2% of the North Carolina Latino population, and Cubans or Cuban-Americans are 1.9%. The remaining 24.8% are from other Central or South American countries, or other Hispanic categories. In contrast, Latinos in the United States are a little less likely to come from Mexico (58.5%). They are slightly more likely to be from Puerto Rico (9.6%), or Cuba (3.5%). A little more than one quarter (28.4%) of Latinos nationally are from other countries.

Nearly two-thirds of the North Carolina Latino population are foreign-born (64.2%) (Table 2:1). Almost all of North Carolina's foreign-born Latinos are non-citizens (58.3%); only 5.9% have been naturalized. In contrast, a little less than half of Latinos nationally (45.1%) are foreign born.[8] Of these, 13.6% have been naturalized, and 31.5% are non-citizens. People reside in the US under many immigration classifications. When we refer to 'non-citizens' we are referring to those who have not been naturalized as US citizens. However, citizenship is not required to live in this country legally. Millions of foreign nationals currently live legally in the United States without citizenship. They may hold student,

"Hispanic" or "Latino"?

Many terms are used to refer to the richly diverse Hispanic/Latino communities. No consensus has emerged among the Hispanic/Latino community on which term to use.

The government adopted the use of the term "Hispanic" in the 1970s, and the Census used that term in the 1980 and 1990 Census. Often, data that are reported by a government source use the term "Hispanic" to refer to the population, and many data systems collect data using that as an ethnic category.

The word 'Hispanic' is derived from España, or Spain. Opponents of its use state that Spanish conquistadores did away with much of the native cultures in Latin America. The word 'Latino' traces its roots back to ancient Rome and some say it's more inclusive of all Latin American countries such as Cuba, Puerto Rico, Mexico, and others.

The use of these terms has become, in some parts of the United States, a political, social or even a generational issue. A poll taken of Hispanics/Latinos in Texas, California and New

York by a national Hispanic magazine reported that most preferred to be called "Hispanic." (Hispanic Trends, 2000). Other terms commonly used include Chicano, Latin American, and Latin. Others prefer to use something that refers to the person's country of origin, as Mexican American, or Mexican national, Puerto Rican, etc.

In North Carolina, we are seeing a more regular use of the term "Latino" although both are still acceptable and widely used. In written documents, both terms are often used interchangeably. The Task Force chose to use the term Latino throughout the report.

tourist, or special work visas (such as J-1, H-1A, H-1B, H-2A). Thousands of 'non-citizens' serve in the US military. Many foreign nationals who live in this country for long periods of time never become naturalized citizens. Those that do become citizens may go through a process that can take years. As North Carolina has a more recent immigrant community, we have a larger proportion of non-citizens who are part of the population.

Presumably, because more of the Latinos in North Carolina are recent immigrants, they have greater language barriers than Latinos nationally. More than one third of the Latinos in North Carolina (34.0%) speak English poorly or not at all, and almost half of all Latinos in the state report not speaking English very well (Table 2:1). In comparison, 21.9% of Latinos nationally report being able to speak English poorly or not at all, and 36.3% report not speaking very well.[9]

Table 2:1
North Carolina Latinos Origin and Language

	North Carolina	United States
Foreign born	64.2%	45.1%
Non-citizens	(58.3%)	(31.5%)
Naturalized	(5.9%)	(13.6%)
Speak English poorly or not at all	34.0%	21.9%
Speak English less than very well	49.9%	36.3%

Source: US Census, 2000 Supplementary Survey Summary Tables PCT006, PCT020.

The Latino community is one of tremendous diversity. North Carolina Latinos come from many different geographic backgrounds. Some of them are united as an ethnic group by a common heritage derived from Spanish language and culture, while others share cultural heritages unique to their countries of origin. The commonalities and differences between Latin American subgroups are often debated; however, key traits that seem most often shared among Latinos include a connection with the Spanish language, strong family relationships and a strong family orientation. Recent Latino immigrants tend to have lower educational and occupational attainment compared to other Americans, and a strong connection with religion, particularly the Roman Catholic Church.

Key differences among the various Latino subgroups revolve around the circumstances of their immigration to the United States. Mexican Americans and Mexican nationals have the longest history in the United States, migrating most often due to economic considerations. Puerto Ricans, as citizens of the United States, have also had a long history of migration to the mainland, also coming most often for economic reasons. Better economic conditions in Puerto Rico have led to a more circular immigration pattern over the past two decades, with many Puerto Ricans returning to the island after immigrating to the United States. Cubans began coming to the United States in larger numbers after the Castro revolution. Unlike many migrations of Latinos to the United States, the migration of Cubans after the revolution included many upper class, highly educated Cubans seeking political asylum. Cuban Americans, as a result, tend to have higher educational attainment and socioeconomic status compared to other Latinos. Central and South Americans have the shortest history of migra-

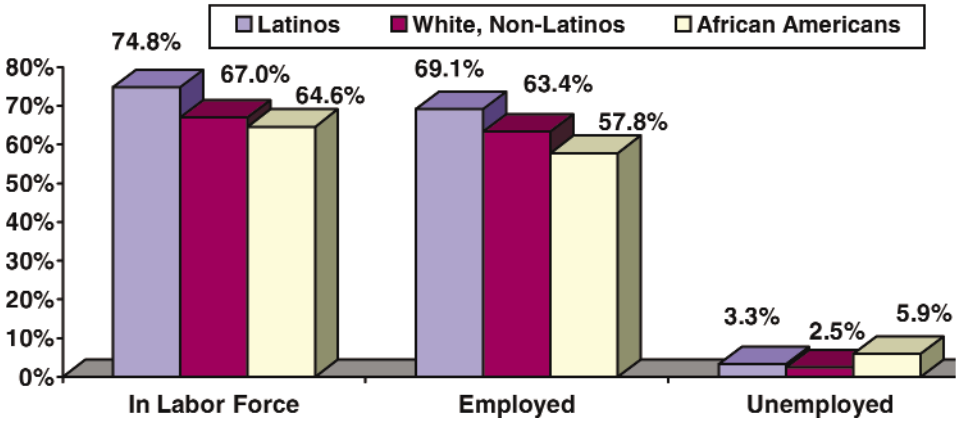
tion to the United States, coming in the largest numbers during the last two decades as a result of civil and economic unrest in their countries.

***Age*:** The growth of the North Carolina Latino population reflects both an increase in immigration and an increase in the number of Latino births. Latinos have a higher birth rate than do other population groups. The number of Latino births has increased more than seven-fold, from 1,752 in 1990 to 12,544 in 2000. Because of the recent immigration and high birth rates, North Carolina Latinos are younger than the general population. The median age of all people living in North Carolina is 35.3 years whereas the median age of Latinos is 24.[10] Nationally, the median age of Latinos is 25.8. Almost twice as many Latinos in North Carolina are under the age of five (12.1%) as compared to the North Carolina population in general (6.7%).[11] Similarly, 20.9% of North Carolina Latinos are under the age of 10 compared to only 13.7% in the general population.

Gender: Initially, male Latinos were the most likely to immigrate to North Carolina to work. However, over the past few years, entire families have immigrated herel, and some women have come alone to work in industries such as the seafood packing companies of the Coast.[12] Nevertheless, the North Carolina Latino population continues to be disproportionately male. Almost three fifths (59.8%) of North Carolina Latinos are male, compared to 49% of the North Carolina population as a whole, or 51.4% of all Latinos across the nation.[13]

Employment and Income: North Carolina Latino adults age 16 or older are more likely to be in the labor force (74.8%) and working or actively seeking work than are non-Latino whites or African Americans (Chart 2:1). North Carolina Latinos are also more likely to be employed (69.1%) than are other population groups in North Carolina, or than Latinos nationally.

Chart 2:1
Employment Status for the North Carolina Population 16 Years and Older (2000)

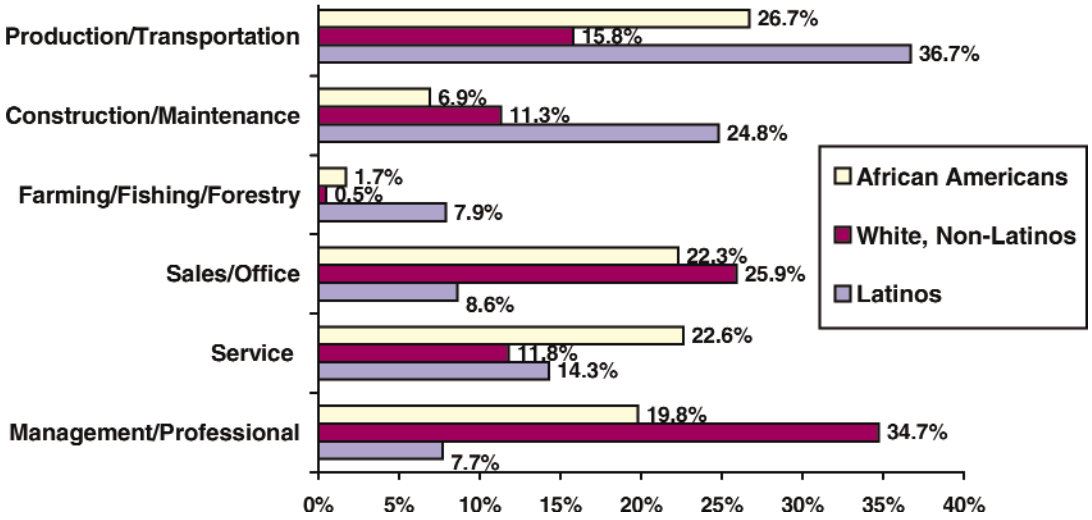


Source: US Census. Census 2000 Supplementary Survey Summary Tables (PCT048)

No longer composed mainly of migrant workers who come and go with the "picking" seasons, the Latino population is represented in most sectors, but tends to be concentrated in lower-paid, less-skilled jobs. They are far less likely

to be employed in management or professional occupations, and more likely to be employed in farming, construction, production, or transportation occupations. More than one third of all Latinos are employed in production, transportation, and material-moving occupations; approximately one fourth are employed in the construction, extraction and maintenance occupations (Chart 2:2).

Chart 2:2
Occupation for the Employed Civilian Population 16 Years and Older

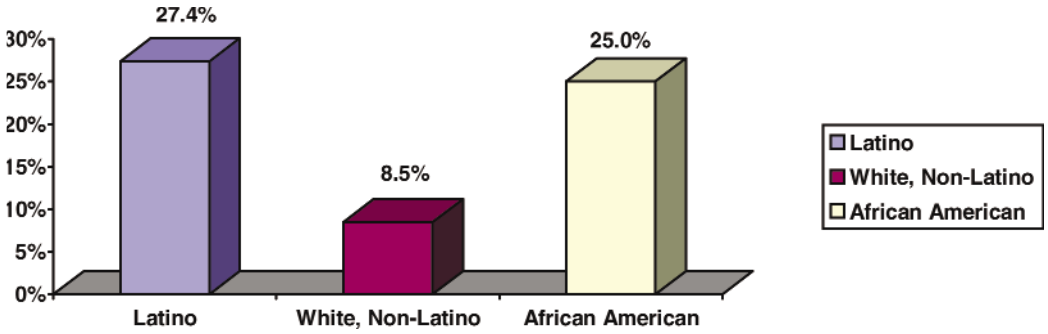


Source: US Census. Census 2000 Supplementary Survey Summary Tables (PCT049)

Almost one tenth of Latinos reported being employed in farming, fishing, or forestry in the 2000 Census. However, the actual number of Latinos employed in the agricultural industry is probably higher, as migrants who work in North Carolina may not be fully counted in North Carolina's Census numbers.[14] North Carolina is the fifth most populous farmworker state in the US, behind California, Texas, Washington, and Florida. Some experts suggest that there are more than 100,000 migrant and seasonal farmworkers working in North Carolina throughout the year. Of these, approximately 60,000 are Latinos.[15] In 2002, the NC Employment Security Commission (ESC) counted 108,900 migrant, seasonal, year-round and H-2A workers working in North Carolina fields.[16] Taking into account the limitations of these estimates, and including dependents, NC's farmworker population is estimated to be over 200,000.[17] The work of Latinos helps drive the state's economy. North Carolina's tobacco, greenhouse and nursery, vegetable and fruit industries rely heavily on the labor of farmworkers, producing more than $2.2 billion in sales.[18]

Although Latinos are more likely to be employed than other racial or ethnic groups, they are also the most likely to live in poverty; i.e., they have family incomes below the federal poverty guidelines ($18,100/year for a family of four in 2002). While Latinos comprise only 4.7% of the state's population, they comprise 10.4% of all poor people in the state. More than one quarter of North Carolina Latinos live in poverty (27.4%), which is slightly higher than African Americans and much higher than non-Latino whites (Chart 2:3).

Chart 2:3
Percentage of North Carolina Population that Lives in Poverty

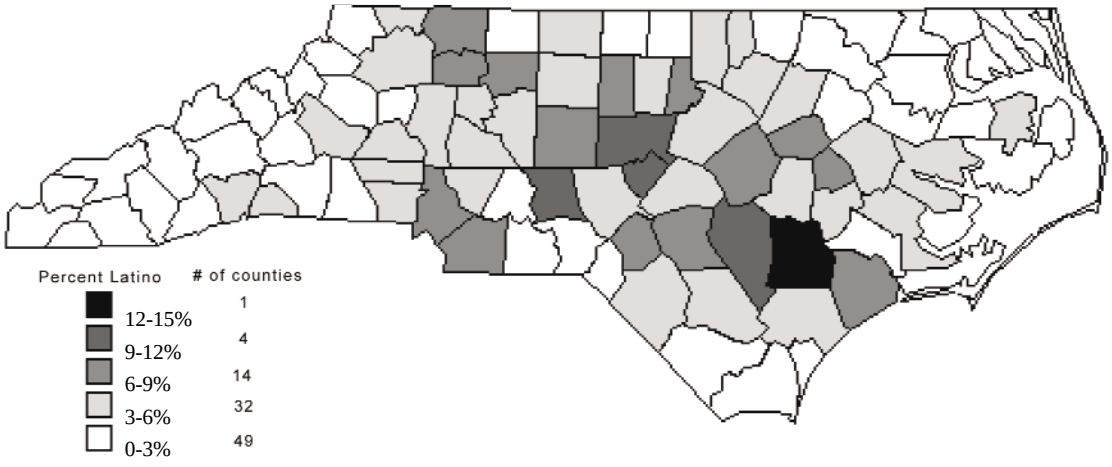


Source: US Census. Census 2000 Supplementary Survey Summary Tables. Poverty Status in the Past 12 Months by Age (P114, P115)

The median family income for Latinos in 1999 was $30,529—similar to that of African Americans ($31,951), but much less than that of non-Latino whites ($51,364).[19] Approximately one out of every ten North Carolina Latino families (10.5%) had incomes less than $10,000 year, compared to 13.4% of African-American families, and 3.6% of non-Latino, white families.[20] Approximately 30% of both North Carolina Latino (29.4%) and African-American (30.3%) families had incomes below $20,000/year, compared to only 11.5% of non-Latino, white families.

Latinos are present in all of North Carolina counties; however, they tend to be concentrated in the Eastern, metro, and military areas of the state (Map 2:1). The presence of Latinos in smaller counties is significant. Indeed, five counties in NC have a reported Latino population of 9% or higher; and another 14 counties have a Latino population of 6% or higher.[21]

Map 2:1
North Carolina Latinos as a Percent of Total County Population, 2000



Source: US Census, 2000. Produced by the Cecil G. Sheps Center for Health Services Research, UNC-CH

Notes

1. Caroline Wang, Steve Keir, and Patrick Link contributed to the research and writing for this section.
2. United States Census Bureau. Hispanic or Latino Origin: All Races. Mapping Census 2000: The Geography of US Diversity. December 7, 2001. Web site. http://www.census.gov/population/www/cen2000/dt_atlas.html (accessed July 18, 2002).
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dependents are calculated into the ESC figure. North Carolina farmworker advocates suggest that there are between 150,000-300,000 migrant and seasonal farmworkers and their dependents in North Carolina. The number of farmworkers and their dependents is derived from the total number of farmworkers minus H-2A workers (since they are unaccompanied), times 1.8 (for dependents). Triantifillou S. NC Primary Health Care Association. Personal Communication. January 2, 2003.

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3 Cultural Factors and the Health of North Carolina Latinos[1]

Introduction

The term "Latino" describes a diverse population whose individual members share some cultural and linguistic similarities. As outlined in the previous chapter, North Carolina's Latino population includes people who differ according to country of origin and experiences, level of education, socioeconomic and immigration status, length of time in the United States, knowledge of English, and rural or urban residence. Therefore, it is difficult to accurately or comprehensively describe a single set of cultural beliefs that applies to all Latinos in North Carolina. It is not the Task Force's intention to generate this type of menu-like list of values and beliefs. Instead, it is our goal to highlight some characteristics common to many Latinos that can affect health, use of the health care system, and expectations of the health system and providers. The Task Force recognizes these characteristics as important for understanding the Latino population and vital to the development of culturally appropriate services.

Health Systems in Other Countries

Persons coming from other countries are accustomed to different systems of health care. Common occurrences within the US health care system, such as co-pays for doctor visits and prescriptions for certain medications, may not exist in a Latino person's country of origin. Options may exist in other countries that do not exist here. For example, health benefits in other countries may offer coverage of an employee's children and parents.[2] The services offered, their availability, and the party who pays for the services vary from country to country. Therefore, recent immigrants may have certain expectations regarding the health care they will receive in the United States. Whether they expect more or less than they actually receive, these expectations affect the manner and frequency with which Latinos access health care services.

Previous health care experiences from other countries can affect health-seeking behaviors and present barriers to health care in the United States. For instance,

injections are commonly used to treat a wide variety of infections and other illnesses in Mexico and other countries. Many Latinos are not accustomed to a health care system that requires a prescription for medication or requires a doctor's visit to get a prescription. A patient may feel more comfortable seeking out immediate treatment with vitamins and medicines that are familiar to the patient from a trusted community source.

In North Carolina, some studies have been conducted about where Latinos seek alternative treatments. Reports of patients arriving at the emergency room with non-prescribed antibiotics, steroids, and other medications are not uncommon. There have also been complaints filed in several North Carolina counties against local food stores known as *tienda*s, for selling medications improperly.[3] Some of these stores may also sell natural medicines, different types of injections, and other unregulated treatments. Little to no information exists on the extent to which North Carolina Latinos are purchasing unregulated treatments from *tiendas* or other sources. It may be said with some confidence, however, that a portion of the Latino population relies on products sold in *tienda*s for treatment of their medical problems either exclusively or in combination with medical care from mainstream providers. Some *tienda* owners in the United States have assumed the role the pharmacy plays in their home countries (*farmacias, boticas, boticarios*). Unregulated products and the provision of health counseling and injections is offered as part of their regular business. Because *tienda*s contribute to the ways in which Latinos in NC access health care, this is an important and nearly untapped opportunity for health education.

In addition, many Latinos in North Carolina seek information or guidance about health and family-related concerns from their churches before getting treatment or advice from a US health care professional. Across the state, many churches, Catholic and other denominations, serve as an important source of spiritual and other support for the Latino community through Spanish-language masses, community outreach, assistance with food, clothing, and other needs. Churches can also play an important role in bridging the cultural and information gap, and providing needed health education for new Latino immigrants. Lay health advisors (as described more fully in Chapter 8) are another trusted source of health and health care information who can facilitate access to care and understanding of health and illness symptoms.

Traditional and Folk Medicine

Information about the North Carolina Latino population's use of traditional and folk medicine is limited. The reliance on traditional healers has been shown to be more common among immigrant segments of the Latino population than in more acculturated Latino groups. It is beyond the scope of this chapter to describe the variety of folk medical treatments and folk beliefs existing across Latino subcultures. Nevertheless, recognizing folk medicine as an important health practice among some Latinos can facilitate culturally appropriate implementation of Task Force recommendations.[4]

The National Council of La Raza's "Latino Health Beliefs: A Guide for Health Care Professionals" outlines some general characteristics of Latinos' use of traditional and folk medicine. The way in which illness causation is viewed varies

considerably among Latinos. Certain traditional Latino folk beliefs give emphasis to understanding illness as a result of an imbalance between hot and cold and the impact of natural forces on the body (e.g., air, food and/or heat, and the existence of supernatural forces such as spirits). Because of the influence of certain cultural beliefs and practices, many Latinos may simultaneously seek the help of both formal medical care and folk healers for either acute or chronic conditions. Commonly used folk healers include c*uranderos, yerberos* (herbalists, who use these ingredients to both treat and prevent illnesses), and *sobadores* (masseuses, who use massage to correct imbalances in muscles and the skeletal system). These practitioners often charge no fees and employ teas, prayers, and rituals to correct imbalances. Generally, they will not treat those with serious or incurable diseases.

There is a strong belief in many Latin American cultures in natural forces, with the three most important being the Sun, the Moon, and the Earth. Belief in the power of these "gods" explains beliefs such as the expectation that exposure of the pregnant woman to an eclipse can cause cleft lip or palate in the newborn. The ancient Aztec practice of placing a knife on the woman's abdomen before she went out at night to protect her unborn baby, has led to the current practice of placing a key or safety pin on one's clothing during pregnancy.

Finally, in addition to the Western-recognized illness and health conditions diagnosed and treated by US health care practitioners, Latino cultures often recognize and define additional maladies, including *susto* (fright), *empacho* (blocked intestine), *mal de ojo* (evil eye), *caída de mollera* (fallen fontanel of an infant), *antojos* (cravings), or *cuarentena* (forty days following childbirth where certain dietary activities and restrictions are observed to allow for the mother's recovery).

Important Latino Cultural Beliefs

The Task Force considered and discussed the importance of cultural orientation and interpersonal behavior in the provision of health care. Health care providers should be aware of the potential impact of certain cultural characteristics found within the Latino community (see Access to Care chapter), but policy makers must also familiarize themselves with certain cultural traits. The following information about cultural beliefs of some Latinos relevant to health care has been adapted from "Latino Health Beliefs: A Guide for Health Care Professionals" (National Council of La Raza, 1998):[5]

- ***Respeto*** ("Respect"): In general, Latinos place a high value on interpersonal relationships. *Respeto* refers to a quality of self that must be presented in all interpersonal relationships.[6] It signifies attention to proper and moral behavior and indicates an expression of deference to the person one confronts. Deferential behavior toward others is determined on the basis of sex, social position, economic status, and position of authority. Latino clients respect health care providers as authority figures. The doctor merits great respect and this may cause Latino clients to be hesitant to question a health care provider or disagree with a plan of care. Clients may state they "understand" the medical regiment when they do not because they do not want to hurt the provider's feelings. In addition, Latino clients may seek help from a

different professional if their symptoms do not subside, so as to avoid hurting the feelings of the first. *Respeto* incorporates diplomacy and tactfulness and discourages confrontation.[7]

- ***Confianza*** ("Trust"): Trust is an important cultural value tied closely with respect. Trust is built on mutual respect over time. It may take an extended period of time with the same provider to develop the trust necessary for a client to accept health-related advice. Latinos often feel that US health care professionals are insensitive to feelings of shame, embarrassment, and discomfort associated with disrobing, being attended by a professional of the opposite gender, or having tests and procedures that invade personal privacy.[8]

- ***Familismo*** ("Family"): Latinos place a great deal of importance on the family as the primary social unit and source of support for individuals. Help and advice are usually sought from within the family system first, and important decisions are made as a group. For this reason, medical conditions and medical treatment are considered a family matter, and not solely the business of the individual. This network of support may include the nuclear family or may include much of the extended family and even unrelated persons from one's hometown.[9]

- ***Machismo/Marianismo***: While traditionally the Latino male has been acknowledged as the authority figure in the family, contemporary research suggests that gender roles in Latino families are changing.[10] Women are still considered the center of the family and are still in charge of the family's health.[11] Both the traditional family roles and new gender roles taken on within the Latino family may affect the way Latinos seek health care.

- ***Fatalismo*** ("Fatalism"): Traditionally, many Latinos classify illness as either "natural" or "unnatural."[12] Natural illness is thought to be caused by God's will or fate, while unnatural illnesses originate from evil done to one by another. In either case, the person feels that control over what has happened and what will happen has an external locus, and hence is wholly out of his or her hands. This leads to a fatalistic view of life and death; the individual perceives little personal ability or responsibility for success or failure in matters of health and illness. There is very little or nothing a person can do to prevent or survive disease. Delays in seeking medical attention for cancer symptoms and higher rates of advanced disease at the time of diagnosis are thought to be associated with these cultural beliefs.

- **Time Orientation**: Latinos are generally more concerned with the present than with the future. Priority is given to current activities rather than planning ahead. Thus, being late for an appointment is not due to lack of respect or reluctance, but to priority and concern over current activity or personal interaction. This "present-time" orientation and approach to time and its management is inconsistent with the way time is viewed in US health care and business operations.

Acculturation

Acculturation is defined as the process in which a person's traditional cultural beliefs are replaced by those of the mainstream community where he or she lives. It is important to note that acculturation and health are closely associated. Latinos in North Carolina, as fairly recent arrivals, have many different cultural beliefs, but also many protective health factors. As will be seen in later chapters, recent Latino immigrants have better health outcomes on a variety of measures. Strong family support systems, coupled with low rates of smoking and traditional diets that emphasize vegetables and grains rather than high-fat foods may explain, at least in part, why recent immigrants as a group are healthy. Some of these protective factors disappear as Latinos acculturate to the lifestyle in the United States.

Conclusion

When making and implementing health policy for Latinos, we must design strategies to bridge the cultural gap that may exist between patients and providers so that common goals can be achieved. Health policies should capitalize on the cultural strengths of the Latino community. Among them are:

- *Familismo* - Emphasis on family as primary social unit and source of support
- Importance of children
- Respect in social relationships, which dictates the appropriate deferential behavior toward others based on age, socioeconomic position, gender, authority status
- *Simpatía* - A pattern of social interaction and verbal communication based on a common desire to have a warm and pleasurable social relationship
- Traditionally prescribed gender roles
- *Personalismo* - importance of personal contact, identification with individuals but not institutions
- Strong religious belief systems
- Present orientation and action orientation

The recommendations of the Latino Health Task Force were developed through careful consideration of these and other cultural characteristics found within the diverse North Carolina Latino community. With the implementation of our recommendations, it will be critical to continue to recognize cultural differences and similarities that will foster the success of new policies and system changes.

Notes

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General Health of Latinos 4

Introduction

Assessing the overall health of the Latino population is difficult for several reasons. Latinos are from different countries or regions with different subcultures, which makes it difficult to generalize findings from one group to another. In addition, there is a general lack of health data specific to North Carolina Latinos. In the past, health data were not collected by race/ethnicity. More recently, some agencies and programs have begun to collect this information, but it is difficult to establish baseline data, or to make accurate comparisons across different Latino subcultures. National research that may have collected race and ethnicity data may not always be accurate, as the research instruments have not always been validated for use in the Latino populations. Some survey data are collected only in English, which has the effect of excluding immigrants with limited English proficiency (typically recent immigrants) from the study results. Most research in the past has been concentrated in a couple of states with historically large Latino populations (such as California and Texas), which may or may not reflect the health status of North Carolina Latinos. For these reasons, it is impossible to get a truly accurate understanding of all aspects of Latino health in North Carolina. Because of the lack of comprehensive state-level data that could be used to analyze the health and health risks of North Carolina Latinos, the Task Force recommended that:

1. **The NC Department of Health and Human Services and other health, behavioral health, dental, and human services providers collect health, behavioral health, dental, and social services related data (including but not limited to utilization and health outcomes) by race and ethnicity, to determine if Latinos are able to access needed health, behavioral health, dental, and social services and whether there are specific health disparities facing the Latino community.**

Though comprehensive, state-level Latino health data are not always available, the Task Force members thought it important to review the data that do exist in order to gain better understanding of the health of North Carolina Latinos.

In general, Latinos in the state are relatively healthy. This may be due, in part, to the fact that Latinos are a younger population than the state as a whole. North Carolina Latinos are also likely to be recent immigrants, and studies have shown that first generation immigrants may be healthier, based in part on some protective factors (such as healthier diets and reduced incidence of smoking), and selection bias; that is, only the healthiest individuals successfully migrate because of the difficulties associated with migration.

Despite their overall positive health status, there are some data that show that Latinos are disproportionately more likely to have certain health problems or to lack access to health services. Furthermore, many health issues disproportionately affecting Latinos are preventable. The following data describe the health status of North Carolina Latinos and highlight differences found among Latino populations versus other North Carolinians in the areas of pregnancies and births, immunizations, general health of children, general health status of adults, oral health, behavioral health (mental health and substance abuse), developmental disabilities, occupational injuries, and violence. National data are presented when North Carolina specific data are not available.

Pregnancies and Births[1]

Latinas of all ages have a higher pregnancy rate[2] than other North Carolina women (Table 4:1). The high pregnancy rate among young Latinas may be partially explained by higher marriage rates. Pregnant Latinas ages 15-17 are 62% more likely to be married than whites (29.7% compared to 18.3% respectively). However, most pregnancies to young women ages 15-19, including Latinas, are to unmarried women. At older ages (20-44), pregnant whites are more likely to be married than Latinas (77.0% compared to 58.8%), but still have lower pregnancy rates than Latinas.

Table 4:1
Pregnancy Rates for Women of Different Ages per 1,000 Females (2000)

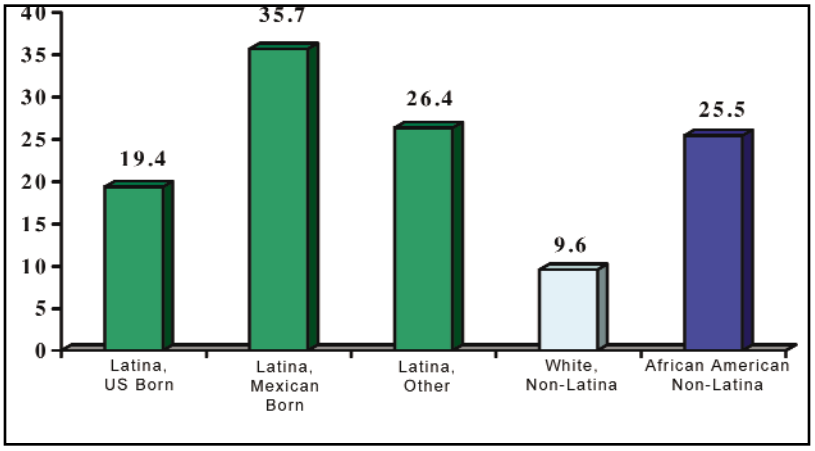
	15-17 years old	18-19 years old	20-44 years old
Latinas	104.5	216.2	160.8
Whites	36.4	108.6	81.9
African-Americans	68.6	159.5	92.0

Source: State Center for Health Statistics. Vital Records. (2000).

Latinas are less likely to have prenatal care initiated during the first trimester, as is generally recommended by health experts (Chart 4:1). Paradoxically, having less prenatal care does not translate into poorer birth outcomes for the Latina population. Infants born to Latinas in North Carolina are relatively healthy. Between 1996-2000, the Latino infant mortality rate was approximately 6 deaths per 1,000 live births; a rate comparable to whites (6.6), and much lower than African Americans (15.0). Latinas are less likely to have low birthweight (LBW)

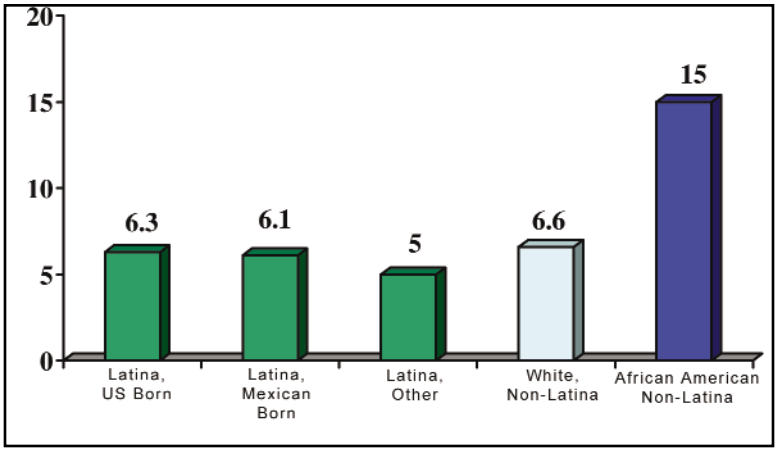
babies (Chart 4:2), which may partially explain why they have these positive birth outcomes. Between 1996-2000, 6.2% of babies born to Latinas in NC were classified as LBW, compared with 7.2% for whites and 13.8% for African Americans. These differences are consistent with national data, which document relatively low use of prenatal care and low incidence of LBW and very low birth weight (VLBW).[3]

Chart 4:1
Percent of North Carolina Women Who Started Prenatal Care After the First Trimester (1996-2000)



Source: Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002. Analysis of Birth and Infant Death Records (1996-2000).

Chart 4:2
Infant Deaths Per 1,000 Live Births (1996-2000)



Source: Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002. Analysis of Birth and Infant Death Records (1996-2000).

No one fully understands why Latina immigrants have such positive birth outcomes (often called "the Mexican Paradox"). Latinas, especially recent immigrants and those coming from Mexico, are less likely to have prenatal care, more likely to live in poverty, and less likely to report using a multivitamin with folic acid every day before pregnancy, but they are also less likely to engage in the

unhealthy behaviors that are associated with low birthweight babies, such as smoking or drinking during pregnancy (Table 4:2). Unfortunately, these desirable birth outcomes do not persist as the Latinas acculturate to the United States, possibly because of changes in smoking and dietary intake.[4]

Table 4:2
Pregnancy Data (1996-2000)

	Latina, US Born	Latina, Mexican Born	Latina, Born Elsewhere	Latina, Total	White, Non-Latina	African-American Non-Latina
Live Birth Certificates by Place of Birth of Mother (1996-2000)41						
Started prenatal care after 1st trimester	19.4	35.7	26.4	31.9	9.6	25.5
Percent low birthweight (less than 2,500 grams)	7.1	6.0	6.1	6.2	7.2	13.8
Percent who smoked during pregnancy	7.8	0.6	1.7	1.9	17.8	11.1
Infant deaths per 1,000 live births	6.3	6.1	5.0	6.0	6.6	15
Number of live births	6,395	28,029	8,358	42,782	354,130	139,944
Pregnancy Risk Assessment Monitoring System (July 1997-December 2000)42						
Unintended pregnancy				37.5	37.1	67.5
Breastfed				82.9	62.8	38.0
Smoked last three months of pregnancy				2.3	18.2	8.0
Tested for HIV				87.1	75.0	88.5
Income less than $14,000				63.1	18.5	45.1
Using birth control when got pregnant				46.6	43.2	40.8
Took multivitamin/ folic acid every day before pregnancy				17.2	29.4	15.5

Source: Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002. Analysis of Birth and Infant Death Records (1996-2000).

Currently, pregnancy outcomes among Latinas in the state are positive, but the state cannot afford to be complacent. Puerto Rican women have been shown to have poor birth outcomes, so the paradox may not apply generally to all Latinas. As Latinas acculturate, the infant mortality rate is likely to increase. In addition, Latino children are more likely to be born with certain birth defects (as discussed later in the section on developmental disabilities).

Further, we know very little about the birth outcomes of migrant farmworkers in North Carolina. Nationally, studies suggest that migrant farmworker women have poorer birth outcomes: the infant mortality rate for farmworkers is 25-30% higher than the national average.[7] This has been attributed to hazardous working and living conditions, and frequent mobility that makes it difficult to access

prenatal care. Pregnant women who work in the field may be exposed to pesticides as well as other hazardous conditions.

Immunizations[8]

Immunizations have long been recognized as one of the greatest public health successes of our lifetime. Yet there are still pockets of the North Carolina population that are under-immunized, leading to preventable illnesses, disabilities, and deaths. The Immunization Branch of the Department of Health and Human Services recently completed a study to look at the immunization rates among different racial and ethnic groups in different geographic areas of the state. The state surveyed kindergarten students in 81 schools across North Carolina, obtaining data from the student's health records to determine the percentage of students who had up-to-date immunizations for the 4-3-1 series by 24 months of age (4 DTaP,[9] 3 Polio, 1 MMR[10])(Table 4:3). Prior to this, the state had little information to determine whether there were racial or ethnic disparities in immunization status.[11]

The Immunization Branch found that Latino children were less likely to have had their 4-3-1 immunization series at 24 months (Table 4:3).

Table 4:3
Point Estimates of 4-3-1 Coverage Rates by Race and Ethnicity

Race or Ethnicity	Percent With Up-To-Date Immunizations at 24 Months	Confidence Intervals α= .01
White	80%	77%-83%
African American	71%	66%-76%
American Indian	73%	60%-86%
Asian	69%	54%-84%
Latino/Latino	64%	55%-73%

Source: Saldana K. Immunization Branch. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002.

There was little difference in immunization rates in different geographic areas of the state. Private providers had slightly higher immunization rates (78%) than public clinics (70%).

While the data show that Latinos have the lowest immunization rates among different racial and ethnic groups, there is no information to know whether the Latino children in the survey arrived in the United States before or after turning 24 months of age. Also, the kindergarten survey was conducted in 2001, which means that it was approximately 1997 at the time that this cohort of students was 24 months old. Since that time, the state has initiated special outreach efforts to immunize Latino children (See Chapter 5).

Providing immunizations to adults, especially those who immigrated from other countries, is equally important. Outbreaks of preventable, communicable diseases have occurred in North Carolina when children and adults were not fully immunized. The 1996 rubella outbreak among Latinos that included Chatham County is a case in point. Rubella immunization programs are in their infancy or not fully accessible to everyone in many foreign countries, and there-

fore many immigrants are inadequately protected when they arrive in the United States. From 1996 to 2000, 24% (293) of all reported rubella cases nationally were from North Carolina. In 2000 alone, North Carolina had 51% of all cases.[12] Although most young children and adults suffer few problems when they contract rubella, a pregnant woman who is non-immune and contracts the disease can create significant health problems for the fetus. Congenital rubella syndrome (CRS) can result in miscarriage, stillbirth, cataracts, hearing impairment, cardiac anomalies, and developmental delay. Nationally, more than three quarters of rubella cases were among Latinos.[13]

The state has initiated an immunization outreach campaign to target Latino children, but more may be needed to ensure that both children and adults receive their necessary immunizations. Without these immunizations, the health of both the Latinos and the general population is at risk.

General Health Status of Children

There are few data available to determine the overall health status of North Carolina Latino youth. Nationally, Latino children are more likely to be obese, have diabetes mellitus and asthma, and live in areas with environmental hazards.[14] However, comparable data are not collected in North Carolina. The only data available that can give a glimpse into the health status of North Carolina Latino youth are from the Youth Risk Behavior Survey, a survey that was last conducted in a representative sample of high schools and middle schools in 2001. The data are self-reported, thus some negative health behaviors may be under-reported. In addition, the data for Latino youth reflected in the survey may not represent all Latino youth because Latinos are more likely to drop out of school, and the students who drop out may be more likely to be at risk.[15] We expect that out-of-school youth will be more at risk than in-school youth for many health problems. Thus, school-based studies may significantly underestimate the need for health prevention, education, and treatment among Latino youth.

According to the Youth Risk Behavior Survey, Latino high school students are more likely to rate their health status and quality of life as poor than either whites or African American high school students. Middle school Latinos are also more likely to rate their quality of life as poor, but not as likely to rank their health status as poor (Table 4:4). Both Latino high school and middle school students are less likely to report going to a doctor for regular preventive services.

Latino youth demonstrate some unhealthy lifestyle habits, but do not appear to be at consistently greater risk than white or African-American youth. Latino youth in middle school are less likely to report using tobacco and more likely to report being threatened and being in fear of going to school than whites (See Appendix B for more complete Youth Risk Behavior Survey findings). They are also less likely to report engaging in vigorous physical activity. About one quarter of Latino children in middle school report themselves as slightly or very overweight.

Table 4:4
North Carolina Middle School Survey (2001)

	Latino	White	African American
Diet and Physical Fitness			
Describe self as slightly or very overweight	25.7	26.4	24.0
Trying to lose weight	45.6	41.2	39.6
Exercised or participated in physical activities for at least 20 minutes that made them sweat and breathe hard on three or more of the past seven days	67.2	79.5	67.9
Self-Perceived Health Status and Use of Health Services			
Rate health status as poor	2.2	1.7	2.6
Rate quality of life as poor	6.9	2.6	3.0
Consider themselves to have a disability	15.3	11.4	10.2
Limited activities in any way because of impairment or health problem	11.0	11.6	13.9
Saw a doctor or health care provider for a check-up or physical exam when not sick or injured in last 12 months	48.3	61.4	51.8
Violence			
Carried a weapon on school property in past 30 days	8.3	3.8	6.4
Did not go to school because felt unsafe at school or on way to or from school in past 30 days	11.2	6.6	11.0
Use of Tobacco			
Smoked cigarettes on one or more days in past 30 days	9.7	12.9	9.4

Source: NC Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina Middle School Survey. Summary Tables.

Latino high school students are less likely to report being overweight and more likely to eat five or more fruits and vegetables than either African-American or white high school students (Table 4:5). However, they are more likely to report their health status and quality of life as poor. They are more likely than whites, but less likely than African Americans, to report a sedentary lifestyle, but are less likely than whites to have smoked a cigarette in the last 30 days. Self-reported data show 26.5% of Latino high school students reported smoking cigarettes on one or more days in the past 30 days, compared to 19.2% of African-American students and 31.9% of white students. Nationally, tobacco use increases the longer a Latino youth lives in the United States and becomes "acculturated."[16]

Table 4:5
North Carolina High School Survey (2001)

	Latino	White	African American
Diet and Physical Fitness			
At risk of overweight*	14.4	12.6	17.8
Overweight**	9.1	11.9	15.5
Ate five or more servings of fruits and vegetables per day during past seven days	20.5	17.2	18.9
No vigorous or moderate physical activity during the past seven days	9.6	8.4	15.4
Self-Perceived Health Status and Use of Health Services			
Rate health status as poor	10.4	3.1	4.4
Rate quality of life as poor	10.2	3.3	5.2
Consider themselves to have a disability	17.4	15.0	11.2
Limited activities in any way because of impairment or health problem	8.2	8.3	6.7
Saw a doctor or health care provider for a check-up or physical exam when not sick or injured in last 12 months	53.8	60.2	62.4
Violence			
Carried a weapon such as gun, knife, club on one or more of past 30 days	20.6	20.2	13.4
Hurt in physical fight and had to be treated by nurse or doctor	8.4	10.4	10.1
Use of Tobacco			
Smoked cigarettes on one or more days in past 30 days	26.5	31.9	19.2

Source: NC Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina High School Survey. Summary Tables. *Students who were at or above the 85th percentile but below the 95th percentile for body mass index by age and sex based on reference data from the National Health and Nutrition Examination Survey. ** Students who were at or above the 95th percentile for body mass index by age and sex based on reference data from the National Health and Nutrition Examination Survey.

Unlike most recent adult immigrants, who generally have a better health status than their American counterparts, Latino youth appear to have adopted many of the same health behaviors as other white and/or African-American youth. This may lead to higher morbidity and chronic illnesses as these children age.

Migrant children may have particular health problems that are not reflected in these statewide data. Nationally, data suggest that children of migrant farmworkers harbor infectious diseases such as malaria, amebiasis, and other parasitic diseases, congenital syphilis, and leprosy.[17] The rate of tuberculosis (TB) among children of migrant workers is not known, but many experts think it is likely to be 20-25 times higher than the national average because children may be infected by an adult in the household who has a higher incidence of TB. Because migrant farmworkers are considered to be at increased risk, the

American Academy of Pediatrics recommends skin testing for this group at the time of immigration, and every two to three years thereafter.[18] The diets of migrant preschool children in North Carolina have also been found to be deficient.[19] Comparisons of the health status of migrant children and children from the general population on the east coast showed that migrant children are almost three times more likely to be reported in fair or poor health.[20]

General Health Status of Adults[21]

Overall, Latino adults appear to be relatively healthy in North Carolina. For example, Latino adults are less likely to report being in fair or poor health (11.3%), as compared to non-Latino whites (15.8%) or non-Latino African Americans (20.9%).[22] Latinos also have lower age-adjusted death rates than whites or African Americans (Table 4:6). They are less likely to die from cancer, diabetes, heart disease, stroke, pneumonia and influenza, chronic lung or liver disease, septicemia, nephritis, suicide, or other injuries than either whites or African Americans, but are more likely to die from motor vehicle crashes (See Appendix A, Table A:2). Latinos are also more likely to die from AIDS and homicides than whites, although less likely than African Americans. (See Appendix A, Table A:2).

Table 4:6
Number of Deaths and Age-adjusted Death Rates by Ethnicity and Race Among North Carolina Residents, 1999-2000 (Deaths per 100,000 Population)[23]

	Latino		White		African American	
	Number	Rate	Number	Rate	Number	Rate
All causes (per 1,000)	1,089	5.9	108,392	8.9	30,980	11.9
Cancer	112	76.3	24,682	197.0	6,494	250.8
Diabetes	23	17.5	2,596	20.9	1,458	57.0
Heart disease	125	99.4	30,494	251.6	7,887	312.5
Stroke	37	31.0	8,684	72.8	2,509	101.3
Pneumonia & Influenza	12	9.9	3,115	26.4	658	26.5
Chronic lung disease	10	7.2	6,392	51.5	833	33.3
Chronic liver disease	9	4.6	1,157	9.2	329	11.3
Septicemia	8	5.5	1,391	11.5	640	25.5
Nephritis	7	4.8	1,537	12.7	877	34.9
Suicide	29	4.1	1,612	13.4	189	5.4
AIDS	18	3.7	201	1.7	716	21.6
Homicides	122	17	564	4.8	669	18.7
Motor vehicle injuries	242	30.7	2,338	19.9	713	21.4
Other injuries	84	12.6	2,700	22.7	763	26.2

Source: Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002. Analysis of Death Certificate Data (1999-2000).

While Latinos are generally less likely to have the chronic conditions that lead to premature deaths, they are more likely than whites but less likely than African Americans to have certain sexually transmitted diseases (STDs) (Table 4:7).

Table 4:7
Rate of Sexually Transmitted Diseases Per 100,000 (2001)

	Latino	White	African American	American Indian	Asian
Primary & Secondary Syphilis	3.7	1.2	18.1	60.8	0.9
Early Syphilis	13.2	2.7	37.4	101.7	0.9
Congenital Syphilis	NA	36.8	52.6	NA	NA
Gonorrhea	90.8	38.0	804.9	110.1	192.9
Chlamydia	389.2	99.7	837.2	261.2	185.2
HIV/AIDS	16.4	6.3	66.5	17.8	8.7

Source: HIV/STD Prevention and Care Branch. North Carolina: 2001 STD Surveillance Report. NC Department of Health and Human Services, Division of Public Health. NA: Because of the small number of cases with congenital syphilis, the state only reports data for "other," which includes American Indians, Asian and Hispanic/Latino. In 2001, the rate of congenital syphilis for the "other" category was 10.5.

There are a number of factors that may explain why Latino adults are generally healthier than other groups. First-generation immigrants may have better health habits than do other people who have lived in the United States for longer periods of time.[24] In addition, people may return to their families and natural support systems in their countries of origin when they become seriously ill, leaving healthier Latinos in the United States.[25] Data from the Behavioral Risk Factor Surveillance System (BRFSS) show that North Carolina Latino adults are more likely to smoke than either non-Latino whites or African Americans, and are more likely to be overweight than non-Latino whites (but less likely than African Americans).[26] If the data are accurate, and Latinos have a higher incidence of obesity and smoking, they may develop more severe chronic conditions over time.

Although not reflected in the mortality statistics, the health of migrant and seasonal farmworkers is generally thought to be worse than the general Latino population. Migrant and seasonal farmworkers and their families have different and more complex problems, many of which can be attributed to a mobile lifestyle and the environmental and occupational hazards of farm work. Migrants and seasonal farmworkers in North Carolina, like elsewhere, are more likely to have HIV infections than other groups.[27] A national study suggests that up to 20% of Latino migrant farmworkers have self-injected medicines, often using shared needles.[28] Migrants also have a 20-25 times higher rate of tuberculosis and communicable diseases than the national average.[29] Prevalence rates for parasites among farmworker populations range from 20-80% in North Carolina migrant farmworkers.[30]

Oral Health[31]

Dental disease is the most common chronic childhood disease, occurring five to eight times more often than asthma.[32] It is very concentrated, typically in low-income populations, with about 25% of children having about 80% of dental disease in permanent teeth. Every 10-15 years, North Carolina conducts statewide

oral health surveys on a representative sample of schoolchildren across the state. In past surveys, it was not possible to collect data specific to the oral health of Latino children. However, national data suggest that Latino children, particularly Mexican Americans, have a greater rate of dental caries (cavities) than children of other races, or ethnic groups.[33] More than two of every five Latino children (43%) aged six to eight have untreated dental caries, compared to 36% of African-American and 26% of white children. Mexican-American children aged two through four and six through eight are more likely to have a history of dental caries than are whites or African Americans, but they are slightly less likely than whites once they reach adolescence (age 15) (Table 4:8). Migrant children are also more likely to have dental decay than other children.[34]

Table 4:8
Percent with Dental Caries

	Mexican American	Non-Latino White	Non-Latino Black
Age 2 to 4	27%	13%	24%
Age 6 to 8	68%	49%	49%
Age 15	57%	61%	69%

Source: Healthy People 2010. Oral Health. Recommendation 21-1c

Not only does a greater percentage of Mexican-American youth have dental disease, they are also less likely to have their caries treated than are non-Latino whites or African Americans (Table 4:9). As they get older, Mexican Americans are slightly more likely to have their dental caries treated than are non-Latino African Americans, although still not as likely as non-Latino whites.

Table 4:9
Percent with Untreated Dental Decay

	Mexican American	Non-Latino White	Non-Latino Black
Age 2 to 4	24%	11%	22%
Age 6 to 8	43%	22%	35%
Age 15	27%	18%	28%
Age 35 to 44	34%	23%	47%

Source: Healthy People 2010. Oral Health. Recommendation 21-2d.

Part of the reason for the oral health disparities between Mexican Americans and non-Latino whites may be differences in socio-economic status.[35] Dental disease is more concentrated in low-income populations and among people with less education. Latinos tend to have lower incomes, higher poverty rates, and less education than non-Latino whites. After adjusting for age, sex, educa-

tion and income, Mexican-American adults are similar to non-Latino whites on most oral health indicators. However, lower income Mexican Americans are less likely to have a full set of teeth (intact dentition), more likely to have untreated decay, and more likely to have severely decayed teeth than non-Latino whites.

Latinos are also less likely to visit a dentist, which may also help explain the higher rates of untreated decay (Table 4:10). Nationally, 13.1% of Mexican Americans reported never visiting a dentist, compared to 5.1% of other Latinos, 4.4% of whites, and 5.8% of African Americans. Further, Mexican Americans are less likely to have had a dental visit in the last year (40.5% had a visit) compared to 53.2% of other Latinos, 59.5% of whites, and 43.2% of African Americans.

Table 4:10
Age-adjusted Percentage Distribution of Persons 2 Years and Older Interval Since Last Dental Visit (1989, US)

	Mexican American	Other Latino	White	Black
Less than 1 year	40.5%	53.2%	59.5%	43.2%
1 year to < 2 years	8.9%	12.3%	9.1%	12.3%
2 years to < than 5 years	15.3%	13.7%	11.6%	16.9%
5 years or more	15.8%	9.9%	10.5%	15.1%
Never	13.1%	5.1%	4.4%	5.8%

Source: United States Surgeon General. Oral Health in America: A Report of the Surgeon General. US Department of Health and Human Services 2000. Table 4.4.

North Carolina high school and middle school surveys (Youth Risk Behavior Survey) show that North Carolina Latino youth are generally less likely to have visited a dentist in the last year than white youth; Latino middle school students were less likely to visit a dentist than either white or African-American students (Table 4:11).

Table 4:11
North Carolina High School and Middle School Surveys (2001)

	Latino	White	African American
High school: saw dentist for check-up, exam, teeth cleaning or other dental work in past 12 months	51.9	74.3	51.2
Middle school: saw dentist for check-up, exam, teeth cleaning or other dental work in past 12 months	42.6	73.0	50.0

Source: NC Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina High School and Middle School Surveys.

Financial barriers as well as non-financial barriers, such as language problems or not understanding the importance of preventive dental care, can deter Latinos from seeking care. Latinos are less likely to have dental insurance coverage (29.0% have insurance) compared to non-Latino whites (41.8%) or non-Latino African Americans (32.4%).[36] In a 1989 study, Latinos (56.1%) were more likely than whites (44.3%), but slightly less likely than African Americans (58.5%), to report that they did not have a dental problem as the primary reason they did not visit the dentist in the last year.[37] This suggests that Latinos do not fully understand the importance of obtaining regular, preventive dental services, as well as that they may not have the coverage needed to obtain such services.

Mental Health, Developmental Disabilities and Substance Abuse Services

The state does not have comprehensive data to identify the number of people who have mental health, developmental disabilities, or substance abuse problems. On a national level, the US Surgeon General studied the effects of culture, race, and ethnicity on mental health and use of mental health care services.[38, 39] Similar North Carolina data are not available, aside from the Youth Risk Behavior Surveys. However, the state does have some data on the incidence of children born with birth defects and some information on the use of alcohol among Latinos.

Mental health[40]

The US Surgeon General's report reviewed all pertinent literature to date studying mental health care and mental illness for Latinos.[41] These studies show a higher incidence of mental illness (roughly 20% of adults in one year) in Latinos who were either born in the United States or have resided in the United States for more than 13 years, than in recent immigrants (less than 10% of adults in one year). This body of research has been conducted in the Mexican-American and Puerto Rican populations. These findings are similar to other studies that suggest that as immigrants live in this country for longer periods of time, their health status more closely matches that of other Americans. The US Surgeon General report hypothesized that some of the reasons for the different prevalence rates of mental illness among recent immigrants and those who have lived in the United States for longer periods of time include "changing cultural values and practices, the stressors associated with such changes, or negative encounters with American institutions (e.g. schools or employers)."[42] Loss of family and the broader social support may also be a factor. The usual social mechanisms are broken down with increasing distance from one's home culture.

While the studies reported by the US Surgeon General suggest that recent immigrants may have a lower incidence of mental illness, the mental health professionals among the Task Force members questioned whether these national studies accurately reflect the mental health status of North Carolina Latinos. In their experience, recent immigrants are frequently observed with symptoms of depression, posttraumatic stress syndrome, and feelings of isolation. This is a particularly acute problem in the migrant community. The pressures of a migrant lifestyle impose both physical and mental stresses on children and fam-

ilies because of frequent relocation in search of work, work and housing insecurity, geographic and linguistic isolation, unreliable transportation, difficult physical labor, health-related concerns, lack of awareness of available services, unsanitary and overcrowded living conditions, and lack of control of these living conditions.[43]

Anxiety, depression, and disruptive behaviors were found to be significant in a survey of North Carolina seasonal and migrant farmworker families, predominantly Latino and African American, with children 8-11 years old.[44] Fifty-nine percent of the children revealed one or more psychiatric disorders. The most common, experienced by 50%, were anxiety-related, including phobias, separation anxiety, overanxiety, and avoidance. Seventeen percent displayed disruptive behaviors and 8% were depressed.

Nationally, there have been few diagnostic studies that have assessed the rate of mental illness in Latino children.[45] North Carolina Youth Risk Behavior Survey data suggest that North Carolina Latino high school students are less likely to consider suicide (14.4%) than whites (20.1%), but more likely than African Americans (13.4%)(Table 4:12). However, they are more likely to report feelings of isolation (18.4%), compared to whites (14.8%) or African Americans (14.6%). Middle school students were not asked about feelings of suicide, but Latino middle school students were more likely than either whites or African Americans to feel so sad or hopeless that they stopped doing some of their usual activities. While not conclusive, the data suggest that there may be some untreated mental health problems—depression, feelings of isolation—among North Carolina Latino youth.

Table 4:12
Youth Risk Behavior Surveys High School and Middle School (2001)

Mental Health and Feelings of Self Worth	Latino	White	African American
High School			
Seriously considered suicide during past 12 months	17.4	20.1	13.4
Felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities	27.5	28.8	30.3
Agree or strongly agree that they feel alone in their life	18.4	14.8	14.6
Agree or strongly agree that they feel good about themselves	75.6	76.8	76.9
Middle School			
Felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities	45.8	22.6	30.6
Agree or strongly agree that they feel good about themselves	20.2	9.4	11.0

Source: NC Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina High School Survey. Summary Tables. North Carolina Middle School Survey. Summary Tables.

Latinos may present with culture-bound mental health syndromes not found in other cultures, such as *susto* (fright), *nervios* (nerves), *mal de ojo* (evil eye), and *ataques de nervios* (nerve attacks). (These are explained in greater detail in Chapter 3.) As a result, health professionals unfamiliar with these symptoms may under diagnose the presence of mental illness.[46]

Developmental disabilities

While the state lacks information on the overall number of Latinos with developmental disabilities, the state does have information showing that Latino children are more likely to be born with certain birth defects than other children (Table 4:13). Latino children have higher rates of neural tube defects, anotia/microtia, and Down syndrome; they have lower rates of hydrocephalus, conotruncal defect and hypospadias/epispadias.

Table 4:13
Birth Defects per 10,000 Live Births by Ethnicity and Race (1995-1999)

Birth Defect	Latino	White, Non-Latino	African American, Non-Latino
Neural Tube Defects, All	18.4	8.8	7.2
Anencephalus	6.1	1.9	2.0
Spina Bifida	10.0	5.7	3.6
Encephalocele	2.3	1.3	1.6
Hydrocephalus	8.5	8.8	13.6
Microcephalus	8.8	4.5	8.6
Anotia/Microtia	11.7	5.2	8.2
Conotruncal Defect	9.7	11.2	10.4
Orofacial Cleft	16.4	16.8	11.0
Pyloric Stenosis	14.3	27.4	12.4
Down Syndrome	18.7	11.7	11.9
Hypospadias/Epispadias	24.9	49.4	44.3
Intestinal Stenosis	5.6	5.2	6.2
Obstruction of Genitourinary Tract	15.8	19.0	15.6
Total Live Births	34,159	347,573	137,606

Source: Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002. Analysis of Birth Defects Registry (1995-1999).

Although Latinos are more likely to be born with certain developmental disabilities, it is unclear whether these higher rates are due to a higher incidence of these congenital defects, or lower abortion rates. Latinos are less likely to have abortions than either whites or African Americans.

Substance Abuse[47]

The exact prevalence of alcohol and drug disorders among North Carolina Latinos is unknown, however there are several sources of data that give some indication about the extent of the issue and indicate it is a problem. The Behavioral Risk Factor Surveillance System collects information about alcohol use among adults.[48] In 2001, the frequency of drinking five or more drinks per month was generally higher for Latinos than whites or African Americans (Table 4:14). Latino adults in North Carolina were less likely to report never

Innovative Practices

Nuestra Seguridad Campaign Addressing Driving Safety and Alcohol Use

El Pueblo, a statewide advocacy and public policy organization that works to strengthen the Latino community, has created a public safety campaign funded by the Governor's Highway Safety Program. The Campaign produced a Spanish-language video about driving safety as one of its initiatives. The 18-minute drama depicts the story of young Miguel, an immigrant who learns valuable lessons about getting a license in North Carolina, the use of child safety seats, and the importance of staying sober on the road. This script was developed with input from a community advisory committee, and community members volunteered to be the actors of the video. This is an excellent example of informing the community in a culturally appropriate manner. The format of the video is that of a telenovela, the Spanish-language equivalent of a soap opera. This video is free to government and nonprofit agencies, and should be available in early 2003.

Innovative Practices

Aprendelas Ahora, O Le Costara Mas Tarde

The North Carolina Department of Labor (DOL) have developed a Spanish/English brochure with information about drinking and driving that has been distributed to Department of Motor Vehicle centers throughout the state. In addition, DOL helped train approximately 3,000 H-2A workers through a culturally appropriate skit about the problems of drinking and driving.[50]

drinking five or more drinks at once and were more likely to report binge drinking three to seven times a month. Overall, Latinos were also more likely to report binge drinking (12.5%), compared to whites (10.4%) or African Americans (6.4%).[49]

Table 4:14
North Carolina Alcohol Consumption (2001)
by Race and Latino Ethnicity[51]

Times	Latino	White	African American
None	74.1%	76.3%	78.3%
1 Time	11.1%	7.0%	8.4%
2 times	3.1%	4.4%	5.0%
3-7 times	11.1%	9.4%	5.8%

Source: CDC. Behavioral Risk Factor Surveillance System. 2001. The survey asked, "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on an occasion?"

Not only does BRFSS data suggest that adult Latinos are drinking more heavily than other groups, they are also more likely to be injured or die while drinking. Data from the Medical Examiner's Office shows that Latinos age 15 years or older are far more likely to die from non-natural causes with elevated blood-alcohol levels. For example, 45.7% of Latinos who died in motor vehicle or other unintentional injury deaths died with a blood alcohol level of .08 or higher, as compared to 26.3% of non-Latino whites or 29.9% of non-Latino African Americans.[52] Similarly, 45.3% of Latinos who died as a result of homicide had an elevated blood alcohol level, compared to 29.2% of non-Latino whites and 26.3% of non-Latino African Americans. This suggests that at least a portion of North Carolina Latinos, particularly men, may have a higher risk of alcohol abuse than either whites or African Americans. National studies have documented larger differences in substance use by gender among Latinos compared to whites, with Latino females having very low rates of alcohol or drug use disorders.[53]

The Youth Risk Behavior Surveillance System collects data about alcohol and other drug use among high school and middle school students.[54] In general, Latino middle school students are more likely to report drinking in the past 30 days, and are more likely to ride in a car with someone who has been drinking (Table 4:15). Latino youth are less likely to report using marijuana than whites or African Americans, but more likely to report using cocaine or sniffing glue. Latino youth are most likely to report that drugs are a problem at their schools.

Table 4:15
North Carolina Middle School Survey
2001 Youth Risk Behavior Survey Results

	Latino	White	African American
At least one drink in past 30 days	17.4	12.8	11.3
Ever rode in car with driver who had been drinking alcohol	29.5	25.2	24.3
Used marijuana one or more times in past 30 days	4.1	5.6	7.6
Ever used any form of cocaine	7.3	4.9	3.9
Sniffed glue, breathed contents of aerosol spray cans, or inhaled paints or sprays to get high once or more in life	17.2	15.2	12.1
Students offered, sold or given an illegal drug on school property in past 12 months	10.1	10.0	10.0
Think drugs are a problem at their schools	17.5	16.5	13.6

Source: Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina High School Survey. Summary Tables.

By the time the children reach high school, Latinos are no longer the most likely to report drinking. Latino high school students are more likely to report drinking or binge drinking than African Americans, but less likely than whites (Table 4:16). However, Latino high school students are still far more likely to report drinking and driving, or riding in a car with a driver who has been drinking. Latino high school students are more likely to have used cocaine or methamphetamines than whites or African Americans, but about equally likely to report using marijuana. Like their middle-school counterparts, Latino high school students are most likely to report that drugs are a problem at their schools.

Table 4:16
Data on Use of Alcohol and Drug Use Among North Carolina High School Students (2001 Youth Risk Behavior Survey)

	Latino	White	African American
At least one drink in past 30 days	35.8	42.5	28.7
Five or more drinks within a couple of hours in the past 30 days	19.1	24.6	12.2
Drove in car in past 30 days with driver who had been drinking alcohol	34.8	24.2	22.9
Drove car after drinking alcohol	12.8	10.7	5.5
Used marijuana one or more times in past 30 days	20.2	21.0	20.3
Used any form of cocaine one or more times in the past year	7.7	3.1	1.2
Sniffed glue, breathed contents of aerosol spray cans, or inhaled paints or sprays to get high once or more in life	16.0	16.5	7.6
Used methamphetamines one or more times in life	13.5	10.0	2.1
Students offered, sold or given an illegal drug on school property in past 12 months	41.5	32.6	33.1
Think drugs are a problem at their schools	53.3	46.8	39.6

Source: Department of Public Instruction. 2001 Youth Risk Behavior Survey. North Carolina High School Survey. Summary Tables.

Innovative Practices

Pesticide Environmental Risk Reduction in Farmworkers

Since 2001, the North Carolina Farmworker Health Program (NCFHP), in collaboration with Americorps, the Pesticide Environmental Trust Fund, and participating health centers, has coordinated an Americorps program in North Carolina that is dedicated to reducing the risk of pesticide exposure among farmworkers and their families. In 2002, four health centers located in Greene, Jackson, Henderson and Columbus counties, recruited seven bilingual, bicultural Americorps members. The projects are incorporated into established migrant outreach programs. All members receive training in health education and become Designated Trainers of the Worker Protection Standards (WPS). This project helps farmworkers increase their knowledge and reduce pesticide risks.

Substance abuse appears to be a bigger problem for Latinos living in the United States than Latinos living in Mexico.[55] Mexico-born Mexican immigrants have much lower rates of substance abuse than Mexican Americans born in the United States, and those living in the United States for shorter periods of time (less than 13 years) had lower rates than those living in the United States for longer periods of time.[56] Similarly, Puerto Ricans living in Puerto Rico have much lower rates than those living in the continental United States.[57]

In a series of focus groups, North Carolina farmworkers reported that alcohol was used as a coping mechanism for emotional problems.[58] Isolation, lack of community contact, and few recreational opportunities, combined with increased access to alcohol, have been suggested as possible reasons for the increased alcohol abuse once Latinos move to the United States.[59]

Occupational Injuries[60]

Employment opportunity is the primary reason for the recent growth of the Latino population in North Carolina.[61] These same opportunities can also create new health risks for Latino workers as they are more likely to work in dangerous industries such as construction, agriculture, and manufacturing, which have the highest rates of occupational fatalities and injuries. Further, not all Latinos receive safety instructions in Spanish.[62] According to the North

Carolina Department of Labor's (DOL) statistics (2001), 25.1% of occupational fatalities were in the construction industry, 15.7% in transportation and public utilities, 11.8% in manufacturing and 8.5% in agriculture, forestry, and fishing. Latinos represent a disproportionate percentage of all fatal occupational injuries—9.8% of occupational deaths were among Latino workers, although they only represent 4.7% of the state's population.[63]

Certain illnesses may also be caused by working conditions. For example, Green Tobacco Sickness (GTS) is one of the many occupational hazards of working in the agricultural industry. GTS can occur when tobacco is harvested by hand exposing the skin to tobacco, especially wet tobacco. Nicotine poisoning can occur from the nicotine found in tobacco leaves, the part of the plant that is harvested. The more of a farmworker's skin that is exposed to the tobacco, the more likely the poisoning is to occur. The symptoms include dizziness, headaches, nausea or vomiting, abdominal cramps, diarrhea, difficulty in breathing, and prostration.[64, 65] Duration of the illness is usually two or three days, but it may lead to higher morbidity and mortality from cardiovascular or cerebrovascular disease.[66] In a recent study in North Carolina, 24% of farmworkers experienced at least one episode of GTS during a growing season.[67] GTS may also be a concern to children who work in agriculture.

Farmworkers are also exposed to pesticides, and may experience heat-related illnesses, dermatitis, respiratory illnesses, or musculoskeletal problems. Nationally, the Environmental Protection Agency estimates that pesticide exposure causes up to 300,000 acute illnesses and injuries to farmworkers each year.[68] While pesticide exposure results in both acute and chronic health problems, little is understood about the long-term effects of repeated low-level exposure. In an exploratory study of occupational health among NC migrant and seasonal farmworkers, 55% reported ever receiving pesticide safety training and 45% reported receiving safety training in the past year. The results of the study show that NC farmworkers are not fully benefiting from current safety and sanitation regulations.[69] Further, pesticide poisoning often goes unreported, because there is no effective testing method to verify or rule out exposure as the cause of a symptom that may resemble viral infection, heat illness, or green tobacco sickness. Heat stress / heat stroke also present a workplace hazard for farmworkers, as the heat index within a row crop is commonly 8-10º F greater than that reported by the National Weather Service.[70] Lack of safe drinking water contributes to dehydration or heat stroke.

Nationally, Latinos miss more days from work due to occupational injury and illness. In 1999, the median work days that Latinos missed due to occupational injuries and illnesses was seven, as compared to five for non-Latino whites and six for non-Latino blacks.[71] In addition, Latino employees were more likely than other employees to have longer absences from work due to injuries (in the 11-31 days or more category). One possible explanation among many is that the injuries and illnesses received by Latinos are more serious than those experienced by other workers.

Innovative Practices

Promoting Health & Safety Among H-2A Workers—A Collaboration with the NC Growers Association

Each agricultural season, nearly 30,000 foreign guestworkers--also referred to as H-2A workers--enter the United States legally with H-2A visas to work in agriculture. Between April and August, the North Carolina Growers Association (NCGA) imports over 10,000 predominantly male, unaccompanied, young Mexican laborers to the state, making NC growers the leading employers of H-2A workers in the US. Since 1997, in collaboration with the North Carolina Growers Association, several NC agencies including the North Carolina Primary Health Care Association, NC Farmworker Health Program, NC AgrAbility Program, NC Department of Agriculture, NC Migrant Education Program and the NC Department of Labor conduct outreach to provide information in Spanish about existing health, education, housing and other resources and assistance available to farmworkers across the state.

Innovative Practices

"Labor One" Mobile Training Unit

The State of North Carolina has taken some steps to improve the working conditions for Latino workers in dangerous industries. The Department of Labor created a Hispanic Task Force to focus attention on the issue of Latino construction workers. Additionally, the Department of Labor has funded a mobile training unit that can deliver free safety education in English and Spanish to agricultural, construction, and manufacturing sites. Called Labor One, the training unit is the first bilingual mobile classroom in the South.

Violence[72]

Crime, particularly violent crime, is a concern for the North Carolina Latino community. North Carolina Latinos have a higher age-adjusted death rate per 100,000 from homicides (17.0) than whites (4.8), but less than African Americans (18.7).[73] Unfortunately, data regarding the race/ethnicity of victims of all crimes are limited, but in a survey conducted in eighteen law enforcement agencies by the Governor's Crime Commission in the fall of 1998, a third of the respondents reported a perception that crimes against members of the Latino population had increased within their respective jurisdictions.[74] Aggravated assault, robbery, and burglary were the three most commonly reported offenses perpetrated against Latinos. Among Latinos, particularly newly arrived immigrants, there is more of a tendency to carry large sums of money and/or retain large amounts within their home due to a lack of understanding of or confidence in the banking system. This can make them more susceptible to robbery and burglary. The Commission recommended the provision of qualified interpreters in criminal justice agencies, education among the Latino population about how the criminal justice system works to increase overall trust and confidence in the system, and cultural training among criminal justice agencies' employees.

Domestic violence is also of concern for Latinos, as it is among all racial and ethnic groups. There is no comprehensive surveillance system that monitors domestic violence on a national or state level, but there are some studies regarding its prevalence. The vast majority of domestic violence victims are women. According to a large national survey of women of all races and ethnicities, Latina and non-Latina women are about equally vulnerable to violence by an intimate partner.[75]

While no North Carolina data are available to document the overall number of victims of domestic violence, there are state level data about the number of women served by domestic violence programs.[76] The overall number of new domestic violence victims served by domestic violence programs increased 117% during the last decade, from 18,494 in 1990 to 40,124 in 2000.[77] The number of new primary victims who are Latinas has likewise increased nine-fold, from 190 (1990) to 1,720 (2000) (Table 4:17). The increase may be due to the increase in the Latino population and/or to the increased number of domestic violence programs and services available to victims.[78]

Table 4:17
Number of Primary Victims Served by North Carolina Domestic Violence Programs

Year	Number of Domestic Violence Programs	Number of New Primary Victims (all)	Number of New Primary Victims Who are Latino	Percent of Victims Who are Latino	Percent of North Carolina Population Who are Latino
1990	62	18,494	190	1.03%	1.0%
2000	765	40,214	1,720	4.28%	4.7%

Source: North Carolina Council for Women (2001)

The proportion of primary victims served by domestic violence programs who are Latino has increased over the past decade from 1.03% in 1990 to 4.28% in 2000. This increase closely matches the percentage of Latinos in the state.[79]

Some studies show that the prevalence of abuse among farmworker women and children may be greater than the rest of the population.[80] A survey of North Carolina seasonal and migrant farmworker families with 8-11 year old children found that 46% of these children had been witnesses to violence, including 20% being witnesses to a shooting and 11% being witness to a murder.[81] One in five children of this age group were victims of violence. A 1997 study conducted in ten states nationwide revealed that 20% of migrant farmworker women had experienced either physical or sexual abuse within a year of being interviewed.[82] More than 80% of the women experiencing abuse were in their childbearing years, and 50% of the battered women were pregnant. Ninety-one percent of the respondents were Latina. Drug and alcohol abuse was significantly correlated with fear of partner and physical and sexual abuse.

While NC domestic violence shelters serve many Latinas, others may be deterred from seeking services because of language barriers. Surveys of NC domestic violence shelters between 1998-2001 showed that only between 25-35% of local domestic violence shelters have bilingual staff.[83] In addition, Latinas face unique barriers when reporting domestic violence. The perpetrators may threaten to report undocumented victims to the INS to keep them from seeking assistance from domestic violence programs or police. Battered spouses and children may not understand that they are considered "qualified immigrants" and thus, retain certain rights despite their undocumented status. Similarly, there may be a lack of knowledge among service agencies about the requirements and restrictions of immigration status in relation to service provision.

Conclusion

North Carolina Latinos are relatively healthy as compared to whites or African-Americans. This is especially true for recent immigrants. Latinos have better birth outcomes and have lower age-adjusted death rates than whites or African-Americans. However, there are some areas of immediate concern. Latinos are more likely to die from alcohol-related motor vehicle crashes and to suffer occupational injuries. Migrant and seasonal farmworkers have greater health problems than Latinos as a whole. Further, if North Carolina Latinos follow national experiences, the health of Latinos is likely to suffer as they acculturate. Already, we are seeing signs that Latino youth are acquiring some of the poor health behaviors that lead to chronic health problems. Latino youth look much like their white and African-American peers in the percentage that report being overweight or at risk of being overweight and leading sedentary lifestyles. One fourth of Latino high school students report smoking; 10% report their health status as poor—a higher percentage than whites or African American high school students. Thus, the state cannot afford to be complacent. Absent culturally appropriate and effective interventions aimed at promoting healthful behaviors among the growing Latino population, Latinos are likely to suffer the same adverse health outcomes as other population groups.

Notes

1. Steve Taylor and Cheryl Lesneski contributed to the research and writing of this section of the chapter.
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6. The Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of new mothers based on a random sample of birth certificates to North Carolina residents. Approximately 1,800 women are interviewed each year. The overall response rate, from mailed and follow-up telephone surveys, is approximately 75%. The surveys are conducted in English and Spanish, between 3 to 5 months postpartum. The survey, which was sponsored by the Centers for Disease Control, has a standardized core set of questions and is administered in about 25 states. There were 374 Latinas, 3,803 non-Latina whites, and 1,870 non-Latina African-Americans interviewed for the survey. Buescher P. State Center for Health Statistics. Presentation to NC Institute of Medicine Latino Health Task Force. June 12, 2002.
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8. Toni Laskey, MD, contributed to the research and writing of the immunization section. Jangho Yoon contributed to the research of the general child health section.
9. The DTaP vaccination protects individuals from contracting diphtheria, tetanus and pertussis. Cases of diphtheria and tetanus are extremely rare in the United States, as a result of wide-spread immunization programs. However, pertussis is still a great threat. Immunity wanes with age. Teenagers and adults may be carriers of this pathogen. Teens and adults who contract this disease may only experience symptoms like a "bad cold;" however, children who are inadequately immunized may contract this disease—commonly known as whooping cough. Whooping cough is potentially fatal for infants or may lead to significant morbidity both with and without underlying lung disease.
10. The MMR vaccination protects individuals from measles, mumps, and rubella.
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15. Much of the data for Latino youth in North Carolina and the US are derived from school-based samples. However, school-based sampling excludes those who are not attending school because they have dropped out or never enrolled in school. In North Carolina, the Department of Public Instruction reported 1,042 Latino dropouts (approximately 9% of Latinos enrolled in high school for the 2000-2001 academic year). A comparison of Census data on the number of children age 10-17 with data from the Department of Public Instruction on the number of Latino students enrolled in 5th-12th grade suggests that many Latino youth never enroll in school. There were 31,626 Latino youth enrolled in 5th-12th grades in 2000-2001. However, cen-

sus data indicate that there were 40,987 youth aged 10-17 living in North Carolina during 2000. Thus, school-based samples miss at least 22% of the population age 10-17. Because youth in the 12th grade may be up to age 22, this is a conservative estimate of the number of Latino youth excluded from school-based samples. Sources: The Census data are from P12H. Sex by Age (Hispanic or Latino). Data Set: Census 2000 Summary File 1 (SF 1) 100-Percent Data. The DPI data are from the Beyond 20/20 web data server and can be found at: http://149.168.35.67/wds/eng/ReportFolders/Rfview/explorerp.asp.

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Workers in the Triangle Area of North Carolina," 2000. The study examined the Latino workers' perception of working conditions and the availability of safety information. While admittedly a small sample, Latinos in this study reported hazardous working conditions and that employers "failed to comply with safety standards." Less than half were provided equipment to protect from falls, although 13% of all fatalities in 2000 were a result of falls. Only about one third of those interviewed (37%) "reported that they receive regular, high quality training in Spanish," but 44% of respondents received no safety instruction at all. For many who experienced poor training, safety information was only provided in English or in written format, which non-literate workers were unable to use. The study found that most of these workers were not aware of their rights and the State of North Carolina's role in protecting their rights. Information about the NC Department of Labor's Latino Task Force and Labor One is available on the internet at: http://www.dol.state.nc.us/ in the Department of Labor statistics (accessed March 21, 2002); www.dol.state.nc.us/news/inj2000.htm; and www.dol.state.nc.us/news/laone214.htm.

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5 Systems of Care

Introduction

National studies have shown that non-citizens are more likely to be without a usual source of care, have less access to ambulatory medical and emergency medical care, and even when they have access, often receive less care than citizens.[1] Although many Latinos in North Carolina are citizens, many others are recent immigrants and have not yet been naturalized. Because of financial and other non-financial barriers, health services are generally more limited for the North Carolina Latino population than for other North Carolinians. As a result, the Latino population relies more heavily on publicly-funded programs or safety-net providers-that is, providers who are willing to see low-income patients for free or on a sliding-fee scale basis. However, these resources are not available throughout the state, and even when available, they may be insufficient to serve all in need. Further, access problems are compounded for the Latino population, many of whom are recent immigrants and may not understand English or understand how to access health services.

Primary Care

Many Latinos receive services through community and migrant health centers, public health departments, free clinics, rural health clinics, hospital emergency rooms, and outpatient clinics. In addition, there are some state and federal funds available to help provide health care services to migrant and seasonal farmworkers.

Community and Migrant Health Centers

Community and migrant health centers (C/MHC) receive federal funds from the Bureau of Primary Health Care, US Department of Health and Human Services to provide comprehensive primary health care services to all in need. Each health center has a consumer majority board of directors, accepts Medicaid and Medicare, and applies a sliding-fee scale based on family size and income

Exemplary Practices

Piedmont Health Services

Piedmont Health Services, Inc., a federally funded community health center (CHC), was started in 1970 to improve assess and remove barriers to health care for residents of Orange, Chatham, Person, Caswell, and Lee Counties. Prospect Hill Center, located in Caswell county, started serving migrants and seasonal farm workers in 1980. Piedmont opened a Nurse Midwife-staffed birthing center and three additional CHC sites in Alamance and Chatham Counties. The newest of these centers is the Siler City Health Center, which serves a population composed of 67% Latino users. The composition of patients at all Piedmont sites has grown from 5% Latino users to 45% in eight years.

Piedmont offers a full range of preventive and primary care services at all sites except the birthing center. Services include medical, dental (three sites), lab, on-site pharmacy, Maternity Care Coordination, WIC Nutrition, Medicaid, and NC Health Choice eligibility. Approximately one half of the 40 medical and dental providers and one fourth of the support staff (160) in seven Piedmont Health Services sites can speak Spanish in order to communicate with their Latino clients. All services are charged on a sliding scale to make care affordable for the uninsured.

Exemplary Practice

Harvest Family Health Center

Since 1984, Harvest Family Health Center (HFHC), the migrant health delivery site of Wilson Community Health Center, Inc. has provided health services to migrant and seasonal farmworkers in Wilson, Nash, and Edgecombe counties. Ninety-five percent of the patients seen at HFHC are Latinos, with 54% being migrant and seasonal farmworkers. More than 90% need Spanish language assistance, so HFHC makes it a priority to recruit and maintain primarily bilingual staff to provide culturally competent, comprehensive primary care, including medical, dental, and pharmacy services. HFHC has also developed specialized programs and services to effectively address priority health care issues among farmworkers including: evening clinics; Spanish-language diabetes classes; a mobile mammogram unit; STD screening, testing, and counseling on-site and at the labor camps along with general health screenings; case management; health education and transportation services coordinated by an outreach coordinator; limited emergency food, transportation and housing assistance in cases of need or during recent natural disasters; and an on-site Spanish-language library.

In 1999, HFHC received funding from The Duke Endowment to fund a Spanish Medical Interpreting program, *Caminos de Salud*. Since 1999, *Caminos de Salud* has provided interpreter services to approximately 450 patients/month at local hospitals, health departments, social services, and private practitioners offices.

In July 2002, with a federal expansion grant as part of the President's Health Centers Initiative, HFHC moved into a new facility with expanded dental capacity.

for families that do not have health insurance or any other means of paying for services. As a result, these centers are generally more affordable to uninsured Latinos than are other private providers. There are 22 C/MHC across the state located in 34 counties. These centers operate more than 65 different clinical delivery sites, serving patients in more than 60 counties. In 2001, these centers provided primary care to 224,669 patients, 25% of whom were Latinos.[2] During the same year, a total of 48,947 patients (21.8%) seen at community and migrant health centers needed an interpreter, sign language, or bilingual services, although not all of these were Latinos. Almost all of the C/MHC have bilingual and/or bicultural interpreters, health providers, and other staff, making health services more linguistically accessible to Latinos with limited English proficiency.

Under the Bush Administration's Health Centers Presidential Initiative, there are now federal funds available to expand, improve, and strengthen the nation's health care safety net for uninsured and underserved people over the next five years.[3] Eighty percent of the federal money will be awarded to existing entities, leaving 20% for new centers. Although the federal funds are not specifically targeted to communities serving Latinos or immigrant populations, North Carolina communities can submit grant applications specifically intended to meet the health care needs of a community that has been identified as having unique and significant barriers to affordable and accessible health care services.

Despite the availability of these new federal funds, there are a number of barriers that deter existing or new health centers from applying for funds. For example, the federal rules governing the program require the organization to be operational within 90 days of being awarded the grant. This is particularly difficult for organizations that need to locate physical space and hire staff before beginning operation. Attracting staff who are both bilingual and culturally competent to serve Latinos is even more difficult. Another problem is that federal grants cover only between 20-40% of a center's costs. Local communities must identify additional funding, through patient revenues, grants, or local/state funding, to make up the difference. Further, many community organizations lack grant writers who can help them complete the federal grant forms. Because of these barriers, only a few North Carolina communities submitted applications last year. The NC Primary Health Care Association (NCPHCA), the state association of Community and Migrant Health Centers, is working with existing C/MHCs and is available to work with other community organizations to increase the number of grant applications.

State-funded Rural Health Clinics

The North Carolina Office of Research, Demonstrations and Rural Health Development (ORDRHD) provides operating grants to 31 rural health clinics, located in 20 counties across the state. As a condition of receiving state funds, these rural health centers must agree to treat Medicaid and Medicare patients, and to serve the uninsured on sliding-fee scale basis. There are no data that show how many Latinos are seen in the state-funded rural health clinics. While state-funded rural health clinics are required to serve the uninsured, not all of them are linguistically accessible. The state provides funds to 20 organizations

that run 31 rural health clinics. Ten of the 20 organizations have bilingual staff. In addition to the 31 state-funded rural health centers, there are 50 rural health clinics that do not receive state funds. These centers are not legally obligated to serve the uninsured, though many do so.

Public Health

Local public health departments also provide some clinical services that are available to Latinos, although most do not provide comprehensive primary care. Almost all of the health departments provide immunizations, family planning, STD diagnosis and treatment, and diagnosis of HIV/AIDS. All but one of the 89 local public health departments have child health clinics, and all but 10 offer prenatal care.[4] Approximately 16% of all Latinos were seen in a health department for some clinical services in State Fiscal Year 2001, although they only comprised 11% of the people seen in public health departments.[5] For specific clinical services the percentage of Hispanic/Latino patients are:

- Maternal health (19%)
- Child health (18%)
- Children with Special Health Services (9%)
- Immunizations (8%)
- Family planning (16%)
- Adult health (7%)

While Latinos are able to obtain some care from health departments, they generally cannot rely on the health department for comprehensive primary care. In 2002, 38 county health departments provided comprehensive primary care services to at least a subset of their patient population; these are health departments that serve as primary care providers for the Medicaid Carolina Access program.[6] These health departments do have the capacity to provide comprehensive primary care to at least a subset of their patient population; however, some limit primary care services to children, and others to adults. It is unclear whether these health departments limit their primary care services to their Medicaid population.

Free Clinics

There are 33 free clinics around the state that provide free primary care. These clinics typically operate one or two nights a week, and are staffed by volunteer health professionals. Services are generally restricted to low-income uninsured people. In addition to primary care, some clinics offer ongoing treatment of chronic conditions, and many offer some help with pharmaceuticals through drugs donated by the volunteer doctors. Few of the free clinics have comprehensive pharmacies. More comprehensive community-care delivery models have been started in Buncombe, Guilford, Moore, Onslow, Pitt, Watagua, and Wake counties.

Hospital Emergency Rooms and Outpatient Clinics

Under federal law, hospitals are required to screen and stabilize anyone who comes to the emergency room.[7] Sometimes, because of a lack of access to other providers, the uninsured use the emergency room as a source of primary care.

Innovative Initiatives

Immigrant Health Initiative at Chatham County Hospital

The project has been in existence for the past 3 years. Its goals are to increase access to medical services and improve the health of Latinos in the community. It uses a lay health advisor model, with three full-time, paid lay health advisors based out of churches, and one health advisor based out of a local industry. The health advisors are trained and coordinated out of a central management team at the hospital that includes participation from the CEO of the hospital to local Latino leaders. One of the unique aspects to this effort is its collaboration with a local industry, Townsend Poultry plant. The project has established positive collaborations with other entities, such as UNC Dental Hygiene Program, a local youth leadership group, and it has established a doula program for local Latinas. Other activities of the effort include child car seat education, dental services through a mobile unit, and information and referral to local health department and community health center.

Exemplary Models

NC Farmworker Health Alliance

North Carolina's efforts to provide quality health care to the state's migrant and seasonal farmworkers are known nationally. Formed in 1994, the North Carolina Farmworker Health Alliance, a statewide collaborative administered and staffed by the North Carolina Primary Health Care Association (NCPHCA) and the North Carolina Farmworker Health Program of the NC Office of Research, Demonstrations and Rural Health Development, aims to improve the health of migrant and seasonal farmworkers. Membership includes over 50 private and public agencies from across the state. Alliance activities range from monitoring local, state, and federal policy affecting farmworkers to organizing an Annual Meeting that brings together farmworkers and farmworker health providers to discuss selected health issues affecting the farmworker community and to identify possible prevention strategies. In addition, the FHA maintains a Farmworker Health Resource Library, which is housed at the NCPHCA. Materials include bilingual health education pamphlets, books, videos, manuals, research papers (published and unpublished), and national and state resources intended to support individuals or organizations who are helping to improve the health status of farmworkers. Efforts are currently underway to catalog the resources and make a list available to others on the World Wide Web.

Anecdotally, the Task Force learned that many Latinos are seen in hospitals-in emergency rooms, outpatient clinics, and as inpatients. However, there are no data available to know how many Latinos use hospital outpatient clinics or emergency rooms as their source of primary care.

Other Private Providers

In addition to safety-net providers, some Latinos receive primary care services through private providers' offices. No data are available to quantify the number of Latinos who are receiving regular primary care services by private providers.

Programs Serving Migrant and Seasonal Farmworkers[8]

The North Carolina Farmworker Health Program (NCFHP), within ORDRHD currently receives $1.1 million in federal migrant funding to expand the availability of primary and preventive health services to migrant and seasonal farmworkers.[9] NCFHP currently contracts with 11 health care providers (four community health centers, four county health departments, two rural health centers, and one Partnership for Children community-based organization) to develop and maintain farmworker health programs at these sites. The funds support 25 bilingual (and often bicultural) outreach workers who spend 70% of their hours outside of the clinic, primarily in the evenings and weekends, to reach migrant and seasonal farmworkers when they are not working.

The outreach workers increase access to care by visiting the labor camps (to share information about available resources in their host clinics and in the community), conduct health assessments and make referrals when necessary, provide health education and case management services, and coordinate evening clinics when needed. The nurse outreach coordinators also offer clinical services both in the field and at residences, negating the need for a referral in many cases. Outreach is an effective means of reaching farmworkers, because farmworkers are often new to the area, live in isolated settings, lack transportation, speak only Spanish, and may fear accessing traditional services. In 2001, the 11 contract sites served a total of 7,725 migrant and seasonal farmworkers with program funding. Of these, 86% (6,643) were migrant and 14% (1,081) were seasonal workers. The majority of patients were Latino (93%) with African Americans comprising the majority of the remaining 7%.[10]

Services are also targeted for migrant and seasonal farmworkers at migrant health centers and many community health centers. In 2001, C/MHCs served a total of 24,679 migrant and seasonal farmworkers, making NC C/MHCs the largest health provider for these workers.[11]

In addition to the federal funds for migrant and seasonal farmworkers, the state Division of Public Health runs the NC Migrant Fee-for-Service Program. Currently, funds are used to pay private doctors, dentists, pharmacists, and hospital outpatient departments for services provided to migrant farmworkers across the state. This program does not serve seasonal farmworkers. Reimbursement is limited to $150 per claim, and the patients are charged a co-pay. The state Migrant Fee-for-Service program is so underfunded that it has a history of running out of money before the end of the fiscal year, leaving migrants without services from this source for the remainder of the fiscal year.

In 2001, the NC Migrant Fee-for-Service Program spent $876,025 and paid 11,636 claims before it had to close on December 31st, because of insufficient funds.[12] Another factor that adds to the vulnerability of this program is that it receives non-recurring funding, and thus is a target of elimination during tight budget years.

Despite the availability of federal and state funds to serve migrant and seasonal farmworkers, it is estimated that less than 20% of these workers access the primary health care services available.

Outstanding Primary Care Needs

Although there are some providers who receive funding or have a special mission to serve Latino or other underserved populations, Latinos still face access barriers. On average, 79% of people in the United States saw their doctors in the past year.[13] However, the available data suggest that there are many counties in the state where less than one-third of Latinos have visited a primary care provider during the year. Public health departments that provide primary care services are not available throughout the state, nor are Community or Migrant Health Centers. Hospitals and private providers, while typically more available, may be unaffordable to Latinos. Further, Latinos may have different cultural expectations of the US health care system. In many countries, Latinos see the doctor only when very sick, rarely for routine preventive care. Further, physicians are not always available in every community. Instead of seeking health care from a licensed health care professional, many Latinos self-diagnose and obtain pharmaceuticals through local *tiendas* (shops) or pharmacies while in their home country. Latinos may also seek care from *curanduras, yerberos, brujos, sobanderos* or other natural healers (see Chapter 3). Navigating the US health system may be difficult for recent immigrants.

To get a sense of the communities with the greatest unmet need, the Task Force examined the proportion of the Latino population being served by either C/MHC or health departments, two of the primary sources of health care for Latinos.

The Task Force's analysis concentrated on those counties that had the highest percentage or largest number of Latinos (5% or 5,000 people or more) (Table 5:1). The Task Force tried to calculate the percentage of Latinos seen in public health departments and community/migrant health centers as compared to the Latino population in that county.[14] This analysis is crude at best, since the data do not give an exact count of Latinos who are receiving primary care services from either health departments or C/MHCs. In addition, data were not available for all sources of care. There are no requirements that certain providers report data (for example, the number of patients seen at private doctors offices, or patients seen in emergency departments or hospital outpatient departments). Further, providers do not always collect information on the ethnicity of the patients seen; therefore, even if total numbers of patients seen was available, there was no way to determine numbers of patients that were Latino. Some communities have organized local Project Access systems, a comprehensive and coordinated care delivery system that provides free health services to uninsured. However, we have no way of knowing how many Latinos are served

Innovative Practice

Portable Health Records Project

Migrant farmworkers often move back and forth from other countries, and usually travel within several states, so they may receive health care at various clinics. To assure better continuity of care for migrant farmworkers and their families, the NC Primary Health Care Association designed a comprehensive bilingual health record that looks like a pocket-sized passport. Essential information, like medication allergies, as well as immunization history, past screening or treatment for tuberculosis, and previous treatment for chronic diseases can be documented in the passport-sized record and carried from place-to-place by the patients. At least 9,000 portable health records have been distributed to migrant farmworkers and their families through C/MHC, health departments, and other health entities in North Carolina and seven other east coast states.

through these projects. In addition, there is no way to get an unduplicated count across different providers (e.g., the same Latino may be seen at the health department and community / migrant health center). Nonetheless, the Task Force used this analysis to provide some indication of the counties where the unmet need may be the greatest.

Table 5:1
Known Availability of Primary Care Services for NC Latinos
(By County)

County (Number Latinos, Percentage of County)	% Latino Adults in County Seen in Adult Public Health Clinic	% Latino Children in County Seen in Child Public Health Clinic	% Latinos in County seen in C/MHC	Other Resources Available
Alamance (C: 8,835 – 6.8%) (FA: 12,607 - 9.3%)	0%	6%	10% (Piedmont +)	Open Door Clinic of Alamance (FC)
Alleghany * (C: 530 – 5.0%) (FA: 781 - 7.2%)	0%	35%		Alleghany Partnership for Children +
Beaufort (C: 1,455 – 3.2%) (FA: 2,345 – 5.1%)	0%	2%		
Bladen (C: 1,198 – 3.7%) (FA: 1,711 – 5.2%)	2%	31%	22.7% (Tri-County+)	
Buncombe* (C: 5,730 – 2.8%) (FA: 7,795 – 3.7%)	18%	43%	NA Minnie Jones Family Health Ctr., Western NC Comm. Health Svcs.	Project Access
Burke (C: 3,180 – 3.6%) (FA: 5,173 – 5.7%)	0%	9%		Good Samaritan Clinic (FC)
Cabarrus* (C: 6,629 – 5.1%) (FA: 11,079 – 7.9%)	0%	35%		Federal CAP grant; Project Access; Comm. Free Clinic (FC)
Catawba (C: 7,886 – 5.6%) (FA: 10,587 – 7.2%)	3%	8%		Hickory Free Clinic
Chatham* (C: 4,743 – 9.6%) (FA: 6,147 – 11.8%)	5%	8%	33.4% (Piedmont +)	Chatham County Hospital
Craven ϕ (C: 3,677 – 4.0%) (FA: 4,710 – 5.1%)	1%	19%		MERCI Clinic (FC)
Cumberland* (C: 20,919 – 6.9%) (FA: 23,104 – 7.6%)	0%	3%	0.5% (Stedman-Wade)	The CARE Clinic (FC)
Davie * (C: 1,209 – 3.5%) (FA: 2,010 – 5.4%)	0%	54%		Storehouse for Jesus Free Medical Clinic (FC)
Duplin* (C: 7,426 – 15.1%) (FA: 10,754 – 21.2%)	0%	22%	25.9% (Goshen +)	Warsaw Med. Center (RHC)

County (Number Latinos, Percentage of County)	% Latino Adults in County Seen in Adult Public Health Clinic	% Latino Children in County Seen in Child Public Health Clinic	% Latinos in County seen in C/MHC	Other Resources Available
Durham (C: 17,039 – 7.6%) (FA: 25,557 – 11.0%)	0%	4%	50.8% (Lincoln Comm.)	
Forsyth (C: 19,577 – 6.4%) (FA: 32,000 – 10.2%)	0%	6%		Reynolds Health Center; Centro de Comunidad (FC) Community Care Ctr. (FC)
Franklin * (C: 2,100 – 4.4%) (FA: 2,628 – 5.3%)	5%	57%		
Gaston ϕ (C: 5,719 – 3.0%) (FA: 8,867 – 4.6%)	2%	26%	NA (Gaston Family Health Services; FQHC-look alike)	
Granville (C: 1,951 – 4.0%) (FA: 2,900 – 5.7%)	0%	27%		Stovall Medical Ctr +
Greene (C: 1,511 – 8.0%) (FA: 1,593 – 8.2%)	4%	40%	160.8% (Greene CHC +)¥	
Guilford ∀ (C: 15,985 – 3.8%) (FA: 25,927 – 6.0%)	0%	2%		Guilford Child Health; Healthserve Ministries (FC), Comm. Clinic of High Point (FC); Project Access
Harnett ϕ (C: 5,336 – 5.9%) (FA: 6,185 – 6.4%)	1%	26%	20.7% (Western Medical Group; Tri-County)	
Henderson ϕ ♦ (C: 4,880 – 5.5%) (FA: 6,604 – 7.1%)	2%	19%	93.5% (Blue Ridge +)	Volunteer Resource Ctr. (FC)
Hoke * (C: 2,415 – 7.2%) (FA: 3,861 – 10.7%)	8%	43%		
Hyde (C: 131 – 2.2%) (FA: 301 – 5.2%)	4%	30%		Ocracoke Health Ctr. (RHC)
Iredell (C: 4,182 – 3.4%) (FA: 6,641 – 5.1%)	0%	15%		Open Door Clinic (FC)
Johnston * (C: 9,440 – 7.7%) (FA: 12,895 – 9.7%)	0%	26%	52.7% (Tri-County +)	Benson Area Medical Ctr. (RHC)
Lee (C: 5,715 – 11.7%) (FA: 9,302 – 18.5%)	0%	5%	21.3% (Piedmont +)	Helping Hand Clinic (FC)
Lincoln (C: 3,656 – 5.7%) (FA: 5,290 – 7.9%)	3%	12%		

County (Number Latinos, Percentage of County)	% Latino Adults in County Seen in Adult Public Health Clinic	% Latino Children in County Seen in Child Public Health Clinic	% Latinos in County seen in C/MHC	Other Resources Available
Macon (C: 454 – 1.5%) (FA: 1,552 – 5.0%)	0%	16%		
Mecklenburg (C: 44,871 – 6.5%) (FA: 63,733 – 8.7%)	0%	1%	1% (Metrolina Comp Health Ctr.)	Carolina Health Care System clinics; Nursing Ctr. for Health Promotion (FC)
Montgomery * (C: 2,797 – 10.4%) (FA: 3,871 – 14.2%)	4%	24%		
New Hanover (C: 3,276 – 2.0%) (FA: 5,214 – 3.1%)	0%	5%	17.3% (New Hanover)	Tileston Outreach Health Ctr. (FC)
Onslow (C: 10,896 – 7.2%) (FA: 13,343 – 8.9%)	0%	3%	0.7% (Goshen +)	Rose Hill Medical Ctr. (RHC); Caring Comm. Clinic (FC); Project Access
Orange (C: 5,273 – 4.5%) (FA: 7,676 – 6.2%)	0%	5%	38.3% (Piedmont +)	Student Health Action Coalition (FC)
Pender* (C: 1,496 – 3.6%) (CH: 2,317 – 5.4%)	14%	47%	4.8% (Goshen)	Black River Health Services (RHC), Rural Health Ctr. (RHC)
Pitt♦ (C: 4,216 – 3.2%) (FA: 5,159 – 3.8%)	0%	10%	23.1% (Greene)	Greenville Comm. Shelter (FC); Health Assist (FC); Pitt County Indigent Care Clinic (FC); HRSA CAP grant to serve uninsured; Project Access
Randolph (C: 8,646 – 6.6%) (FA: 13,615 – 10.1%)	0%	10%		MERCE Medical Clinic (FC)
Robeson * (C: 5,994 – 4.9%) (FA: 8,449 – 6.7%)	2%	29%	21.6% (Robeson Health Care +)	
Rowan * (C: 5,369 – 4.1%) (FA: 7,386 – 5.5%)	0%	9%		Community Care Clinic (FC); Good Shepard's Clinic (FC)
Sampson * (C: 6,477 – 10.8%) (FA: 7,667 – 12.3%)	2%	8%	50% (Tri-County +)	Four County Medical Ctr. (RHC); Newton Grove Medical Ctr. (RHC)
Surry ϕ (C: 4,620 – 6.5%) (FA: 6,452 – 8.9%)	3%	53% +		Surry Medical Ministries Clinic (FC)
Tyrrell (C: 150 – 3.6%) (FA: 313 – 7.5%)	23%	80%		Columbia Medical Ctr. (RHC)
Union ϕ ♦ (C: 7,367 – 6.2%) (FA: 10,914 – 8.0%)	0%	25%		
Vance (C: 1,957 – 4.6%) (FA: 2,726 – 6.2%)	0%	16%	7.6% (HealthCo)	

County (Number Latinos, Percentage of County)	% Latino Adults in County Seen in Adult Public Health Clinic	% Latino Children in County Seen in Child Public Health Clinic	% Latinos in County seen in C/MHC	Other Resources Available
Wake (C: 33,985 – 5.4%) (FA: 41,210 – 6.1%)	0%	35% +	2.2% (Wake Health Services)	Open Door Free Clinic (FC); Community Mental Health Clinic (FC); Project Access; Tarboro Rd. Family Medicine +; Project Access
Wayne (C: 5,604 – 4.9%) (FA: 7,472 – 6.5%)	0%	15%		Mt. Olive Family Medicine Ctr. (RHC): WATCH Mobile Unit (FC)
Wilkes ϕ (C: 2,262 – 3.4%) (FA: 4,306 – 6.5%)	3%	61%		West Wilkes Medical Ctr. (RHC); Boomer Medical Ctr. (RHC)
Wilson (C: 4,457 – 6.0%) (FA: 5,706 – 7.6%)	0%	26%	NA (Harvest Family Health Ctr; Wilson Comm. Health Ctr.)	Wilson Comm. Health Ctr. (RHC)
Yadkin * (C: 2,357 – 6.5%) (FA: 3,336 – 8.9%)	13%	54%		
Yancey (C: 478 – 2.7%) (FA: 927 – 5.1%)	0%	55%		

Source: C: US Census Bureau. 2000 Census. FA: Faith Action, 2002 Latino Estimates. Health Department data from: Division of Public Health. NC Department of Health and Human Services. HSIS Data. July 2000-June 2001.[15] Community/Migrant Health Center data from: NC Primary Health Care Association. Uniform Data System. 2001.

* County is listed as a primary care provider for the Carolina Access program for all ages.

ϕ County is listed as a primary care provider for the Carolina Access program for children.

♦ County is listed as a primary care provider for the Carolina Access program for pregnant women.

∀ County is listed as a primary care provider for the Carolina Access program for adults.

+ The health center, clinic, or health department receives federal funding as a migrant health center or as a NC Farmworker Health Program contract site.

FC: Free Clinic.

NA: Not Available.

¥ Greene County Community Health Center serves a large number of migrants who are not counted in the Census.

To further refine the data, a small work group comprised of representatives of the Office of Research, Demonstrations and Rural Health Development, NC Division of Public Health, NC Primary Health Care Association and NC Hospital Association examined the data to determine if there were other community resources available that were providing primary care services to a significant percentage of the county's Latino population. Based on this analysis, the Task Force identified a number of communities where there is the greatest unmet need for primary care services for Latinos:

- *Greatest identified access problems for adults and children in communities with more than 5,000 Latinos* - Less than 20% of adults or children seen by health department or Community Health Center, and no other comprehensive system to care for uninsured: Alamance, Catawba, Cumberland, Randolph, Rowan, Wayne.

- *Greatest identified access problems for adults and children in communities with less than 5,000 Latinos* - Less than 20% of adults or children seen by health department or Community Health Center, and no other comprehensive system to care for uninsured: Beaufort, Burke, Craven, Iredell, Lincoln, Macon, New Hanover.
- *Greatest identified access problems for adults in communities with more than 5,000 Latinos* - Less than 20% of adults seen, and no other comprehensive system to care for uninsured: Gaston, Surry, Union, Wilson.
- *Greatest identified access problems for adults in communities with less than 5,000 Latinos* - Less than 20% of adults seen, and no other comprehensive system to care for uninsured: Alleghany, Franklin, Granville, Hoke, Hyde, Montgomery, Pender, Wilkes, Yadkin.
- *Significant access problems for adults and children in communities with more than 5,000 Latinos* - Less than 50% but more than 20% of adults or children seen by health department or Community Health Center, and no other comprehensive system to care for uninsured: Chatham, Duplin, Harnett, Lee, Robeson.
- *Significant access problems for adults and children in communities with less than 5,000 Latinos* - Less than 50% but more than 20% of adults or children seen by health department or Community Health Center, and no other comprehensive system to care for uninsured: Bladen.
- *Significant access problems for adults in communities with less than 5,000 Latinos* - Less than 50% but more than 20% of adults seen by health department or Community Health Center, and no comprehensive system to care for uninsured: Davie, Tyrrell.
- *Access barriers for adults and children in communities with more than 5,000 Latinos* - Less than 80% but more than 50% of adults or children seen by health department or Community Health Center, and no other comprehensive system to care for uninsured: Durham, Johnston, Sampson.
- *Unclear access* - Communities with more than 5,000 Latinos that have more comprehensive systems of care through hospital outpatient clinics, Project Access systems or federal CAP grants, but uncertain what percentage of Latinos are being seen: Buncombe, Cabarrus, Forsyth, Guilford, Mecklenburg, Onslow, Orange, Pitt, Wake.
- *Latino health needs appear to be met* - Communities that have federally funded migrant health centers that appear to be meeting the needs of the Latinos in the community: Greene, Henderson.

While certain areas of the state have a more acute need, the Task Force recognized a need for more primary care services throughout the state.

Tiendas

Because of the dearth of affordable, linguistically accessible, and culturally appropriate health care services, some Latinos in this state turn to local *tiendas* when they get sick. *Tiendas* are stores that sell a variety of products, including food, clothing, and music. Some *tiendas* operating in North Carolina also sell pharmaceuticals that they obtain from Mexico or mail order wholesalers in the

United States.[16] The drugs available through some *tiendas* include steroids; injectable vitamins; oral, injectable, and cream antibiotics; and even some controlled substances. A Burke county sheriff inspected one *tienda* and found more than 75 different pharmaceuticals for sale. Further, some of the medications on the shelf were out-of-date or manufactured for use in animals only. The availability of non-prescribed medications administered by non-licensed individuals raises serious concerns about the potential health risks associated with the use of these medications. Nationally the deaths of several children can be traced back to the use of self-prescribed medications obtained from unlicensed health care providers. In addition, non-sterile use of injectables has been suggested as a link to some HIV infections. The Food and Drug Protection Division of the NC Department of Agriculture, and the Dairy and Food Protection Branch of the Department of Environmental Health, have jurisdiction to monitor these *tiendas*, but to date, few enforcement actions have been taken.

Recommendations

The state should continue to support publicly funded programs that are already providing services to the Latino population, while at the same time help to expand the availability of services throughout the state. While many communities are underserved, efforts to expand services should target the communities that are most underserved. As a starting point, the state could look at the counties that have been identified as having the greatest need for primary care services.

Given the state's current fiscal crisis, the Task Force recommended that priority be placed on identifying federal or private funding to expand primary care services. However, the state and local communities also have a responsibility to help serve the growing Latino population.

Further, the Task Force members recognized that Latinos are likely to continue seeking medications from *tiendas*, until health care services become more accessible and affordable. While not condoning this practice, the Task Force members recommended that top priority should be placed on expanding the availability of affordable, linguistically, and culturally appropriate health care services provided by fully licensed health care professionals. Concurrent with this effort, the state should collaborate with Latino organizations to launch a public education effort to inform Latinos about the importance of first seeking medical advice from a trained health professional, how to navigate the US health care system, and potential risks of using self-prescribed medications. Similar information should be provided to the owners of the *tiendas*.

The Task Force recommended that:

2. **The NC Primary Health Care Association, in conjunction with the NC Office of Research, Demonstrations and Rural Health Development and other state agencies, encourage and assist communities in seeking federal Community and Migrant Health Center (C/MHC) funds to expand the availability of primary care, dental, and behavioral health services. Additionally, the NC General Assembly should appropriate funds to C/MHC to be used as support for federal grants.**

More effort is needed to encourage communities to apply for federal funding. The NC Primary Health Care Association has already started outreach efforts to work with existing C/MHC and other groups interested in applying for this money. However, additional outreach efforts are needed to identify potential community organizations interested in applying for these funds. The Primary Health Care Association should work with other potential collaborators including: free clinics, Latino-based community organizations, area mental health, developmental disability, and substance abuse programs (MHDDSAS), health departments, faith-based organizations, and other community groups.

The ORDRHD can assist the NC Primary Health Care Association by helping to eliminate barriers to new C/MHC start-ups or expansions. For example, the Office of Research, Demonstrations and Rural Health Development should continue its collaboration with the NC Primary Health Care Association to help community organizations with board development, grant writing, and seeking funds for the The Kate B. Reynolds Charitable Trust or The Duke Endowment for capital needs. Funding from the General Assembly would help in this effort. Federal funds cover only 20-40% of a health center's budget, the rest must come from patient revenues and local sources. Funding from the General Assembly can be used to match federal funds, bringing more federal funds to the state and increasing access to Latinos.

3. **The NC General Assembly increase funding for the Migrant Fee-for-Service program so that the funds are sufficient to provide health services year-round.**

The NC Department of Health and Human Services should request full and recurrent funding for this program.

4. **The NC General Assembly appropriate additional funds to the Office of Minority Health and Health Disparities (OMHHD) to expand the capacity of OMHHD to focus on Latino Health issues. Specifically, the OMHHD should expand its technical assistance, communicate with communities about funding opportunities, provide cultural diversity and interpreter training to local agencies, non-profits, and community groups, and conduct research into the major health issues facing Latinos.**

    - **As part of this effort, the OMHHD Hispanic Health Task Force should be expanded to include a broader collaboration of state agencies and other organizations. This collaboration should help support the development or expansion of local coalitions to address the health needs of Latinos.**

    - **If no new state funds are immediately available, the Department of Health and Human Services should explore state, federal, and private grant sources to obtain additional revenues to support the work of OMHHD.**

The OMHHD's Hispanic Health Task Force should review its mission in light of this Task Force report and expand to include additional partners as needed to ensure the implementation of the Task Force recommendations, and to develop

ongoing policies and program to address the health care needs of Latinos. Collaborating partners should include, at a minimum, the Division of Public Health, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Division of Medical Assistance, Division of Social Services, NC Office of Research, Demonstrations and Rural Health Development, Area Health Education Centers, and the NC Primary Health Care Association. In addition, the collaboration should provide technical assistance and support to local communities to encourage them to develop broad-based collaborations to address the health care needs of Latinos at the local level. As part of the overall assistance provided to local community groups, the Department of Health and Human Services should take the lead on monitoring federal, state, and private foundation funding sources, providing information about the availability of these funds, and providing technical assistance in applying for available resources.

5. **Latino organizations and leaders, in conjunction with the NC Department of Health and Human Services, the NC Board of Pharmacy, the NC Department of Agriculture, and the NC Medical Society launch a public education effort using the Latino media to educate Latinos and owners of tiendas about the importance of seeking medical advice from a trained health professional. This media effort should also teach Latinos how to navigate the US health system and about the potential health risks of using self-prescribed medications.**

Reproductive Health

The Women's Health Branch, of the NC Division of Public Health, NC Department of Health and Human Services, operates certain programs and services to improve the health and well being of women during their reproductive years. This includes maternity services, family planning services, and programs that target teen pregnancy prevention. In addition to operating programs directly, the branch works with other state agencies that operate programs or services to improve women's health and/or reduce infant mortality.

Maternity Services

Latinas may not qualify for Medicaid during their pregnancy if they are undocumented or recent immigrants. As a result, many Latinas are uninsured throughout the course of their pregnancies. Because of the growth in the Latino population, the need for prenatal services has grown without an increase in funding to cover the costs. Pregnant Latinas can get limited Medicaid coverage to cover prenatal care services, but that requires the women to apply for Medicaid and be determined presumptively eligible. Generally, the period of presumptive eligibility lasts for a maximum of two months. Many health providers are not set up to help women obtain presumptive eligibility. Further, lack of Medicaid reciprocity from state-to-state makes it difficult for pregnant, migrant women to receive benefits.

In 2000, 68 local health departments reported that they provided more than $7 million in uncompensated maternity care services to pregnant, uninsured Latinas. This has caused severe financial hardship to many health departments, who are trying to provide the services without specific reimbursement.

Innovative Initiatives

Catawba Centering Model

Catawba County is testing a new way of providing prenatal care to Latina pregnant women. The approach, called a Centering model, offers education and support to a group of pregnant women (while continuing to provide clinical examinations on a one-on-one basis). Center models can help reduce transportation costs, increase trust in the health system, and enhance community support. There are no new funds for this model, but existing maternity clinic funds could be used to support a Centering model.

Community health centers and other providers also provide uncompensated prenatal care. One Task Force member commented that it is actually financially disadvantageous to encourage pregnant Latinas to seek early prenatal care, as there will be more uncompensated costs to the clinics. While Medicaid will cover the costs of the delivery (emergency Medicaid), it will not cover the costs of providing prenatal care. Another problem noted is that some women may have health insurance coverage through work, but the cards are not in their own names. This makes it difficult for them to use their insurance coverage for prenatal care, delivery, or other health-related needs (see Chapter 7).

In the past, the March of Dimes has helped fund a folic acid awareness campaign along with some state funds. Although folic acid awareness is no longer a national March of Dimes funding priority, the North Carolina chapter continues to provide some support for the campaign. Folic acid has been shown to significantly reduce birth defects; a multivitamin with folic acid taken prior to conception can reduce the incidence of neural tube birth defects by 70%. Thus far, the state's folic acid awareness campaign has targeted Latina women only to a limited extent, even though Latinas are at higher risk for having babies with a neural tube defects. Campaign activities for the 2002-03 fiscal year include an expansion of outreach to the Latino community. An effective outreach campaign would involve the faith-based organizations and Spanish media (newspaper, radio, and television).

Family Planning[17]

The Women's Health Branch of the Division of Public Health helps fund four family planning pilot projects aimed at Latinos. The funds are provided to four agencies in three counties (two in Planned Parenthood agencies, one in a community health center, and one in a family resource center). Funding is used for outreach, transportation, and language services in addition to contraceptives. Currently, the programs serve approximately 1,000 Latinos. The state's goal is to eventually expand these initiatives for the entire state.

North Carolina can improve access to family planning services by expanding community clinic-based preventive service projects and expanding access to contraceptive methods of choice. The pilot projects demonstrate that Latinas are more willing to use family planning services when offered in community-based settings with pre-existing ties to the Latina community. Health care providers are not as well trained in the use of contraceptive methods that are favored with Latinas, including IUDs and natural family planning. Several years ago, IUDs fell out of favor with US doctors because of the litigation surrounding the Dalcon Shield. Now there are safe and effective IUDs, and there is a need to retrain doctors and other health professionals in IUD insertion. The Women's Health Branch has started to address this by offering trainings on natural family planning and IUD insertions. Additional training is necessary to ensure that there are sufficient numbers of providers to insert IUDs or counsel women on natural family planning methods.

Additionally, the state is seeking a Medicaid waiver that would enable all Medicaid-eligible women with incomes below 185% of the federal poverty

guidelines to receive preventive health and family planning services. The state estimates that one pregnancy will be delayed for every 3.8 women provided family planning services. However, because of laws that restrict recent immigrants from qualifying for Medicaid (see Chapter 7), many Latinas will be ineligible for this program. A similar program is needed for non-Medicaid eligible women with similar incomes who have a history of serious medical conditions and/or poor reproductive health outcomes.

Teen Pregnancy Prevention Programs

The state operates two programs aimed at reducing teen pregnancy: Teen Pregnancy Prevention Initiatives (TPPI) and Adolescent Parenting Programs (APP). TPPI projects are aimed at preventing first time pregnancies, and APP programs are aimed at delaying second pregnancies and in helping teen parents finish high school. The state funds 71 projects across the state, although reduced budget proposals for the 2003 fiscal year will result in the loss of about one-third of that number, to between 45 and 53 projects. Few of these projects target, or even reach, Latino teens. For example, the APP projects only work with teen parents who are in school. Since Latinos have a higher high-school dropout rate, they have less chance of participating in one of the APP projects. One way of increasing Latino participation in these programs is to reach out to Latino community groups to encourage them to apply for these funds, and to develop new models for APP projects that would encourage teens who dropped out of school to return to school. Over the past three years, the Adolescent Pregnancy Prevention Coalition of North Carolina, a non-profit statewide organization working on teen pregnancy prevention, has organized meetings for providers interested in increasing their outreach to the Latinos.

Recommendations

Aside from the four targeted Latino family planning projects, few other reproductive health or women's health initiatives target Latinas. Instead, support for services to Latinas has been integrated into overall program services. Existing funding has supported outreach and interpreter services and acquisition of Spanish-language materials for client education. However, existing resources are stretched thin, and cannot accommodate the needs of all Latinos for reproductive health services. Further, culturally and linguistically accessible family planning services, teen pregnancy prevention projects, and maternity services are not available throughout the state.

Latinas have much higher pregnancy rates and are less likely to initiate prenatal care in their first trimester than other population groups. Health departments and community and migrant health centers try to provide pregnant Latinas with prenatal and family planning services, but the ability to provide services is limited by the lack of funding. Latinas, especially those born outside the United States, have lower infant mortality rates, but national studies suggest that these positive birth outcomes are unlikely to continue as Latinas acculturate to the United States. More is needed to ensure that Latinas receive culturally and linguistically appropriate reproductive services.

Innovative Practices

Lee County *Cambios*

In 2000, Lee County had the second highest teen pregnancy rate in the state, over 25% among Latinas. The Coalition to Improve the Quality of Life in Lee County, using DHHS teen pregnancy prevention funding, helped develop a special program to encourage Latino teens to avoid pregnancy and to stay in school. The Coalition worked with Latino community leaders, parents, the school system, the Lee County Health Department, 4-H Clubs, and other youth organizations to implement *Cambios*, a Spanish teen pregnancy prevention curriculum. The program was included as part of the after school program offered to migrant and immigrant children in two Lee County middle schools, and in the ESL class offered at the high school. A total of 120 Latino students have been served in the first year and a half. Since the program began, no participants have become pregnant.

Parental support and involvement is a key to the success of teen pregnancy prevention programs in Latino communities, and the Lee County project has shown particular success in reaching parents. Parent education events have included "*Noches Latinas*" with as many as two hundred Latino parents attending and learning, not only how to communicate with their children about sexuality, but also, how to pass along cultural values to their children, and how to negotiate the American school system.

The Task Force recommended that:

6. **The NC Division of Public Health lead the effort to expand the availability and accessibility of culturally appropriate maternity services, family planning, and teen pregnancy prevention services to Latinos across the state.**
    - **These efforts may include, but not be limited to, assisting local health departments in maximizing federal funds to pay for prenatal care, expanding the availability of group prenatal projects, expanding availability of targeted family planning programs offering culturally appropriate services, and targeting some of the available teen pregnancy prevention funds to Latino youth.**
    - **In addition, the NC General Assembly should appropriate additional funds to expanding the availability and accessibility of culturally appropriate maternity services, family planning, and teen pregnancy prevention services to Latinos across the state.**

Additional funds are critically important to expand the availability and accessibility of culturally appropriate maternity, family planning, and teen pregnancy prevention services. However, even in the absence of new funds, the Division of Public Health can take steps to improve the accessibility of existing programs. Specifically, the Division can:

Maternity Services:

- Provide technical assistance to local health departments and other community providers to enable them to develop Centering programs (group prenatal care projects), using either nurse midwives or doctors to provide clinical services.
- Provide technical assistance to local health departments and community-based providers to ensure that they maximize Medicaid funds through use of presumptive eligibility. One way to assist in this effort is to encourage DSS to outstation eligibility workers to health departments and community clinics that serve large Latino populations, or to allow pregnant women to apply through the mail.
- Ensure that any state funded folic acid campaign targets Latinas as well as other populations.
- Develop other methods to make folic acid more accessible to the Latina population, including providing folic acid multi-vitamins directly to low-income women, and working with the Department of Public Instruction to make sure that school meals include folic acid.

Family planning:

- Expand the targeted Latino community clinic-based family planning projects to other sites across the state.

- Train health providers in health departments and the private sector (through medical schools and continuing medical education) in IUD insertion and in other forms of contraceptive choice among Latino women.

Teen Pregnancy Prevention:

- Increase outreach to Latino community groups to encourage them to apply for funding for TPPI and APP projects, and ensure that all groups that receive funding through TPPI or APP grants do outreach to involve Latino teens.
- Give priority in TPPI/APP funding to community collaborations that include mental health, primary health, DSS, and community organizations.
- Work with other community groups to develop new APP models for teens who have dropped out of school.

When new state funds become available, the General Assembly should appropriate funds to:

- Cover the uncovered costs of prenatal care for pregnant immigrants below 185% of federal poverty guidelines who do not qualify for Medicaid. While exact estimates are not available, a survey of 56 health departments in 2001 revealed that more than $7 million in uncompensated prenatal care was being provided statewide. Given that some pregnant immigrants receive prenatal care from other providers, it is likely that additional funding would be needed to fully address the costs of providing prenatal care to low-income pregnant immigrants.
- Increase funding for Maternity Care Coordination (MCC) for non-Medicaid at-risk pregnant women. The cost of providing MCC services to undocumented immigrants would be $2,105,400 for SFY 2002.
- Ensure access to family planning services for at least two years after a pregnancy for all low or moderate-income teens or women. The state can use the current women's preventive health and maternal health appropriations as the match for this waiver. Using this approach, the state would gain $9 in federal Medicaid dollars for every $1 spent providing family planning services to Medicaid-eligible women with incomes below 185% of the federal poverty guidelines. The state should provide funding for family planning services for non-Medicaid eligible women who are at-risk of pregnancy complications or poor birth outcomes.

Child and Adult Immunizations

The NC General Assembly funds a universal childhood vaccination program that provides free childhood vaccinations to participating physicians. Physicians who participate in this program can charge families a small administration fee to administer the vaccine, but may not charge for the cost of the vaccination. In addition, free vaccinations are available through local public health departments and many community and migrant health centers. While the child immunization program has helped eliminate most of the financial barriers to the receipt of immunizations, there are still other barriers such as lack of knowledge of the

Innovative Practices

Vacunas Para Todos

With the help of the First Lady, Mary P. Easley, and funding from GlaxoSmithKline, the Immunization Branch has developed a special initiative called Vaccinations for Everyone (*Vacunas Para Todos*). This pilot project is operating in four counties: Cabarrus, Chatham, Henderson, and Pitt and is aimed at increasing the immunization rates among children and women of childbearing years. The Chatham County project is also targeting working adults. The same four counties will help pilot the state's immunization registry.

importance of early immunizations, language, or transportation barriers which prevent some Latino families from receiving immunizations.

Latino children are less likely to have up-to-date immunizations than children of other races. Only 64% of Latino children had their 4-3-1 immunization series by 24 months, compared to 80% of white children, 71% of African American, 73% of American Indian, and 69% of Asian children in North Carolina.

The state hopes to implement an immunization registry next year. The registry is being funded by the Centers for Medicare and Medicaid Services (CMS) and is a collaborative project between the Immunization Branch and the Division of Medical Assistance (that operates the Medicaid program). Most of the funding comes from CMS, but the state has to provide matching funds. Once the immunization registry is operational statewide, the state will be able to capture more timely data to determine if there are racial, ethnic, or geographic disparities in immunization status. The new immunization registry has the capacity to collect racial and ethnic data, as well as the full names of Latino children.

While the state has made strides trying to immunize Latino children, there has not been a similar effort to provide immunizations to Latino adults, except in response to rubella outbreaks. The recent rubella outbreaks during 1996-2000 show that there is an ongoing need to provide immunizations to adults as well as children. In many foreign countries, the effort has been on providing polio and measles vaccinations, but not rubella. Further, some countries are more focused on coverage (i.e., immunizing all children), and not necessarily on whether the immunizations are provided in a timely manner (i.e., by 24 months). Therefore, some Mexicans enter the country without measles-mumps-rubella (MMR) vaccinations.

Recommendations

The Task Force recommended that:

7. **The NC Department of Health and Human Services expand its immunization outreach efforts to ensure that Latino children and adults receive appropriate immunizations.**

As part of this strategy, the Department should:

- Replicate successful immunization strategies developed in the pilot counties throughout the rest of the state.
- Implement regular worksite vaccinations for Latino workers.
- Enhance outreach efforts into the Latino community to educate parents about the need to obtain immunizations for themselves and their families; where and how to get vaccinations; and to help build the trust in the Latino community with the public health system.
- Support the implementation of the immunization registry to enable the state to collect more accurate information about immunization rates among different groups of children.

Dental

Improving oral health requires both prevention and treatment efforts. A number of different oral health prevention activities focus on children in North Carolina. Since the mid-1970s, the NC Oral Health Section has operated a school-based preventive dentistry program that provides preventive and educational services primarily to children in elementary grades. Currently, the school-based program includes oral health screening with subsequent referral and follow-up for children in need of dental treatment. The program also includes provision of preventive dental sealants for children at highest risk for dental caries. The Oral Health Section also promotes the fluoridation of community drinking water supplies, a well-proven disease prevention tool that benefits all segments of a community. Depending on availability of funds, grants of up to $10,000 are awarded to cities and towns in North Carolina to encourage development and continuation of community water fluoridation operations by the NC Oral Health Section. Public schools often benefit from these enhanced water fluoridation efforts.

In the late 1990s, the Oral Health Section collaborated with the NC Partnership for Children and the Ruth and Billy Graham Children's Health Center to pilot an innovative program to prevent early childhood dental caries in preschool-age children in western North Carolina. This program, *Smart Smiles*, helped deliver preventive oral health services to children of low-income families through their primary medical care providers. As a result of the work on *Smart Smiles*, the NC Division of Medical Assistance initiated a statewide program, *Into the Mouths of Babes*, to reimburse primary medical care providers for delivering this preventive oral health package to children who are from 9-36 months of age and enrolled in Medicaid. There are no ongoing dental health prevention activities that target adults, however.

While dental health prevention activities are available for many children, the availability of ongoing, comprehensive dental care remains limited. Low-income people, including those with Medicaid as health insurance coverage, often have difficulties finding dentists who are willing to treat them.[18] Medicaid recipients face substantial problems accessing dental services, primarily because of the low dental reimbursement rates. Medicaid pays between 40-60% of typical dental fees, as a percent of usual, customary, and reasonable (UCR) charges. In contrast, NC Health Choice pays 95-100%.[19] Dentists are far more likely to participate in NC Health Choice than in Medicaid because NC Health Choice pays closer to the usual charges. Problems finding dentists are compounded for the Latino population, many of whom are uninsured and experience language barriers.

To expand access to dental services for low-income and underserved populations, the Oral Health Section and the Office of Research, Demonstrations and Rural Health Development have supported expansion of the dental safety net within health departments, community and migrant health centers and other non-profit organizations. There are currently 73 non-profit organizations that operate close to 100 safety net dental facilities (i.e., both fixed clinics and mobile dental vans) that provide ongoing dental care to low-income Medicaid and/or uninsured individuals (Map 5:1).[20] Local health departments operate half of

Innovative Practices

Lee County Health Department Dental Clinic

With help from the Kate B. Reynolds Charitable Trust, Lee County health department developed a dental clinic to serve low-income and other uninsured children. The dental clinic is staffed by one Latino dentist and two Latino dental assistants. The Lee County health department commitment to serving their Latino community members is reflected in the overall composition of the Lee County health department's staff-about 20% are Latino. Approximately 42% of the children seen in the dental clinic are Latino. The clinic has been in operation for two years, and serves patients from both Lee and Chatham counties. The health department has plans to expand the dental clinic to adults.

Innovative Practices

NC Baptist Hospitals

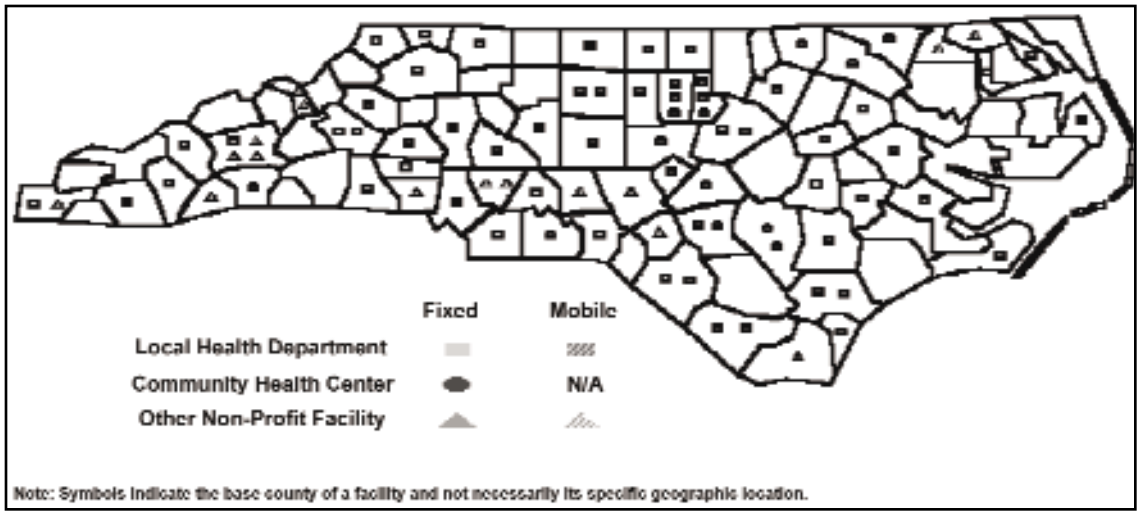
NC Baptist Hospitals has two dental centers and a mobile dental unit that offer services to underserved populations of all ages, including Latinos. The Mineral Springs Dental center is located, by design, in a largely Latino neighborhood. The office coordinator is bilingual. The Cleveland Avenue Dental Center is located in a low-income neighborhood with many Latinos. There is an interpreter there three days each week. Several other staff have some Spanish-speaking skills. Both of these dental centers offer the full gamut of dental services and are open evening hours to accommodate those who work or are in school. The mobile dental unit provides the same services as the dental centers in several locations and has a half-time interpreter on staff. The mobile unit spends about two thirds of its time in neighboring rural counties that have no Medicaid providers, and other time in selected public schools with a large number of Latino children. It also provides some services to migrants in Yadkin County in the summer. The combined dental programs served 393 Latino patients in FY2000 (10% of the total). In FY 2002, 1,890 Latino patients were served (17% of the total).

these dental facilities, while community-based organizations (including community and migrant health centers and other non-profits) operate the remainder. These safety net dental clinics serve more than 80 counties across the state. While some of these clinics limit their services to children, others are open to all in need. In addition, there are 12 free clinics around the state that offer limited dental services.[21] (Map 5.1)

Map 5:1

Dental Care Safety Net Facilities as of 2002

Source: Venezie R. NC Oral Health Section. Presentation to the NC IOM Latino Health Task Force. June 2002.



In addition to the dental safety net facilities that serve low-income Medicaid and uninsured people generally, the state allocates $150,000 in contracts with seven organizations to provide dental services to migrants.[22]

Recommendations

Despite the availability of dental prevention services and dental care safety-net facilities, more effort is needed to improve the oral health of Latinos in North Carolina. Access to comprehensive dental care requires a three-prong strategy: focusing on patients, payers, and providers. Patients need to be informed and educated about the importance of regular dental care. In addition, strategies are needed to overcome barriers, including language, cultural differences, and transportation, which deter patients from seeking services. Access to care also is dependent on finding dental professionals willing and able to serve the population in need. The NC IOM Task Force on Dental Care Access found that the primary reason dentists were unwilling to serve the Medicaid population was the low dental reimbursement rates. Increasing the Medicaid reimbursement rates can help improve access for this population, but other strategies are needed to expand dental access for uninsured Latinos. North Carolina also has a shortage of dentists, which compounds the problem.[23]

The Task Force recommended that:

8. **The General Assembly appropriate additional funds to increase access to culturally and linguistically accessible dental services for Latinos.**

    - **These efforts should include, but not be limited to additional funds to recruit bilingual dental professionals, increasing Medicaid reimbursement rates, and funding dental care coordinators.**

    - **In addition, the NC Department of Health and Human Services should continue and expand existing programs that provide dental services to Latinos by providing technical assistance to local organizations to help establish dental safety-net programs, expanding the provision of preventive school-based services, and continue funding the *Into-the-Mouths of Babes* program.**

Specifically, the General Assembly should:

- Appropriate $10.57 million to increase Medicaid reimbursement rates for dental services.
- Appropriate $2.0 million to provide additional funds to ORDRHD to recruit dentists to safety-net dental clinics, through loan repayment and other methods. Funds should be used to target bilingual dental professionals.
- Appropriate $375,000 to fund care coordinators who can help eliminate barriers that prevent Medicaid recipients from accessing dental services (such as transportation).

In addition, the General Assembly should explore the development of a dental care case management program (similar to Carolina Access, a primary care case management program), where dentists would be paid a case management fee to manage the patients' dental needs.

Even without new funding, the Department should continue some of its existing efforts to expand access to dental services for low-income and uninsured individuals. North Carolina philanthropies can assist in this effort by funding additional or expanded dental safety-net clinics with the capacity to serve Latinos. This can have a positive impact on the Latino community, many of whom are in need of dental services.

Mental Health, Developmental Disabilities, and Substance Abuse Services

The state of North Carolina does not collect data on the prevalence of mental health problems among its citizens, including its Latino populations. However, the mental health professionals on the Task Force reported that many recent Latino immigrants experience depression and stress-related symptoms associated with the isolation they experience in leaving their families and the stress involved in migration. There are also some North Carolina data to suggest that Latino males have higher incidence of alcohol abuse than other population groups. Thus, while the Task Force was unable to quantify the full extent of mental health and substance abuse problems (e.g., behavioral health problems) among Latinos, it was clear that these problems do exist. Further, Latino children are more likely to be born with certain birth defects, including neural tube defects and Downs Syndrome.

It is also clear that the Latino population's use of publicly funded mental health, developmental disability, and substance abuse services is very low (Table 5:2). Latino children with developmental disabilities receive publicly funded services at a higher rate than Latino adults or children with mental health or substance abuse problems; however, even Latino children with developmental disabilities are underserved compared to other client populations.

Table 5:2
Active MHDDSAS Clients per 1,000 Total Population (SFY 2001)

	Child	Adult	All
Total Active Clients			
All persons served	43.5	37.6	39.0
Latinos	12.4	11.1	11.5
Mental Health			
All persons served	26.4	20.1	21.6
Latinos	5.3	4.2	4.6
Developmental Disabilities			
All persons served	7.9	2.2	3.6
Latinos	4.5	.02	1.5
Substance Abuse			
All persons served	4.0	11.3	9.5
Latinos	1.2	4.3	3.3

Source: NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Client Profile Statistical Report for the Fiscal Year 2000-01.

Statewide, North Carolina's Mental Health, Developmental Disabilities, and Substance Abuse System (MHDDSAS) serves 1.4% Latinos, about one-third of the number of Latinos in proportion to their representation in the population.[24] Put another way, the area programs serve 11.5 Latinos per 1,000 Latinos, compared to 39.0 per 1,000 people overall. Latinos are less likely to receive services from area programs than African-Americans (61.1 per 1,000), whites (32.6 per 1,000), Native Americans (49.6 per 1,000), or other racial groups (20.0 per 1,000). These data suggest that Latinos are being underserved, although this assumes that Latinos need mental health services to the same extent as other groups of people.

Some area programs do a better job serving the Latino community. For example, the Neuse Center serves 33.5 Latinos per 1,000 in their catchment area. Albermarle, Roanoke-Chowan, Alamance-Caswell, Foothills, Rockingham, Smoky Mountain, Wilson-Greene, and Centerpoint all serve more than 20 Latinos per 1,000 Latinos in their service area. In contrast, some area programs, including Edgecombe-Nash, Davidson, Pathways, Durham, Southeastern Regional, OPC, Wake, Mecklenburg, Trend, Piedmont, Pitt, Riverstone, and Johnston appear to serve fewer than 10 Latinos per 1,000 Latinos in their service area. (See Appendix C).

The Division of MHDDSAS conducted a statewide consumer satisfaction survey to gauge consumer satisfaction with the services provided by the area programs.[25] Overall, Latinos were about equally satisfied with the services they received as other groups. A couple of the area programs receive higher consumer satisfaction ratings, including Randolph and Duplin-Sampson area programs. Satisfaction surveys have a major drawback, however, in that they meas-

Innovative Practices

Neuse Area Program

The Neuse Area Program, together with the Smart Start program in Jones County, purchased a mobile camper that they outfitted with toys, Spanish language books, and brochures. For six months of the year, a clinical staff member drove the camper to various Latino migrant camps and fields. The therapist disseminated free car seats, toys, and other such items to the children, and provided their parents with Spanish language brochures and materials on MH/DD/SA issues, treatment, and resources. This therapist also identified children with developmental disabilities in need of special treatment, and parents and children in need of mental health services.

The informal, rewarding, and non-threatening nature of these contacts in a location both familiar and comfortable to the Latino community enabled the Neuse Area Program to develop a good reputation and trusting relationships with their Latino migrant community.

ure satisfaction of individuals who have already found their way into the system of care. Those who have been discouraged or never seek mental health, developmental disabilities, or substance abuse services are not included in survey results. Aside from language and cultural competence, confidentiality may be a barrier that prevents some Latinos from seeking care. Latinos may not understand their rights with regard to confidentiality, and may fear that they will be reported to INS if they seek mental health services from a public agency.

State Mental Health Plan

The Department of Health and Human Services has developed a new state reform plan for mental health, developmental disabilities and substance abuse services (called *State Plan 2002: Blue Print for Change)*. In the past, area MHDDSAS programs delivered services directly. Under the new plan, area programs will become contracting agencies (Local Management Entities, or LMEs). LMEs are required to develop a business plan that will ensure that a full range of services will be available to serve the population in their catchment area, following their transition from their role as a service provider to their new role as overseer of the public MHDDSA system.

The plan also includes provisions to address racial and ethnic disparities, which should help make services more accessible to the Latino population. Some of the key tenets of the plan are:

- To involve families and consumers in the local system development.
- To require cultural competence of all its qualified professionals.
- To require the Division and LMEs to track, identify, and develop strategies to address racial/ethnic disparities in access to services or supports.
- To shift its priorities and resources to serve target populations.
- To put emphasis on "best practices" for all consumers.

Recommendations

The Task Force proposed a set of recommendations to ensure that publicly-funded mental health, developmental disabilities, and substance abuse services are accessible to the Latino community. Many of these recommendations are implicit in the tenets of the new state plan. However, specific action steps were recommended to ensure that services were linguistically and culturally appropriate for Latinos. Specifically, the Task Force recommended that:

9. **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Local Management Entities take aggressive steps to recruit and train sufficient providers who can provide linguistically and culturally appropriate services. In addition, the Division and LMEs should collect outcome data by race and ethnicityto identify possible disparities in access to MHDDSA services and consumer outcomes. If disparities are found in access or outcomes, the state should take specific steps to address these disparities.**

In order to ensure that services are culturally and linguistically accessible, the Division should:

ExemplaryPractices

Casa Cosecha / Harvest House

Harvest House, located in Newton Grove, is the only residential rehabilitation facility in the state that exclusively provides bilingual services for Latinos with drug and alcohol addiction. Bicultural and bilingual staff members offer a program based on a 12-step holistic approach that is open to any adult male regardless of ability to pay. They operate on sliding-fee scale. Residents stay for 28 days and attend both individual and group discussions with the intent of helping residents recognize how drug and alcohol addiction have affected their lives. The Harvest House provides structure, case management, and assistance with the educational and vocational needs of their clients. The program is open to residents of all counties. During periods of high volume, there is sometimes a waiting list.

In addition, the Harvest House offers Spanish-language courses for persons arrested while driving under the influence of alcohol. These courses fulfill the court-mandated driver's education for those arrested for DUI. The Harvest House is funded through the Tri-County Community Health Center, which receives both private and state/federal funding.

- Establish incentives for the development and retention of individual and agency-based providers who are representative and part of the Latino community.
- Establish standards for cultural proficiency that include an understanding of Latino cultures. What is considered "normal" behavior is culturally based, so providers need to use culturally appropriate methods and standards of assessment, diagnosis, and treatment.
- Identify materials that can be standardized across area MHDDSAS to be translated by the division. Currently each area program develops its own program materials. The Task Force recommended that the state identify those materials that can be standardized across LMEs, and that the state have these materials translated into Spanish.
- Develop and disseminate Spanish language video presentations on MHDDSA topics, such as overcoming depression or addressing alcohol problems, that can be shared across the state.

Local Management Entities should take the following steps to ensure that their services are linguistically and culturally appropriate:

- Conduct state and national searches for bilingual/bicultural staff. The state should consider centralizing the recruitment of bilingual staff, so individuals can consider various job options.
- Ensure that there are sufficient bilingual staff or interpreters to meet the needs of the Latino community served by the LME.
- Support employees or providers who are interested in taking Spanish classes.
- Establish strong mentoring relationships with bilingual professionals that are new to the agency.
- Offer cultural diversity training to all employees.
- Establish a review process to ensure that locally translated forms and brochures are linguistically correct and culturally appropriate.
- Advertise service availability in Latino publications, public service announcements, and with local churches or agencies that serve the Latino population.
- Actively solicit referrals from agencies serving Latino clients.
- Partner with local Latino leaders and agencies on efforts to train staff and reach out to this community. For example, El Pueblo offers a one-day training session on Latino issues, including demographics, cultural beliefs, and how to increase an agency's capacity to serve the community. These are offered at AHECs or can be offered directly to specific agencies.
- Ensure that consumer and family advisory committees reflect the general racial and ethnic demographics of the community.

- Provide outreach and offer MHDDSAS services for Latinos in other community organizations and schools.
- Work with primary care providers to help them identify potential mental health, developmental disabilities, and substance abuse services for Latino patients and to identify Spanish language resources.

Outreach to Latinos During Emergencies

The ice storm that spread across North Carolina in early December 2002 affected millions of residents. Power outages lasted for several days in many communities and cold temperatures drove people to use extreme measures to heat their homes. Many residents attempted to use their charcoal grills and other heating devices designed for the outdoors to warm themselves inside their homes. Latinos, in particular, made up a majority of persons seeking treatment from resultant carbon monoxide poisoning at Durham, Orange, and Wake county hospitals. At least two Latinos died from carbon monoxide poisoning during the weeklong period following the storm.[26] After the ice storm, the power outages affected many Latino organizations as well as prominent Spanish radio stations. Officials turned to door-to-door canvassing to spread alerts. Even so, Latino residents without power had difficulty locating emergency shelters and could not understand or navigate county emergency telephone lines.

Certain agencies responded quickly. In Durham, police, firefighters, and volunteers from El Centro Hispano went door to door to pass out fliers with emergency information. Durham's director of human relations visited Latino neighborhoods using a bullhorn to spread alert messages. Duke Power created a toll-free number for Latino residents to report power outages; CP&L already had messages available in Spanish. The Governor's Office of Latino Affairs developed information in Spanish on what to do and not to do in the case of a power outage. Governor Mike Easley personally called key Latino media to ensure that the message was being disseminated. Despite these efforts, not all Latinos affected by the storm could be reached in a timely manner.

These events highlight the need for improvement in communications with the Latino community following emergencies. After Hurricane Floyd in 1999, the Governor's Office of Latino Affairs, the North Carolina Cooperative Extension Service, the AgrAbility Program, and El Pueblo developed a natural disasters manual in Spanish and English ("*Helping the Spanish-Speaking Population Deal with Natural Disasters in North Carolina*,"[27]). The manual includes a number of posters and handouts in Spanish to distribute to the Spanish-speaking population, public service announcements for the radio, and a directory of organizations that could reach the Latino community. Unfortunately, local and state agencies continue to rely on a few key organizations to reach the Latino community and that can quickly overwhelm those organizations. While such natural disasters and their consequence are impossible to predict, agencies must equip themselves to deal with all groups that make up the population they serve. Governor Easley created the NC Natural Disaster Preparedness Task Force under the leadership of the Secretary of the Department of Crime Control and Public Safety, the Honorable Bryan E. Beatty. The Task Force is charged

with reviewing the response and recovery to the December 2003 ice storm and determining ways the state can improve communication and support to Spanish-speaking residents. Other members include the Secretaries of the NC Department of Health and Human Services, NC Department of Transportation, and NC Department and Environment and Natural Resources, and the Chair of the Utilities Commission.

Recommendations

To address this problem, the Task Force recommended that:

10. The Secretary of Crime Control and Public Safety work with state and local agencies and emergency officials to incorporate rapid, linguistically and culturally appropriate outreach to the Latino community into their overall emergency response plans.

Specifically, agencies should designate a bilingual person who will serve as the contact person for the agency, and should maintain a current list of disaster services that details eligibility requirements for immigrants. Telephone messages for reporting power outages and other disaster-related issues should be in both English and Spanish. Agencies should have materials in Spanish available for immediate distribution following a natural disaster.

Counties and cities (where applicable) should ensure that services for Latinos are part of their written Emergency Plans so they can be prepared for future disasters. Local agencies should have a list of trained bilingual volunteers that can be recruited after an emergency. Someone who knows the community should coordinate the volunteer effort to ensure that the strategy is effective. For example, El Centro Hispano helped direct the efforts of the National Guard in Durham in their efforts to reach the Latino community. This strategy needs to be prepared in advance, so that volunteers without knowledge of the affected community will know where to go and how many people are needed. Further, shelters should be located in areas or in institutions where Latinos have access and trust. Bilingual volunteers should be designated to staff these shelters to facilitate communication.

Notes

1. Kaiser Family Foundation. Immigrants' Health Care Coverage and Access. Kaiser Commission on Medicaid and the Uninsured: Key Facts. March 2001.

2. National Association of Community Health Centers. 2000 Access to Health Care: North Carolina. Spring 2001.

3 Bruton S. Executive Director, NC Primary Health Care Association. Presentation to the NC IOM Latino Health Task Force. May 7, 2002. There are resources available for new and existing health centers:

   - $650,000 is available for new starts (e.g., for communities without an existing C/MHC. These C/MHC must assure that they can provide or contract for dental and mental health services. In addition, they must be operational within 90 days of when the grant is funded. The time constraint means that some things must be in place prior to the granting of funds: facility, staff. The lack of facility and staff is preventing some communities from applying for federal funds. The center must eventually see at least 3,000 patients.

   - $550,000 is available for existing centers that wish to open a new primary care, dental or mental health site. The new site must eventually be expected to see 3,000 new patients.

   - $600,000 is available for existing centers that want to expand medical, dental, or mental health services at an existing site. For example, a clinic that has mammogram screening can seek funds to add cervical cervical screening.

   - Additional funds are available for special needs, including black lung victims, public housing residents, healthy school programs and the homeless. However, the Bureau of Primary Health Care is not seeing many applications for special needs or migrant health funding categories.

4. MacCracken S. Women and Children's Health Section. Division of Public Health. N.C. Department of Health and Human Services. Personal communication. February 2002.

5. Howell E. State Center for Health Statistics. Special Data Run from SFY00-01 Health Services Information System. April 2002.

6. Division of Medical Assistance. Carolina Access Primary Care Providers. April 2002. 25 provide primary care to individuals of all ages, 8 to children only, one to pregnant women only, 1 for women only, and 4 for pregnant women and children.

7. 42 USC 1320a-7b

8. Stephanie Triantifillou, Elizabeth Freeman Lambar, and Andrea Radford contributed to the research and writing of this section.

9. The federal government's definition for seasonal and migrant farmworkers varies slightly depending on the program. The federal definition of farmworkers for health-related programs is more restrictive compared the definition for education-related programs. The definition in the health field describes migrant and seasonal farmworkers as:

   Migrant farmworker: an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes a temporary abode.

   Seasonal farmworker: an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker (i.e., does not move).

   However, for educational programs, farmworkers include people who work in timber, dairy, and poultry. Whitehead-Doherty C. The North Carolina Farmworker Health Program. NC Office of Research, Demonstrations and Rural Health Development. Presentation to NC IOM Latino Health Task Force. May 7, 2002.

10. Twenty-four percent of the patients seen in 2001 by NCFHP contract sites were children. Almost all of the patients are poor (95%) and most reported that they were uninsured (82%). Less than 1% reported private insurance, and 1.3% were enrolled in Medicaid. The remaining farmworkers did not provide insurance information to the clinics, so the state does not have information on their insurance status.Whitehead-Doherty C. North Carolina Farmworker Health Program. ORDRHD. Presentation to NC IOM Latino Health Task Force. May 7, 2002.

11. The CHCs that receive targeted federal funding include: Goshen, Tri County Community Health Center, Greene County Health Care, Harvest, Blue Ridge, Robeson Health Care Corp., and Piedmont Health Services. Of these seven CHCs, four receive significant federal migrant dollars directly from the Bureau of Primary Health Care and four receive migrant funding from the North Carolina Farmworker Health Program in the Office of Research, Demonstrations and Rural Health Development.

12. The Migrant Fee-for-Service Program does not keep data on the number of patients served, only on claims paid.

13. National Center for Health Statistics. Health United States. 2000. http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf#Ambulatory, Table 72

14. Data on the percentage of Latinos seen by health department clinics are available through the Division of Public Health's Health Services Information System (HSIS). While information is available about the number of Latinos seen in each of the health departments, there are no data about whether the health department provides comprehensive primary care. Historically few health departments provided comprehensive primary care services, focusing instead on preventive screenings, prenatal care, and immunizations. More recently, some health departments have started offering primary care to some population groups. The health departments that participate as primary care providers for the Medicaid Access program were identified as having the capacity to provide full primary care, although whether they were providing comprehensive primary care to uninsured Latinos was unknown. Information about the percentage of Latinos seen by Community and Migrant Health Centers was an extrapolation from data submitted by each C/MHC on the Uniform Data System (UDS) to the Bureau of Primary Health Care. The UDS data include total users and percent Latino that was used to calculate an approximate number of Latinos served. Some of the centers provided information on the counties included in their service area. The Task Force took the approximate number of Latinos served in each C/MHC and divided it by the total number of Latinos in each health center's service area in order to get a rough estimate of the Latino penetration rate for each C/MHC.

15. The HSIS data are submitted at the clinic level (i.e., a local health department may see Latinos in their adult health, maternal health, child health, or epidemiology clinics.) Each health department also submits data on the unduplicated number of Latinos served during the year. The Task Force calculated an estimate of the penetration rate by dividing the number of Latinos seen by the health department, divided by the total Latino population in that county.

16. Work D. Executive Director. NC Board of Pharmacy. Presentation to NC IOM Latino Health Task Force. October 2002.

17. Ellen Wilson contributed to the research and writing of this section.

18. NC Institute of Medicine. Task Force on Dental Care Access. April 1999.

19. Venezie R. Oral Health Section. NC Department of Health and Human Services. Presentation to the NC IOM Latino Health Task Force. June 12, 2002.

20. NC Office of Research, Demonstrations and Rural Health Development. NC Department of Health and Human Services. Dental Safety Net Providers Database. January 2002.

21. North Carolina Association of Free Clinics (2002). http://www.ncfreeclinics.org/ (accessed February 2002).

22. NC Migrant Health Program. Contracts for Migrant Dental Health Funds for FY 02-03.

23. There is also a shortage of dentists in North Carolina. North Carolina ranked 47th in the number of dentists per 100,000 population (1998). The North Carolina General Assembly just passed legislation to authorize dentists and dental hygienists from other states with a requisite number of years of practice to practice in North Carolina (called licensure by credentials). While this legislation will hopefully help improve the dental supply, it would not necessarily address the maldistribution problem.

24. Kurtz B. Presentation to the NC IOM Latino Health Task Force. July 9, 2002. Data from the FY 00-01 MHDDSA client statistical report.

25. A Spanish language version was made available to people in all area programs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services received 195 usable surveys from people who identified themselves as Latinos, of which 110 were received on the Spanish language survey forms.

26. *Raleigh News and Observer,* December 11, 2002.

27. Available at: http://www.ayudate.org/ayudate/emergencias.html

6 Access to Care

Introduction

Latinos face many challenges in accessing needed health services. New immigrants often have different health care beliefs, and may not understand how the US health system works or how to access services (see Chapter 3). Many Latinos face significant financial barriers, with a disproportionate number of Latinos lacking health insurance coverage, and many afraid to seek services from governmental agencies (see Chapter 7). Like other low-income populations, many Latinos work and have difficulty taking off work to go to the doctor; others have transportation barriers. Latinos, especially recent immigrants, also face significant language barriers. These problems are compounded for migrant farmworkers who travel with the growing season, staying in each individual community for short periods of time. Because of the transitory nature of their work, migrant farmworkers may have little understanding of the local health care systems. Migrants are often isolated, live in rural areas, lack telephones, and may lack transportation.

This chapter focuses on language and cultural barriers faced by the population. Language, in particular, is one of the biggest challenges North Carolina faces with the influx of Latino immigrants. According to the US Census, approximately half of North Carolina Latinos have limited English proficiency (LEP) or are unable to speak English very well.[1] These language barriers can impair a Latino's ability to access needed programs and services. Further, almost 30% of North Carolina Latinos immigrated to the United States recently (since 1995), and may not be knowledgeable about how the US health care system works.[2]

Federal regulations, interpreting Title VI of the Civil Rights Act of 1964, have provisions to ensure that language does not prevent people from accessing federally-funded programs. Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal

assistance.[3] This includes both public agencies receiving federal funds (such as state or local health departments, area mental health programs, or departments of social services) and private individuals and institutions that receive federal funds, including Medicaid or Medicare payments. Title VI regulations prohibit both intentional and unintentional discrimination resulting from policies that may appear to be neutral, but, in fact, have a discriminatory effect. Thus, the failure to make services and programs linguistically accessible to LEP individuals has been interpreted to have a discriminatory effect on the basis of a person's national origin. As North Carolina has experienced one of the fastest growing rates of Latino immigration in the country, complying with Title VI has become a critical issue.

In October and November of 2001, the Office of Civil Rights (OCR) within the US Department of Health and Human Services conducted a review of the NC DHHS to determine their compliance with Title VI. Each of North Carolina's one hundred counties filled out a survey as part of this review. OCR selected specific counties for on-site reviews of local public health and DSS agencies, including Chatham, Randolph, Johnston, Wake and Forsyth. Based on these surveys and site visits, the OCR sent a letter at the request of the NC DHHS outlining their "preliminary assessment" of the situation. The letter described several instances of poor compliance and concluded:

> "…The evidence gathered by OCR during the course of the … review indicates that overall, the NC DHHS fails to provide adequate language assistance to Hispanic/Latino, Hmong and other national origin groups who speak a primary language other than English. This failure makes it more difficult for members of these population groups to access the various services, programs, and benefits provided by NC DHHS and/or outright be denied access to the same. In addition, a lack of adequate language assistance also causes some national origin minorities who are also the agency's LEP clients or prospective clients to be subjected to differential treatment. Accordingly, OCR's preliminary findings reflect that NC DHHS conduct, in the context of the specific circumstances uncovered during the course of this review, constitutes a violation of the Title VI regulatory provisions… Based on the deficiencies briefly summarized [in this letter], OCR's preliminary analysis indicates that the NC DHHS would likely be found out of compliance with Title VI." (*Letter from Roosevelt Freeman, Regional Manager, Office of Civil Rights, Region IV to Secretary Carmen Hooker Buell, dated May 24, 2002, hereinafter referred to as "OCR letter."*)

The failure to comply fully with Title VI could threaten the federal financial assistance received by state or local agencies or private providers. Even absent the threat of loss of federal funds, the Task Force recognized the underlying need to address linguistic and cultural barriers that prevent Latinos from seeking health care services. Thus, the Task Force placed a high priority on ensuring that the NC Department of Health and Human Services, local agencies, and private providers comply with the requirements of Title VI.

Compliance with Title VI involves the provision of linguistically and culturally appropriate services. This seemingly simple statement requires effort and

action on many levels. To the extent possible, care should be compatible with the individual's cultural health beliefs and practices. Further, Title VI requires federal-fund recipients to make services linguistically accessible, by providing free language assistance through translated materials, interpreters, or bilingual staff. Task Force members recognized that the goals of ensuring linguistically accessible and culturally appropriate services could best be met through the use of bilingual providers. This is especially critical when dealing with sensitive health issues or areas, such as counseling, where direct communication between provider and patient is critical. However, there are currently insufficient numbers of bilingual, culturally proficient providers. In the interim, interpreters coupled with skilled professionals who are able to recognize and respond to the health-related beliefs and different cultural understandings of Latinos are needed. To accomplish the provision of culturally and linguistically appropriate services, collaboration is needed between state and local agencies, and between public and private organizations.

The Task Force thoroughly reviewed Title VI guidelines and recommendations issued by several agencies at the national level. OCR issued guidelines on how federal-fund recipients can comply with Title VI (hereinafter referred to as "OCR guidelines").[4] Similar guidelines were published more recently by the US Department of Justice (hereinafter referred to as the "DOJ guidelines").[5] The DOJ guidelines, in particular, try to balance the competing needs of people with limited English proficiency in accessing services or programs against the additional costs that could be incurred.

While the guidance is designed to be a flexible and fact-dependent standard, the starting point is an individualized assessment that balances the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. As indicated above, the intent of this guidance is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.[6]

Using both the DOJ and OCR guidelines as a base, the North Carolina Department of Health and Human Services has developed a Title VI compliance plan that it submitted to OCR. This plan was reviewed by the Task Force, and when appropriate, endorsed as part of its overall recommendations. However, other recommendations were also made to ensure compliance on the part of public and private organizations.

The following sections, including the recommendations, are divided into eight areas that are essential to compliance. These are: *Assessment; Provision of Culturally and Linguistically Appropriate Services; Translation of Written Materials; Training Staff; Monitoring and Reporting; Complaints; and Community Partnerships, Publicity, and Education*.

Assessment

OCR found that the NC DHHS has "failed to conduct an assessment regarding the language needs of (LEP) population groups... As a result, program administrators do not have sufficient understanding regarding the variety and/or overall size of the LEP populations in their respective service areas." (OCR letter) Further, OCR found that the NC DHHS also failed to gather information about the frequency with which members of different LEP categories attempted to access services and programs. Assessment is an important first step in adequately providing language services to LEP groups.

OCR and DOJ guidelines require Title VI recipients, including the NC Department of Health and Human Services, to identify the language needs of LEP persons that are eligible for services or likely to be affected by the program. Federal fund recipients can use census data, client utilization data from program files, and data from school systems and community agencies and organizations to try to ascertain the language needs of LEP individuals. This needs to be done at both the state and local level. In addition, all federal fund recipients are required to collect utilization data by race and ethnicity.

The NC Department of Health and Human Services can help analyze state-level data sources to determine the number of potential LEP individuals in a community. For example, the state can analyze Census data, school enrollment data, or Medicaid/NC Health Choice eligibility information files to identify the number of Latinos or other immigrants in a county. While Census numbers and other state-level utilization data may help identify the number of immigrants in particular areas of the state, these sources are not as helpful in identifying the language skills and cultural background of community members who might seek assistance from a federally-funded agency or health provider. Local monitoring and assessment are needed to adequately identify the language skills and cultural background of community members who might be seeking services.

The OCR guidelines state that federal fund recipients should identify the language needs of each applicant, and document this in the client file. In addition, local agencies must make available language identification cards that allow LEP individuals to identify their language needs. Recognizing that each local agency will not have the capacity to meet the language needs of every individual who seeks services, the OCR guidelines require agencies to identify community resources to help address these needs, and to establish mechanisms to access these services in a timely manner. In addition, the Task Force recognized the importance of understanding the cultural background of the clients, so as to provide culturally appropriate services.

Recommendations

After reviewing the OCR and DOJ guidelines and the draft of the NC Department of Health and Human Services compliance plan, the Task Force recommended that:

11. **The NC Department of Health and Human Services analyze existing data to identify the potential number of individuals with limited English proficiency. These data should be shared with local agencies and health care**

organizations. Local agencies and other federal fund recipients should use this information, along with their own client data, in their assessments to determine the language needs and cultural background of their client population. In addition, federal fund recipients should ask their clients (or program applicants) of their language needs. If an individual self identifies as having limited English proficiency, this information must be recorded in the client's file so that interpreters and/or written translated materials can be provided.

Specifically, the Task Force suggested the following:

- The NC State Center for Health Statistics should collaborate with other NC DHHS Division staff to analyze census and program utilization data at the county level. The Census data will show the numbers of Latinos and other immigrant populations in the county and some income information to help determine potentially eligible individuals for means-tested programs. DHHS and local data systems can examine the Health Services Information System (HSIS) and other state data systems to identify the number of Latinos who use services. NC DHHS should identify any population group where the potential number of LEP persons exceeds five percent of the population or 1,000 people.[7]
- NC DHHS should help local agencies access appropriate language identification cards. Language identification cards help identify individuals with limited English proficiency and also help identify the language needs of individuals. These cards are available from the US Department of Health and Human Services, and are also available through the Internet.[8] The NC Department of Health and Human Services can help local agencies access these resources by developing a Title VI web page for the Department, linking to the US DHHS website that includes the language identification cards. This Web site could also contain all LEP materials the state develops, such as translations of notices, application forms, instructions, and outreach materials.
- The NC General Assembly should require DHHS to work with other groups (e.g., AHEC, state licensure boards, Carolina Association of Translators and Interpreters, Community Colleges) to develop a registry of health professionals who are proficient in other languages (or sign language). The Board of Nursing and the Board of Pharmacy already collect these data, or are in the process of doing so. Other licensure boards should be contacted and encouraged to include similar questions as part of their periodic licensure renewals. By linking LEP persons in need of health care with providers proficient in their language, DHHS will provide persons with a higher quality of care and avoid the cost of providing interpreter services.
- DHHS should make available an assessment tool to enable health and social services programs to evaluate their agency-specific assessment plans and their capacity to meet OCR guidelines (i.e., technical assistance for organizations desiring to improve compliance). An assessment tool is available from the US Department of Health and Human Services.[9] This assessment tool

should be evaluated to determine whether it meets the needs of the state, local agencies, and private sector care providers. If so, links to this assessment tool can be included in the NC DHHS Title VI web page.

- Local agencies and health care providers and institutions should determine the language needs of each applicant/recipient at the first point of contact. Information about language needs should be collected on the program applications or on patient records. Individuals with limited English proficiency must be informed of their right to have an interpreter at no cost.
- State and local agencies and health care providers should develop a written plan that outlines policies and mechanisms to ensure they provide culturally and linguistically accessible services. The plan should be tied to the organization's mission, should include the personnel or departments responsible for implementing the plan, and should include a mechanism for ongoing self-assessments to determine the extent to which the organization is meeting its goals of providing culturally and linguistically accessible care.

Provision of Culturally and Linguistically Appropriate Services[10]

OCR in its evaluation of the linguistic accessibility of local health departments and social services agencies in North Carolina, found that individuals with limited English proficiency were, in some instances, "effectively denied the services" because no interpreter was available.

> "The record also shows that national origin minorities who are LEP have been subjected to unjustified, differential treatment as prohibited under Title VI. There are specific instances in the record where LEP clients were not provided interpreters as needed. In many of these situations, LEP clients did not receive the services sought at the time.... there is also evidence that in a number of situations, after being turned away because no interpreters were available, several LEP clients were never provided the programs or services being sought. In other words, they were effectively denied the services being requested." (OCR letter)

In other instances, local agencies were requiring LEP clients to bring their own interpreters, a policy that violates Title VI.

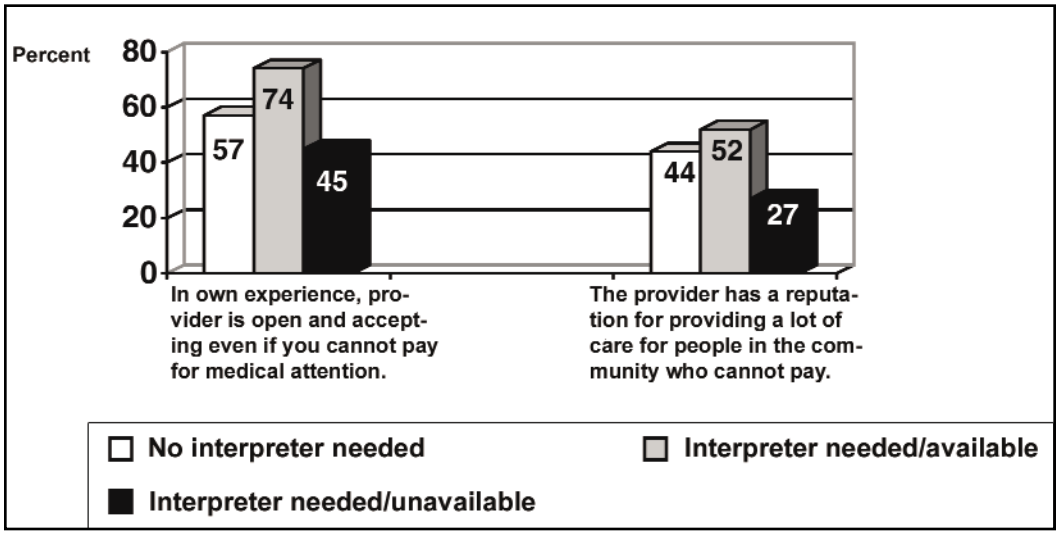
> "…in many instances the agency implements a policy of requiring LEP clients to use their family members, including minor children, and friends as interpreters. The record documents several situations involving LEP clients being turned away because they did not bring their own interpreters with them. In such cases, they were denied assistance altogether or delayed because they were asked to return later with an interpreter. This practice compromises the confidentiality and accuracy of the communication between agency personnel and the clients/patients/beneficiaries." *(*OCR letter*)*

Agencies need to understand that this practice is inappropriate, as it compromises confidentiality and the accuracy of communication.[11] Family members may also be unfamiliar with medical terminology and appropriate methods of

interpreting.

When there are no Spanish-speaking providers or interpreters available, clients are not adequately served. National studies of patients with language barriers show that this population is generally less satisfied with their care, less willing to return to the specific facility where they received care, and less likely to be given a follow-up appointment compared to those without language barriers (Chart 6:1).[12, 13] Needing an interpreter and not receiving one also results in more confusion about how to take prescribed drugs and led to negative attitudes about future use of the facility.

Chart 6:1
Respondents with Positive Perceptions of Provider's Openness to Uninsured and Reputation in Community[14]



Having access to an interpreter may lessen the likelihood that uninsured LEP patients will avoid or delay needed health care.

In North Carolina, interpreters are available at many state and local public and private organizations. For example, almost all health departments have mechanisms to provide translation and interpretation for certain services. Ninety-four DSS offices offer some interpreter services, either through paid interpreters, volunteers, contracts or language lines.[15] Some mental health agencies also have interpreters or bilingual staff. The actual number of interpreters or bilingual staff in local agencies is unknown. Determining the actual number of people who serve in this capacity would be difficult as few agencies have large numbers of dedicated staff interpreter positions. Many bilingual staff members serve in other positions in the agency and their interpreter duties are in addition to their primary responsibilities. These individuals are not listed as interpreters, but as bilingual staff or volunteers. The larger the budget, the greater chance there is a professional interpretor or a high-level bilingual staff member. In smaller counties it is more common to find volunteers or staff that serve multiple roles.

Exemplary Practices

Duke's Organization of Interpreter Services

Duke University's International Patient Services (IPS) office provides interpreter services to Duke Hospital and 17 outlying clinics. During business hours, medical interpreters (including Spanish, Arabic, French, German, and Mandarin) are dispatched from the IPS office. Providers call a central number to request interpretation services immediately or to schedule services for a later time. Interpreter services can also be provided over the phone, which is useful when patient-provider interactions are brief, patients need help making appointments or asking questions, or when assistance is needed with the billing process. After business hours, interpreters are dispatched from the hospital's Service Response Center. One interpreter remains on duty after hours and on the weekends, and a backup interpreter works from home. Overnight and during the weekends, the hospital uses a local contract service that dispatches Spanish medical interpreters to a number of hospitals and agencies.

Training is a central part of the interpreter services provided at Duke. IPS provides extensive training to all new interpreters before they are allowed to interpret in difficult medical situations. In addition, IPS staff members have been certified to give a "Bridging the Gap" course each year that teaches interpreter skills, cultural competency, communication skills, advocacy skills, and professional development to Duke interpreters. IPS hopes to extend the training program so that other local hospitals can participate.

Similarly, private providers, especially those likely to serve the Latino community, also try to have interpreters or bilingual staff available. Community and Migrant Health Centers routinely offer interpreter services, and many have bilingual staff. Eight of the 19 state-funded rural health organizations have at least one bilingual medical provider.[16] However, having one or more people on on staff who speak Spanish may not be sufficient to meet the needs of all the Spanish-speaking people in the service area that have limited English proficiency and are eligible for services.

Each of North Carolina's 140 hospitals has a senior level manager in charge of ensuring that interpreters are available when needed.[17] Since hospitals provide services twenty-four hours a day, these managers are faced with the challenge of providing interpreter services at all times of the day and night. Additionally, maintaining interpreter programs involves the availability of appropriately trained staff, verification of skills and competence among interpreters, costs of recruiting bilingual providers, translating patient-education materials, and establishing back-up services.

While many agencies have started to hire interpreters or bilingual providers, the capacity of these agencies and local providers to meet the language needs of the state's rapidly growing Latino population is still limited. The NC Center for Public Policy Research study in 1995, along with the recent OCR review, showed that the lack of interpreter services and bilingual staff is one of the overriding concerns in meeting the health needs of the Latino population.[18]

Although there are many people in this state who speak Spanish, particularly with the growing Latino population, identifying individuals who are competent to serve as interpreters is not a simple matter. The OCR and DOJ noted that federal-fund recipients must offer competent interpreters free of charge to the LEP individuals. This can be accomplished by either hiring bilingual staff, hiring staff interpreters, contracting with outside interpreter services, arranging for voluntary community services, or arranging/contracting for the use of telephone interpreter services. The DOJ guidelines allow the LEP person to use a family member of friend, if appropriate and the person is competent.[19] However, it is difficult to ensure competency of individuals not specifically trained to be interpreters. Because of the concern over potential breaches of confidentiality as well as the need to ensure trained interpretation, OCR specifically notes that agencies may not suggest or encourage LEP individuals to use friends, minor children or family members as interpreters. If a person chooses to reject the agency's offer of a trained interpreter, or chooses to bring his or her own interpreter, this must be recorded in the file. The NC Department of Health and Human Services, in its proposed compliance plan, requires agencies to inform LEP individuals of their right to free interpreter services.

An important part of providing linguistically and culturally appropriate services is publicizing these services so that consumers will use them. In its evaluation of the NC DHHS, the OCR found that “throughout the State, the agency fails to provide notice to program participants that interpreter services are available to them at no cost." (OCR letter) All health care organizations need to publicize, in English and Spanish, the fact that they provide interpretation services

to those who need them. Further, the NC DHHS Office of Citizens Services' toll-free hotline (CARELINE) should be publicized so that individuals who need information about the availability of publicly-funded services and / or interpreter services can obtain information. The Office of Citizens Services has bilingual staff who can answer questions and refer individuals with limited English proficiency to appropriate state and community resources.

Covering the costs of interpreter services is more complicated, especially for private providers. Some of these costs can be reimbursed through Medicaid, for example, interpreters used during the DSS eligibility process can be reimbursed as an administrative cost at a 50% federal match rate. However, only 67 of the 100 DSS offices claim the 50% administrative match for interpreter services.[20] Interpreters used by health professionals during the provision of medical services may be included as part of the cost-based reimbursement paid to public providers, community and migrant health centers, and rural health clinics. Some private providers may be able to build some or all of the interpreter's costs into their reimbursement system; but this may not always be possible, particularly when the state pays based on a fixed payment scale (for example, physicians are reimbursed as a percentage of Medicare's physician payment system. There is no mechanism in the state's current payment system to enhance payments to physicians who hire interpreters to serve the Latino population).

Information from the National Health Law Program showed that a number of states have obtained federal funding to help offset part of the costs of interpreter services.[21] Idaho, Hawaii, Maine and Utah receive reimbursement for interpreter services as a covered service, thus obtaining reimbursement at a higher match than the traditional 50% administrative match rate. Hawaii, Washington and Utah contract with agencies to provide interpretation services. The state pays for these services directly. Washington plans on moving to a contract broker system for all interpreter services, which is expected to result in reduced rates. In New Hampshire, interpreters contract with the state as participating providers. Idaho, Maine and Minnesota require providers to pay for interpreter services, but then the state reimburses the providers for these costs.

While training and finding payment sources for interpreters is critically important, it does not replace the need for hiring bilingual staff or providers who can work directly with the Latino population. Under the state personnel system, state agencies can increase salaries for bilingual staff by 5%.[22] While this option is available, it is not always used. Similar systems are not always available at the local level. Further, special recruitment efforts are needed to recruit bilingual and bicultural providers and agency staff, and to encourage Latino youth to seek health care professions.

Recommendations

To address these needs, the Task Force recommended that:

12. The North Carolina General Assembly appropriate funds to AHEC and the NC Department of Public Instruction to develop specific career development strategies targeted to middle and high school LEP and Latino students to promote educational success and to foster interest in higher edu-

Exemplary Practices

Union County DSS

Union County's Department of Social Services is at the forefront of developing culturally appropriate and linguistically accessible services. The agency has hired a Spanish-speaking receptionist and five caseworkers to help determine eligibility for public assistance programs. They also contract for the services of interpreters/translators for other programs provided to families. Before these employees were hired, they had only 50 Spanish-speaking cases. Their Latino caseload has grown to more than 1,000 Medicaid cases and 350 Food Stamp cases. In addition, Union County DSS developed a training video and other materials, including basic information on Latino culture, demographics, public assistance eligibility issues, and child welfare services for Latino families for use by its staff. This video has been used by several other county social services agencies, both inside and outside of Union County. The video's production costs were all donated.

cation (including associate, college and post-graduate education) to enter health and human services professions. Community Colleges and Universities should help facilitate the entry of Latinos and other bilingual individuals into health and human services professions.

Ultimately, the best way to address the language barriers of the Latino population is to train native-Spanish speaking individuals in the health professions. Not only will training native-Spanish speaking individuals in health professions help address the language barriers that currently exist, but it can also help ensure that more patients receive culturally appropriate care. Identifying Latino youth who may be interested in a health care or human services profession, and encouraging them to obtain the needed training may be the best way to address the health care needs of the growing Latino population. One promising way to identify these youth is to collaborate with Latino organizations that have youth leadership programs, such as El Pueblo, El Centro Hispano of Durham and the NC Society of Hispanic Professionals.

One of the major barriers to this approach is the current policy of the NC Community College System, which restricts undocumented immigrants from enrolling in college level or other post-secondary courses for academic credit. According to the state's interpretation of federal immigration law,[23] Community Colleges can only enroll undocumented immigrants in GED preparation, Adult Basic Education, Adult High School, English as a Second Language (ESL) or other continuing education courses, and not in post-secondary institution (whether or not the student is willing to pay the full costs of their education). Other states, including New York, California and Texas, have developed systems to enable undocumented immigrants to enroll in their post-secondary institutions for college level courses.

The Task Force also recommended that:

13. **The Department of Health and Human Services help local communities in their efforts to recruit and retain bilingual and bicultural providers and to hire and train interpreters. The Department will take responsibility for identifying possible grant sources for these efforts, and will assist local communities in seeking these funds. In addition, the Department should develop systems to maximize federal funds to reimburse providers and agencies for interpreter services. The NC General Assembly should appropriate funding to the Department of Health and Human Services to assist in recruiting bilingual and, if available, bicultural health professionals and pay for interpreter services.**

The Department of Health and Human Services should coordinate the state's efforts to recruit and retain culturally appropriate bilingual staff and interpreters. The state should also monitor possible federal grant sources, and help local agencies apply for these funds for culturally appropriate interpreters or bilingual providers when available.

Funding from the General Assembly should be provided to the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) to recruit additional bilingual and bicultural providers. Recruitment should be broadened to include all types of health professionals (including dentists, mental health providers, substance abuse counselors, doctors, nurses, certified nurse midwives, and physician assistants). In addition, ORDRHD should develop materials to assist local agencies in recruiting bilingual and bicultural providers.

The NC Department of Health and Human Services should also work with the Office of State Personnel to determine whether there is an existing classification for interpreters, and whether staff that serve in dual capacities (both as interpreters and as another job function), could qualify for differential pay based on a differential job classification. This could affect interpreter pay at both the state and local level. Counties use the state's classification system in establishing an employee's classification, although the amount of pay for each job classification is determined at the county level. Thus, an upgraded classification could yield higher pay, which could assist in recruitment efforts. Durham County DSS, for example, currently pays a differential salary for bilingual staff members.

In addition, the Department should develop methods to use Medicaid and NC Health Choice funds to reimburse private providers who use interpreters when providing services to Medicaid-eligible individuals or children covered by NC Health Choice. The Department should consider the experiences of other states to determine whether there are less costly methods of paying for the costs of interpreter services through Medicaid and NC Health Choice.

Additionally, the Department may have some ability to negotiate lower rates for telephonic interpretation services. Using the purchasing power of the state, the NC Department of Health and Human Services should explore the possibility of negotiating lower rates for telephone interpretation services for all state and local agencies. If possible, these lower rates should be made available to other local health providers and organizations providing health and human services to LEP individuals. Alternatively, the Department may want to consider Washington's approach of entering into a contract with a broker, who can provide interpreter services to public agencies and private providers. The Division of Public Health has a contract with Tri-County Community Health Center to provide interpreter services to health professionals; however, the availability of these services is limited. The state may want to explore whether this contract can be expanded or another contract entered into, so that telephonic interpretation is available 24 hours / day, 7 days / week.

To address the issues around certification and credentialing of foreign health professionals, the Task Force recommended that:

14. **The Governor's Office and NC Department of Health and Human Services explore the issues around certification, credentialing and licensing of foreign graduates and research what other states are doing to develop systems to enhance recruitment of bilingual and bicultural health, behavioral health, dental, and human services providers.**

- **Because of the immediate need for bilingual and bicultural mental health**

and substance abuse counselors, the NC Department of Health and Human Services should work with the NC Social Work licensure board and the NC Certification Board for Substance Abuse Counselors and Office of State Personnel to facilitate the certification, credentialing, licensure and employment of bilingual, bicultural social workers and substance abuse counselors.

- **The General Assembly should appropriate funds to the University and Community College systems to provide course work tailored to foreign graduates to assist them in preparing for certification, credentialing and licensure in social work, substance abuse, nursing and other allied health and human services professions to increase the recruitment of bilingual, bicultural providers.**

Some health, behavioral health and other human services professionals that have been trained in a Spanish-speaking country have moved to North Carolina, but it is currently difficult for them to practice in North Carolina because of state licensure and certification requirements. The Task Force did not study this issue in great detail, but recognized that some of these professionals may be competent to practice in North Carolina, and can address the gap in the availability of bicultural, bilingual health, behavioral health and social services providers. Several North Carolina organizations have investigated this issue over the past two years and are collaborating with national associations that are also interested in the issue. The Task Force recognized that a more extensive review of this issue is generally necessary; however, wanted more immediate attention focused on removing barriers for foreign-trained social workers and substance abuse counselors in order to address the dire lack of bilingual and bicultural behavioral health professionals.

The Task Force also recommended that:

15. **Staff at health, behavioral health and social services organizations, including the leadership and governing boards be diverse and representative of the community that they serve.**

In order to help promote cultural awareness and understanding, staff should be ethnically and racially diverse, and should reflect the population the organization serves. This will improve the organizations' ability to provide culturally appropriate services.

Translation of Written Materials

OCR requires that certain vital documents be translated into other languages for each LEP group of people who are likely to be affected or served by the agency. These vital documents include: applications; consent forms; letters containing important information regarding program participation; notices pertaining to the reduction, denial or termination of services or benefits, and the right to appeal; notices advising individuals with limited English proficiency of the availability of free language assistance; and other outreach materials. Generally, this rule applies to languages of groups that constitute five percent or 1,000 persons in a given population (whichever is less). The 5%/1,000 people threshold is a "safe harbor," which means that if the state translates written materials for

population groups that meet the 5%/1,000 person threshold, that such translation will constitute strong evidence that the state is complying with these requirements. In addition to Latinos, there are several other population groups that potentially may meet the 5%/1,000 person threshold. These include the Hmong and other population groups that comprise more than 1,000 people who could be eligible for services and who may need language assistance.

The NC DHHS compliance plan ensures that vital documents will be translated into Spanish and made available to local entities. If local information needs to be included, it must be provided in the individual's primary language. Local agencies are responsible for the translation of programs specific to their community.

The Task Force found that there is no standard practice on how to translate materials into other languages. Public agencies need more resources and guidance so that all vital documents can be translated into Spanish. With the assistance of Latino leaders and organizations around the state, the NC DHHS developed a guide for translating documents into Spanish that has been available on the Internet since 2000 (*Developing, Translating and Reviewing Materials in Spanish)*.[24] However, it is not clear whether this document is well-utilized.

The Task Force also wanted to encourage the coordination and sharing of information among agencies. There have been past efforts, led by the now-defunct Bilingual Resources Group within the NC Department of Health and Human Services, to centralize documents that had been translated into Spanish by local public health departments, but the effort to develop a centralized database of translated materials was abandoned for lack of funding. The effort to maintain a library of health care resources available in Spanish has been more successful through the AHEC system's Spanish Language and Cultural Training Initiative's web page (a project funded by The Duke Endowment).[25] Similarly, the North Carolina Primary Health Care Association houses the NC Farmworker Health Alliance Resource Library, intended to support individuals or organizations who are helping to improve the health of farmworkers and their families. Efforts are underway to catalog the resources and make the inventory available to others on the Internet. Similar efforts to share resources are needed among public agencies, including local health departments, departments of social services, and area mental health programs.

Even when materials are available in Spanish they are often underutilized. For example, public benefit program forms in English are being sent from the state agency headquarters to Spanish-speaking people. This represents a lack of coordination between the state agency and county administrative agencies and it has caused some LEP persons to be dropped from the rolls of public benefit programs forcing them to reapply for benefits. Coordination between state and local agencies needs improvement so that translated materials are well-utilized.

Innovative Practices

The Spanish Language and Cultural Training Initiative

The Spanish Language and Cultural Training Initiative is an effort supported by The Duke Endowment and coordinated by the North Carolina AHEC (Area Health Education Centers) Program. The five components of the initiative are language training for providers and students, interpreter training, instructor training in basic medical Spanish, mental health and substance abuse, and immigrant health information resources. The NC AHEC partners with the Area L AHEC, the Duke University AHEC Office, the UNC Chapel Hill School of Public Health and Health Sciences Library, and the NC DHHS Office of Minority Health and Health Disparities (OMHDD). Each of the partner organizations has taken the lead in one of the initiatives. For example:

OMHDD offers interpreter training several times a year in various AHEC locations across the state. In total, since 1998, 54 Interpreter Trainings have been offered to over 1,068 participants. In 2002 alone, 19 trainings were offered to over 329 participants.

The UNC School of Public Health has developed a video, a handbook, sequenced workshops, and the Language Across the Curriculum Program (LAC) as part of the language-training component.

The Mountain AHEC offers a two-day seminar to train instructors on how to teach the basic Spanish course.

The Duke AHEC Office provides basic Spanish for mental health and substance abuse providers and training on Latino cultural issues in mental health.

The Area L AHEC has helped develop a Spanish-language materials website with a wealth of information for use by providers and students.

Recommendations

To address these issues, the Task Force recommended that:

16. **The NC Department of Health and Human Services take the lead in translating vital documents into languages needed by groups of individuals with limited English proficiency. Local agencies have an independent responsibility to translate written materials (such as notices, applications, outreach materials) if the forms or services are unique to the local communities and the LEP populations that meet the OCR prevalence thresholds.**

Specifically, the NC Department of Health and Human Services should, whenever possible, standardize social services, health department, and mental health, developmental disabilities and substance abuse area program applications, forms and notices. Materials that are necessary for all clients must be translated into principal languages other than English, and should be made available to all public programs serving LEP persons. In addition, the state should develop standardized notices informing LEP persons of their right to receive an oral translation of written materials. These forms should be developed in the principal languages of individuals served by the state and at reading levels appropriate for the groups to be served.

As noted earlier, Title VI applies not just to public agencies, but to any provider who receives federal funds. Thus, to ensure that other vital records are translated, the Task Force recommended that:

17. **The NC Hospital Association, NC Medical Society, Administrative Office of the Courts, and Health Lawyers Section of the NC Bar Association work collaboratively to identify standardized legal forms that affect health care (such as health care power of attorney, guardianship forms, and living wills). These forms should be translated into Spanish and other needed languages and made available to Latino organizations, individuals in need of the forms, and through the Internet.**

Training Staff

The OCR guidelines state that staff who are likely to have contact with LEP persons must be trained to ensure they are knowledgeable about LEP policies and procedures, work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between clients, providers and interpreters. The NC Department of Health and Human Services proposed compliance plan models this guideline. For example, North Carolina's proposed Title VI access policy requires appropriate training at new employee orientation and continuing training programs. The training should include language assistance policies and procedures, resources available to support such procedures, how to effectively use interpreters, and familiarization with the discrimination complaint process. Each local agency must also develop cultural awareness training programs for appropriate employees. Agencies should maintain records of the training provided to each staff member. In addition, local agencies have a responsibility to ensure that grantees, contractors, and other entities that receive state or federal dollars are trained in these requirements.

The NC DHHS compliance plan includes a provision that appropriate training is provided to bilingual staff and interpreters employed by or utilized by local entities. This training should include confidentiality, the ethical responsibility of interpreters, how to accurately and impartially interpret, and specialized terminology needed to interpret. Interpreter training must ensure that the person learning to be an interpreter has effective communication skills in English and in the primary language of the LEP individual, and has demonstrated cultural proficiencies.

Since 1994, the NC Interpreter Task Force, an interagency group consisting of the NC Primary Health Care Association, Department of Health and Human Services, El Pueblo, AHEC and others has worked to develop a training curriculum for interpreters as well as helping to set state-level policy on the issue. In 1998, as part of the AHEC Spanish Language and Cultural Training Initiative, the Interpreter Task Force was able to hire a full-time coordinator (who was housed at the Office of Minority Health and Health Disparities) and develop a Level II and III training. These are currently offered through AHECs.

Currently, many interpreters lack this type of training. The OCR found that the NC DHHS "fails to have sufficient measures to evaluate the competency of those serving as interpreters." (OCR letter) In North Carolina, no formal test exists to certify interpreters. Many times the persons hiring interpreters are not bilingual and have no way of assessing applicants' language skills. A standardized test of interpreter competence is needed.

Providers also need training about the use of interpreters. Even when qualified interpreters are available, the NC DHHS has no clear procedures informing staff on how and when to access interpreters. The policies that do exist are unfamiliar to many staff members. More education needs to occur so that providers use existing interpreters effectively. The Interpreter Task Force has also developed a training "How to Effectively Work with an Interpreter." This should be more widely available.

The NC Area Health Education Centers (AHEC) Program has taken the lead, working with other statewide partners, in developing interpreter training courses, and implementing language skills among health care professionals (see sidebar). Private educational institutions, such as Duke University and Wake Forest University, have developed their own curricula to increase their health career students' capacity to serve Latinos. Further, the University of North Carolina at Chapel Hill currently offers a 10-session non-credit course that covers speaking and listening comprehension; but is in the process of developing a one- or two-semester intermediate Spanish course to be offered to health professions students. The goal is to eventually make this training available statewide through DVD and the Internet.

The community colleges also offer Spanish-language classes as well as interpreter classes. The Z. Smith Reynolds Foundation recently awarded the Community College system a $200,000 grant over a two-year period to establish a liaison from the System Office to work with community colleges to enhance the services provided to Latino learners, increase the number of classes where

interpreter training is offered, and collaborate with other agencies that offer similar training.

The Task Force recognized a need for two types of trainings: training for agency staff in both public and private agencies about Title VI requirements and how to provide assistance to individuals with limited English proficiency; and training to ensure that interpreters have certain core competencies.

Recommendations

To address these issues, the Task Force recommended that:

18. **The NC Department of Health and Human Services develop a model training curriculum that can be shared with local agencies, and if appropriate, private providers, to inform staff about Title VI policies and how to make services more accessible.**

19. **The OMHHD expand the availability of cultural diversity training to staff at local health departments, DSS, mental health and other health, dental, behavioral health, and human services agencies.**

All agency staff that interact with clients should be provided language and cultural diversity training. The training should be geared to different types of staff who work in health, mental health, dental, and social services organizations, including but not limited to receptionists, eligibility workers, social workers, health, dental, and mental health professionals. The training should include many topics, including but not limited to: the effects of culture on workplace encounters, effective communication, the organizations written policies and procedures, information regarding Title VI, strategies for conflict resolution, and the impact of culture on health, diagnoses and treatment, and health outcomes. Training should be tailored to the specific organization.

While a number of efforts have been undertaken to ensure that there are sufficient numbers of trained interpreters, many of these efforts are operating under time-limited grant funding. To address the ongoing need for interpreters, the Task Force recommended that:

20. **The NC General Assembly appropriate funding to maintain and expand the AHEC Spanish Language and Cultural Training Initiative and the Office of Minority Health and Health Disparities interpreter training and cultural diversity training courses.**

The AHEC/OMHHD program has received national recognition. However, the foundation funding for this initiative is limited, and scheduled to end by December 2003. The General Assembly should give a high priority to continue funding this initiative, to ensure that the state has sufficient numbers of trained interpreters. Further, the state, working with the Community College system, should develop a registry of students who successfully completed the training, and this registry should be made available to public agencies and private providers who are seeking trained interpreters.

21. **The University of North Carolina and Community College systems review all program offerings and should offer language/cultural competency courses for health professional students and place a priority on offering such courses. In addition, the Community College system should expand the availability of interpreter training courses offered throughout the system.**

Some initial work has started on this issue. A few community colleges currently offer and/or have offered Associate Degrees in interpreting. The NC DHHS, Office of Minority Health and Health Disparity Hispanic Health Task Force, AHEC and the Community Colleges should collaborate to develop such offerings.

Monitoring and Reporting

Absent a mechanism to monitor the provision of services and program operation, there is no way to ensure that services are culturally and linguistically accessible. The OCR guidelines require that federal fund recipients monitor the programs and services provided to ensure linguistic accessibility and cultural appropriateness at least annually. As part of its annual monitoring, the federal fund recipients must:

- Assess the current LEP makeup of its service area and communication needs of LEP applicants and clients.
- Determine whether the agency's existing language assistance is meeting the needs of such persons.
- Determine whether staff is knowledgeable about policies and procedures and how to implement them.
- Assess whether sources of and arrangements for assistance are still current and viable.

The Department's compliance plan requires local agencies to conduct an annual compliance report. Self-monitoring must be conducted on a quarterly basis by state and local agencies. A standard reporting system will be developed by the state, and should be used by local agencies. In addition, the Department and local agencies must ensure that other subcontractors that receive federal funding also conduct self-assessments and provide additional training or modify services if necessary.

Because the state has not yet implemented its compliance plan, there is no ongoing monitoring system. The Task Force recognized that individual agencies and local providers have primary responsibility for monitoring service delivery to ensure that services are linguistically and culturally appropriate. Nonetheless, the NC Department of Health and Human Services has ultimate responsibility for ensuring that Title VI requirements are met. This means that the state has an independent responsibility to monitor and oversee the provision of services by local agencies.

Exemplary Practice

***El Centro Hispano* of Durham**

El Centro Hispano is a grassroots community-based organization dedicated to strengthening the Latino community and improving the quality of life of Latino residents in North Carolina and the surrounding area by developing programs in the areas of education, leadership development, community organizing, community support, and economic development. Some of their programs include: English as a Second Language, GED, parenting classes for adults, counseling, summer camps for children and youth, women's and youth leadership groups, problem solving community forums, referrals, interpretation, advocacy, consultation with agencies in the county that are trying to better serve the Spanish speaking community, and providing micro-enterprise development training. Project LIFE - a project that provides health education and prevention in the area of HIV / AIDS, diabetes and/or sexually transmitted diseases (STD).

Recommendations

To address this issue, the Task Force recommended that:

22. The NC DHHS establish a standardized OCR compliance reporting system for use by state and local programs and agencies; and ensure that local agencies coordinate their Title VI compliance activities with that of the Department. The local monitoring will include a standardized consumer/client assessment instrument to assess the extent to which the programs and services are linguistically accessible. In addition, NC DHHS should conduct periodic site visits to determine the extent of Title VI compliance by local agencies.

Complaints

Individuals who have been harmed by a federal-fund recipient's failure to follow Title VI requirements can file a complaint to OCR and NC DHHS. Under federal law, individuals have 180 days from the date of the alleged discrimination to file a complaint to OCR. To implement this provision, the NC DHHS compliance plan instituted a proposed process to investigate and address complaints. Under the DHHS policy, individuals who have complaints must file them within 180 days of the date of the alleged discrimination. Individuals who do not speak or write English must be given assistance in their primary language in filing the complaint. The state agency or Division shall investigate the complaint, generally within 30 days of when the complaint is issued. All interested parties have a right to submit evidence. The goal is to be able to resolve the issue informally if the investigation shows a violation occurred. However, if the state Division or Agency cannot resolve the complaint informally within 60 days, then the matter will be referred to the Secretary's Office with a recommendation that appropriate proceedings be brought under applicable state or federal law.

Recommendations

To ensure that this provision is implemented, the Task Force recommended that:

23. The NC DHHS require each state or local agency or Division within NC DHHS to notify the NC DHHS Office of General Counsel every time a complaint is filed, so that the Department can maintain a database of complaints to discern if there is a pattern of the types of complaints raised, and if any additional action is needed at the state level to address these issues. Language accessibility issues raised with the Office of Citizen Services should also be reported to the NC DHHS Office of General Counsel.

Community Partnership Publicity and Education

Community-based Latino organizations in certain counties have established collaborative relationships with their local public health and social service agencies. These community collaborations have involved community outreach, organizing health fairs, recruiting staff, and many other efforts. Examples of this include Hispanic Action Office in Winston-Salem and *El Centro Hispano* in Durham. El Pueblo, as a statewide Latino organization, actively participates in several NC DHHS committees and Task Forces, as well as provides input in program planning and evaluation of local and state health-efforts aimed at Latinos.

It is important and necessary for the state to build its own capacity in serving the needs of LEP clients. This responsibility cannot be transferred to non-profit organizations operating in the community, as most community-based organizations are not funded by the state and have limited resources. However, the Task Force recognized that collaborations among and between these agencies are of benefit to the community and should be encouraged.

Recommendations

One way to enhance the capacity of local communities to address the health needs of the growing Latino population is to train more Latino community leaders around health issues. To address this need, the Task Force recommended that:

24. El Pueblo, in collaboration with AHEC and other organizations, create a Latino Health Institute dedicated to improving the health of North Carolina Latinos.

The Task Force recognized a need for leadership in Latino health. Many agencies throughout the state, both public and private, require assistance in their efforts to address Latino health issues and reach out to the Latino community. Over the past few years, El Pueblo, as a statewide organization, has served in this capacity. Different Latino organizations and individuals have also worked to meet the health needs of Latinos across the state. Discussions have begun about the creation of a Latino Health Institute specifically devoted to Latino health. This entity would dedicate itself to improving the health of Latinos in North Carolina from a Latino perspective and would undertake projects in the following areas:

- Leadership development
- Health policy and advocacy
- Direct services
- Training
- Coalition work
- Research and evaluation
- Technical assistance

Notes

1. US Census, 2000. Supplementary Survey Summary File 3. PCT006, PCT020.
2. US Census 2000. Supplementary Survey Summary File 3. PCT64H.
3. 42 USC § 2000d and implementing regulations found at 45 C.F.R. Part 80.
4. OCR policy guidance, December 5, 2001. Available on the Internet at: www.hhs.gov/ocr/lep/guide.html (accessed November 10, 2002). Note: since the publication of this policy guidance, the US Department of Justice has issued guidelines. In general, the two guidelines are similar, however there are some differences-particularly as it relates to written translation of materials. The US Department of Health and Human Services is in the process of updating their policy guidance, to reflect the changes from the DOJ guidelines. When the two guidelines vary, reference is given to the DOJ guidelines.
5. US Department of Justice. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. Available on the Internet at: www.usdoj.gov/crt/cor/lep/DOJFinLEPFRJun182002.htm. Accessed November 14, 2002.
6. 67 Fed. Reg. 41455 at p. 41459. June 18, 2002.
7. *Ibid.*
8. Available on the Internet at: http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards.pdf
9. Available on the Internet at: www.lep.gov
10. Julie Dombrowski, Lipi Vaidya and Ellen Wilson contributed to the research of this section of the report.
11. OCR policy guidance, December 5, 2001. Available on the Internet at: www.hhs.gov/ocr/lep/guide.html, (accessed November 10, 2002).
12. Carrasquillo O, Orav J, Brennan T, Burstin. Impact of Language Barriers on Patient Satisfaction in an Emergency Department. Journal of General Internal Medicine, Volume 14, pgs. 82-87, 1999.
13. Sarver J, Baker DW. Effect of Language Barriers on Follow-Up Appointments After an Emergency Department Visit. Journal of General Internal Medicine, Volume 15, pgs. 256-264, 2000.
14. What a Difference and Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency. April 2002. Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. http://www.accessproject.org/downloads/c_LEPreportENG.pdf [Accessed November 2002].
15. DSS Interpreter Survey. Compiled by the Division of Medical Assistance. December 2002.
16. Price J. Office of Research, Demonstrations and Rural Health Development. Presentation to NC IOM Latino Health Task Force. May 7, 2002.
17. Spade J. Vice President, NC Hospital Association. Presentation to NC IOM Latino Health Task Force. May 7, 2002.
18. In 1995, the NC Center for Public Policy Research conducted a study that included a literature review, interviews and field visits, and a survey of all local health departments, community and migrant health centers, rural health centers, and rural hospitals across North Carolina. When asked to indicate the most significant barriers to Latinos obtaining adequate health care, the language barrier was cited most frequently. Scharer, J.; "Hispanic and Latino Health in North Carolina: Failure to Communicate? "Insight. August 1999; 18 (2-3):2.
19. The Department of Justice guidelines define interpreter competency. When using interpreters, the federal fund recipient must ensure that they:

    "Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation); Have knowledge in both languages of any specialized terms or concepts peculiar to the entity's program or activity and of any particularized vocabulary and phraseology used by the LEP person; and understand and follow confidentiality and impartiality rules to the same extent the recipient employee for

whom they are interpreting and/or to the extent their position requires."

67 Fed. Reg. 41455 at p. 41461. June 18, 2002.

20. DSS Interpreter Survey. Compiled by the Division of Medical Assistance. December 2002.

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22.. Hodges MT, DHHS Compliance Attorney. Presentation to NC IOM Latino Health Task Force. May 7, 2002.

23. 8 USC § 1621. The NC Community College system policy can be read at: http://www.ncccs.cc.nc.us/Numbered_Memos/Memos_for_2001/cc01-271.pdf

24. Available on the Internet at: http://www.dhhs.state.nc.us/dph/DEVSPAN-web.pdf

25. Available on the Internet at: www.hhcc.arealahec.dst.nc.us/hhcrindexf.thml

7 Health Insurance & Workers' Compensation

Introduction

Nationally and in North Carolina, a greater percentage of Latinos are uninsured compared to other racial and ethnic groups. Latinos are more likely to work for small employers or in industries that do not offer health insurance coverage to employees. In addition, because many Latinos are recent immigrants, they are unable to qualify for public insurance. Latinos who work in the agricultural industry face another problem-under North Carolina laws, many agricultural workers lack workers' compensation protection which could also be used to help pay for medical expenses if hurt on the job.

Private Health Insurance Coverage

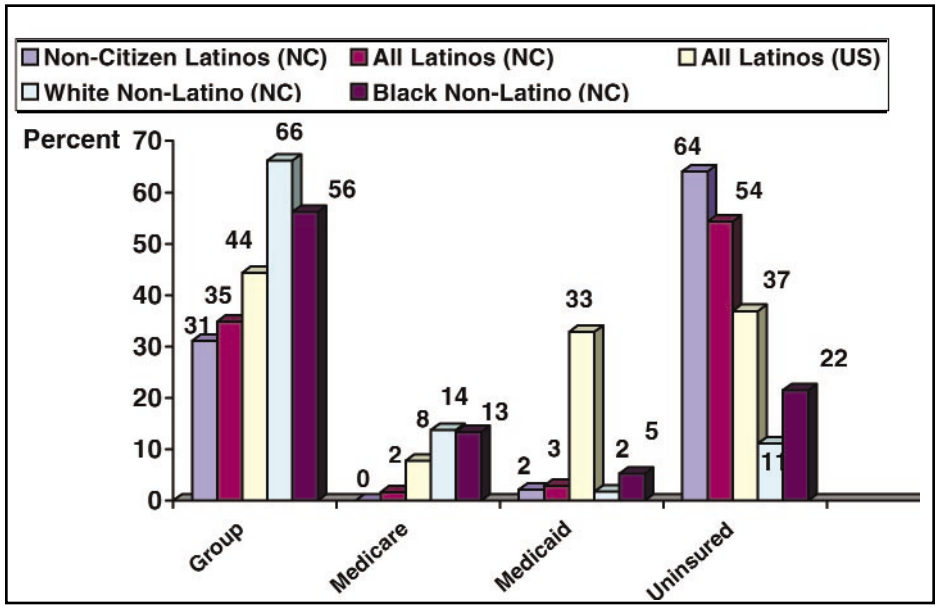
Nationally, immigrant Latinos are more likely to be employed in small firms as compared to non-immigrant Latinos or non-Latino whites.[1] Businesses with less than 25 employees are less likely to offer coverage; thus, these immigrants are less likely to have employer-sponsored health insurance. Recent immigrants are also more likely than whites to work in industries such as agriculture and construction that are less likely than other industries to offer health insurance coverage.

Immigrant couples are slightly younger than the average non-immigrant US Latino couple, and are more likely to have a child six years old or younger. These immigrant families are more likely to have just one worker in the household, perhaps due to having the young child. With just one worker, the family is less likely to have access to employer-sponsored health insurance, and may be less able to afford health insurance if offered. The combined effect of these high rates of one-worker couples and working for industries that are less likely to offer coverage is reduced access to employer-sponsored coverage for immigrants.[2] The cost of premiums is such a large issue that in some studies, affordability is a larger barrier to coverage than language barriers.

The Task Force heard presentations from the construction, hotel and poultry industries in North Carolina. Health insurance coverage was often offered to the Latino workers, but not all Latinos were able to afford or saw the need for the coverage offered.

North Carolinian Latinos are more likely to be uninsured than Latinos nationally (Chart 7:1). More than half (64%) of the Latino non-citizens in North Carolina are uninsured. This compares with 54% of all North Carolina Latinos, and 37% of Latinos in the United States. Further, North Carolina Latinos have a higher chance of being uninsured than non-Latino whites (11%) or African Americans (22%) in North Carolina. Fewer Latinos in North Carolina or the United States have private group-based insurance coverage. The percentage of farmworkers who are uninsured is even higher because most farmworkers in North Carolina are not covered by any employer-based plans.[3] Latino adults nationally are more likely to be covered by publicly-funded programs like Medicaid (33%), but this is not true for North Carolina Latino adults (3%).

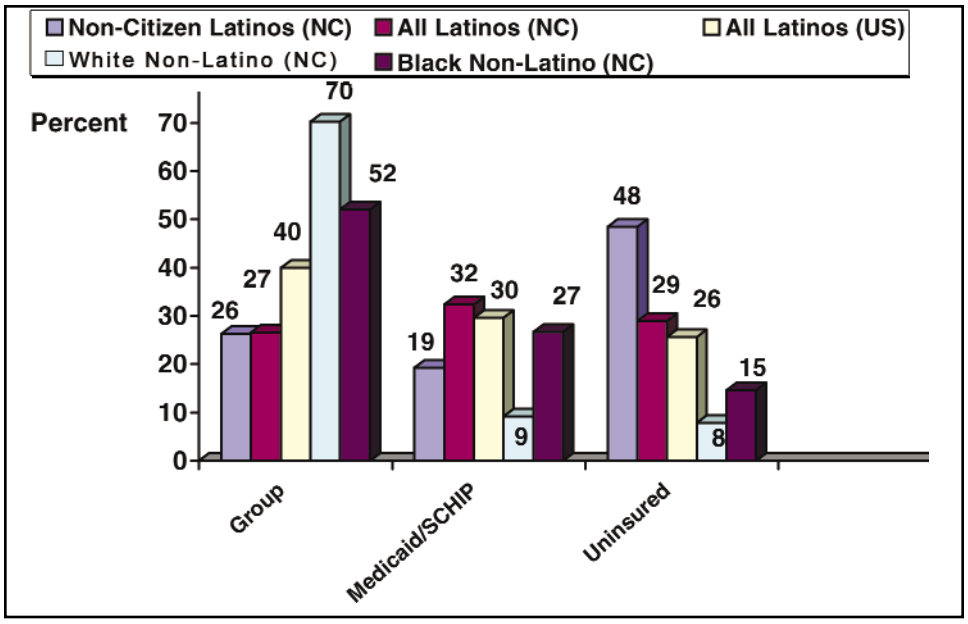
Chart 7:1
Insurance Status for Latino Adults (18 or older)[4]



Source: US Census. Current Population Survey (2000, 2001, 2002). Totals do not equal 100% because Champus and private, non-group insurance are excluded from chart.

Similarly, Latino children are more likely to be uninsured (Chart 7:2). Almost one-half (48%) of non-citizen Latino children younger than 18 years of age are uninsured, compared to 29% of all Latino children in North Carolina. North Carolina Latino youth are slightly more likely to be uninsured than are Latino youth nationally (26%), and are significantly more likely to be uninsured than non-Latino white children in North Carolina (8%) or non-Latino black children (15%).

Chart 7:2
Insurance Status for Latino Children (0-17)[5]



Source: US Census. Current Population Survey (2000, 2001, 2002). Totals do not equal 100% because Medicare, Champus and private, non-group insurance are excluded from chart.

While Latinos are less likely to have group health insurance coverage than other non-Latinos, some Latinos do have private employer-sponsored health insurance coverage. Having a health insurance card does not always translate into meaningful coverage. Some immigrants, especially those who are recent immigrants or undocumented, have experienced difficulties using their health insurance coverage. Latinos, particularly new immigrants, are often unfamiliar with health insurance and how to use it. Further, immigrants may have difficulty using their health insurance because the name on the insurance card is different than the name they use when presenting to a health care provider. This may occur because Latinos use multiple last names (including both the name of the father and the mother). Employers and insurers may not understand which last name to list—so that the last name listed by the insurer may be different than the one used most often by the individual. Alternatively, some immigrants working in the country without documentation may be using a false Social Security card with another name listed, and that name is the one listed with the employer's health insurance carrier.

The Task Force heard that some providers are unwilling to bill the insurer when a different name is presented for fear that this may be considered insurance fraud.[6] The NC insurance fraud laws were enacted to ensure that individuals do not provide intentionally misleading information in order to obtain health insurance coverage or payment for services that they would not otherwise obtain. Presumably, the name of the individual has little to do with whether the individual is likely to use health care services, or whether the insurer would otherwise provide that person with insurance coverage. Nonetheless, some health care providers have been fearful of submitting a health insurance claim

Innovative Practices

Affordable Health Insurance in Durham

El Centro Hispano in Durham, Lincoln Community Health Center, Duke University Health System, the Durham County Department of Social Services, Blue Cross Blue Shield of North Carolina, and other interested individuals are currently working on an initiative to provide affordable health insurance to the Latino population in Durham County. The group is developing a network-based insurance product. To keep premiums low, the providers who are in the network have agreed to accept 50% of the insurers' normal payment as payment in full. Latinos who seek care from a network provider would have to pay a small copayment, but no coinsurance. However, if the insured individual seeks care from a non-network provider, they will be required to pay the copayment, plus 50% coinsurance.

because of the anti-fraud provisions in current state law. As a result, insurers get a financial windfall as both employers and employees are paying the insurance premiums without receiving meaningful insurance coverage in return. Although the Task Force heard anecdotal information about the existence of this problem, there were no data available to know the prevalence of this problem or the extent of its consequences for the NC Latino population.

Publicly Funded Insurance

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) changed the rules for how immigrants can qualify for most publicly-funded programs, including Medicaid and NC Health Choice. Prior to these changes, immigrants could qualify for coverage if they met other program requirements, had been naturalized, were lawful permanent residents (LPR) or were permanently residing in the United States under color of law (PRUCOL). Undocumented immigrants were ineligible for non-emergency Medicaid coverage.

The new laws made coverage more restrictive, especially for legal immigrants. Rather than looking at whether immigrants are "legal" or undocumented to determine eligibility, the new rules determine eligibility on whether the immigrant is "qualified" or "non-qualified." Qualified immigrants can qualify for federally funded public benefits if they meet program rules, although they may be barred from receiving means-tested public benefits,[7] such as Medicaid and NC Health Choice, for a certain length of time. Non-qualified immigrants are ineligible for all but emergency Medicaid, and certain other limited programs that are not subject to these same restrictions (see below).

Qualified immigrants include:

- Lawful permanent residents
- Refugees, asylees, and persons granted withholding of deportation / removal
- Cuban and Haitian entrants
- Immigrants paroled into the US for at least one year
- Certain battered spouses and children[8]

Latinos are most likely to obtain authorization to live and work in the United States as lawful permanent residents. LPRs who enter the country after August 22, 1996, are ineligible for assistance from a means-tested program for the first five years after receiving their green card (authorization to live and work in the United States).[9] Certain publicly funded programs are covered by the five-year bar, and others are not. In general, means-tested programs are subject to the five-year bar. Other publicly funded programs that do not base eligibility on income or assets are not subject to the five-year bar.

Once a qualified immigrant meets the five-year bar, they may still be ineligible for assistance because of "sponsor deeming." Most immigrants who entered the country after December 17, 1997, had to obtain affidavits of support from a

"sponsor" who agreed to support the family at a level equaling 125% of the federal poverty guidelines. This "support" is considered available to a qualified immigrant when they apply for public benefits (in other words, the income and resources of the sponsor are "deemed" available to the immigrant family-such that the immigrant family will be considered to have income equaling 125% of the federal poverty guidelines). The deeming continues until the immigrant becomes a citizen or the immigrant has 40 quarters of earnings. If the immigrant is married, the spouses can combine their quarters of earnings. However, the deeming rules will not apply if a person would go hungry or homeless without the benefits or if the person is a domestic violence victim.

While LPRs are subject to the five-year bar, other "qualified" immigrants are not. The following immigrants are exempt from the five-year bar on federal means-tested public benefits:

- Refugees (including Hmong), persons granted asylum or withholding of deportation, Amerasian immigrants, Cuban / Haitian entrants
- Veterans, active duty military, spouse, unremarried surviving spouse, or child of veteran / active duty military
- Victims of trafficking

These individuals are eligible for the first seven years after entering the United States. They can continue to receive assistance after the seven years if they later qualify as an LPR or obtain their citizenship.

Any immigrant who doesn't fit one of the categories listed above is "not qualified." Immigrants who are "not qualified" are ineligible for most federally-funded public benefits (including Medicaid and NC Health Choice) even if they have work authorization and are lawfully present in the United States.

Limited Medicaid Coverage

While ineligible for regular Medicaid coverage, all immigrants regardless of immigration status may be eligible for emergency Medicaid as long as they meet other Medicaid eligibility rules. A medical emergency is defined as a medical condition (including labor and delivery) with acute symptoms that could place the patient's health in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. Medicaid will pay for the labor and delivery charges of women, regardless of the immigration status of the mother.

Further, pregnant immigrants may be eligible for limited Medicaid coverage during a presumptive eligibility period. A pregnant woman who applies for Medicaid can receive coverage immediately upon confirmation of the pregnancy. This "presumptive eligibility" period lasts for no more than two months, while the full Medicaid application is being processed. Coverage during the presumptive eligibility period is guaranteed, even if the woman is later determined to be ineligible because of immigration status (or other reasons). Therefore, pregnant Latinas can obtain time-limited coverage for their prenatal care by seeking presumptive eligibility.

Innovative Practices

NC Health Choice Targeted Outreach efforts

The Duke Endowment provided funding to six NC agencies to conduct special NC Health Choice outreach efforts targeted to the African/American, Latino and Native American communities. Three projects specially targeted the Latino community in 25 counties, including New Hanover County Partnership for Children, Charlotte's Catholic Social Services, and the Access Project at UNC-Greensboro. In addition, the Robert Wood Johnson Covering Kids Project provided funding for a demonstration project to target Latino children in Forsyth county. According to outreach workers, the best way to reach Latinos was through institutions they trusted, including churches, grocery stores, Catholic social ministries, health care providers that targeted Latino populations, organizations specifically serving Latinos, and Latino media.

Eligible Children of Immigrant Families

While most non-qualified immigrants are ineligible for assistance, their children may qualify if born in the United States. Nationally, 85% of immigrant families have at least one citizen member, usually a child.[10] Immigrant families with children experience greater poverty—21.3% have incomes at or below federal poverty guidelines (compared with 11.2% of citizen families).[11] Thus, these families are more likely to meet the income and resource requirements of the federally-funded means-tested programs.

Children who are citizens should have equal access to public benefits by virtue of being citizens; but because they live in immigrant households, they are less likely to receive public assistance. For example, of the 6.7 million uninsured children in families with incomes below 200% of the federal poverty guidelines in 2000, 20% were citizen children with non-citizen parents.[12] In North Carolina, 11.3% of all NC Health Choice children were Latino in SFY02, as were 10% of all Medicaid recipients.[13]

Barriers That Discourage Eligible Families from Applying

Many immigrants are afraid to apply for their children because they fear they may be labeled a "public charge," making it more difficult later to qualify for lawful permanent resident status. Additionally, some immigrants may be afraid of reporting their (possibly false) Social Security number to DSS, for fear of deportation. Because of these issues, some Latinos are afraid of seeking services from governmental agencies. And, as noted in other chapters, the lack of forms or notices translated into Spanish and the inadequate number of Spanish speaking eligibility workers in some counties make it difficult for some families to apply. The application and re-certification processes for many governmental programs are complicated; language barriers compound this problem. Special barriers also exist for migrant families, as their mobility and irregular income make it difficult to obtain coverage.

Public charge

The Immigration and Naturalization Services (INS) must assess whether an immigrant will become dependent on the federal government for subsistence (i.e., become a "public charge") in deciding whether to grant the person lawful permanent resident status and issue a so-called green card.[14] Many immigrants fear that applying for health care coverage for themselves or their children will adversely affect their ability to obtain a green card. This fear was exacerbated because of an initial INS misinterpretation about what factors to consider in determining whether a person is a public charge. Under federal law, the INS is not allowed to consider the use of health or nutrition support in the public charge consideration. This includes Medicaid, NC Health Choice, Food Stamps, or WIC (although INS may consider health coverage if used for long-term residential assistance, like nursing home care, in their public charge consideration). INS is allowed to consider the receipt of cash assistance such as SSI or TANF, but only for the immigrant who receives the benefit, not for other family members unless it is the sole means of support for the family. Overall, the INS is supposed to look at the totality of the circumstances to determine if the person/family is likely to become a public charge. Thus the INS can determine that

a poor family is likely to become a public charge even if the family does not receive publicly-funded services. Conversely, even if the immigrant did use cash assistance in the past, INS may not determine them to be a public charge if they have a more recent history of work. Refugees, asylees, and citizenship applicants are exempt from these rules. People who already have a green card are also exempt from these rules.

Fear of Deportation

As a general rule, states must obtain Social Security numbers of *applicants* for many federal programs. While states may seek the Social Security number (SSN) of applicants, they may not require that non-applicants provide their SSN. This means that states may not deny benefits because a non-applicant in the family or household has not provided information on immigration status or his or her SSN. Parents need not supply their SSNs when applying solely on behalf of their children.[15]

Requesting SSNs from non-applicant parents may discourage some immigrants from applying for publicly-funded programs, even if they are only applying for their children. Many immigrants, depending on their immigration status, are not issued SSNs. If non-applicant parents see application forms that seem to require SSNs from all household members, the parents may not apply for benefits for their children since the parents do not have SSNs. Other immigrants may have invalid SSNs they use to obtain work. These immigrants may be afraid that the SSN will be used to determine if they are in the country legally, and that if they are not, they will be reported to INS. Many immigrants are afraid to seek assistance even if the SSN is not requested, as they fear that their immigration status may be reported to INS.

Immigration enforcement is the responsibility of the Immigration and Naturalization Service of the newly created US Department of Homeland Security (DHS). DSS agencies are generally not responsible for enforcing immigration laws, and are under no duty to report the immigration status of Medicaid or NC Health Choice applicants. DSSs do have an affirmative duty to report the immigration status of TANF applicants, but only if the agency *knows* the legal immigration status.

Under federal guidance, an agency can only appropriately know or seek to know the immigration status of an applicant for publicly-funded program. Thus, DSS can never know the actual immigration status of parents who apply solely on behalf of their citizen child(ren). If an ineligible parent applies on behalf of his or her eligible child, only the immigration status of the child is at issue. The parents' immigration status should never become an issue. Further, the agency can only know the immigration status if they have seen a formal INS deportation document. In addition, under federal law, the determination that someone is subject to deportation is a formal determination, subject to administrative review. Until the deportation review process has been completed, a DSS agency can never "know" whether a person is subject to deportation.

In North Carolina, parents can apply for Medicaid for their children only; they need not be included when seeking Medicaid coverage. The NC Medicaid man-

ual (for families and children) states that DSS may request a Social Security number from the non-applicant parents, but may not require it. However, the application form contains a space to include the parent's Social Security number. This may be confusing both to the eligibility workers and to the immigrant families; some ineligible immigrant parents may be unaware that they need not provide their Social Security number if they are applying solely for their children, not themselves. In addition, the Privacy Act states that, unless the state is required by Federal law to solicit an SSN, they may ask for SSNs but must make clear that the request is voluntary and how the SSN will be used. Because DSS is not required by federal law to solicit SSNs from non-applicants, the workers must clarify what the number will be used for, and that the request is voluntary.

The current NC Health Choice application forms do not request the Social Security number of the parents. However, in some parts of the state, DSS offices are using old forms, which include a place for the parents' Social Security numbers. Because of the high turnover among DSS eligibility workers, not all of the eligibility workers may understand that Social Security numbers are not needed for the parents. The use of old applications in any place throughout the state could raise Title VI and Privacy Act concerns.

In addition, there is nothing in the DSS manual that prevents or discourages workers from reporting the parent's suspected immigration status to the INS. Thus the fear of deportation may discourage some eligible immigrant families from applying.

Recommendations

The North Carolina Department of Health and Human Services needs to ensure that it is using the correct policies so that eligible immigrants are not mistakenly denied benefits for which they are eligible. To that end, the Task Force recommended that:

25. The NC Division of Medical Assistance and DSS re-examine the Medicaid, NC Health Choice and other DSS applications, notices and policies to make services more accessible to the Latino population.

- **As part of this effort, the NC Department of Health and Human Services should help train Latino service organizations and other organizations to assist applicants in filling out Medicaid, NC Health Choice and other public assistance applications. Funding from private foundations would assist in supporting this work.**

Specifically, the NC Division of Medical Assistance should ensure that:

- DSS workers do not require non-applicant parents to supply their own Social Security numbers when applying for benefits for their children. Ideally, non-applicant parents should not be requested to provide their SSN, but if they do, it must be clear that providing the information is voluntary, not mandatory.

- Information is included on the application, the recipient rights and responsibilities notice and in the procedure manuals to help immigrant families understand that applying for Medicaid or NC Health Choice will not be considered in determining whether the individual or family will become a "public charge."
- The manual provisions are changed to affirmatively ensure that DSS does not report suspected immigration status to the INS, unless DSS makes a formal finding of fact or conclusion of law supported by administrative review that the person is applying for benefits for themselves for TANF or Food Stamps and this DSS finding is supported by a determination by the INS or Executive Office of Immigration Review that the person has been found to be unlawfully present, resulting in a final order of deportation.
- Training on these topics should be provided to DSS eligibility workers. In addition, this training should be videotaped and made available to each DSS so that it can be included as part of orientation training of new DSS eligibility workers. The training materials should also be made available to local NC Health Choice outreach committees, for outreach to the Latino community.

In addition, the Division of Medical Assistance and Division of Social Services should help train Latino services organizations and other organizations in filling out Medicaid applications. Latinos may be more comfortable filling out a Medicaid, NC Health Choice or other public assistance application through an organization they trust, rather than a governmental organization.

Special barriers for migrant families

One of the biggest problems for migrant families is their mobility. Migrants, and specifically those who are farmworkers, may be in the state for only short periods of time, so that the regular application processing time period may be too long to provide meaningful coverage for this transient population. Another problem is the state-based structure of Medicaid. Although Medicaid coverage is portable from county to county (e.g., if a family is determined eligible in one county, they can continue to receive Medicaid if they move to another county), Medicaid coverage is not generally portable from state to state. Another problem is how the state counts income. Since farmwork is not typically year-round employment, calculating farmworkers' annual income by using a weekly or monthly pay stub will overestimate farmworkers' annual income. The Division of Medical Assistance already has a provision to annualize the income of a farmer, but not that of a farmworker.[16] In addition, it is sometimes difficult for farmworker families to provide proof of income when they are paid in cash, and the grower is unwilling to provide a written statement verifying wages.

There are several ways to address this problem. First, the state could establish a system of interstate portability and reciprocity of Medicaid benefits, so that Medicaid-eligible families moving in the migrant stream can use their Medicaid coverage in other states. Wisconsin was the first state to create such a system. Wisconsin accepts out-of-state Medicaid cards for farmworkers in the migrant stream.[17] Second, the Division of Medical Assistance can rewrite its Medicaid

eligibility manual, clarifying that a farmworker's income—like that of a farmer—should be calculated on an annualized basis. North Carolina could also establish a presumptive eligibility process in Medicaid and NC Health Choice for children. The Task Force was interested in exploring the possibility of seeking a federal waiver to allow the state to implement a presumptive eligibility period to cover migrant children. Specifically, the Task Force recommended that:

26. The NC Division of Medical Assistance explore methods to improve migrant families' access to Medicaid and NC Health Choice.

For example, the Division should explore the possibility of entering into an interstate compact to recognize the Medicaid eligibility of migrants who have been determined eligible in their home state, when working in the North Carolina migrant stream; develop alternative methods of counting farmwork income to more closely reflect the farmworkers' annual income; and explore the possibility of obtaining a waiver to implement presumptive Medicaid and NC Health Choice eligibility for migrant children.

Once changes are made, the Division should provide training to DSS eligibility workers about farmworker-specific eligibility considerations, such as verification of wages and mobility.

Federally-funded Programs Available to All Immigrants

There are some federally-funded services and programs that are available to all immigrants, regardless of immigration status. The health-related services and programs that are available to all immigrants, both documented and undocumented, include: Community Health Centers, emergency Medicaid and other emergency medical services, immunizations, testing and treatment of communicable diseases (whether or not symptoms are caused by such disease), WIC (at state option), and programs delivered at the community level that do not condition assistance on income or resources and are necessary to protect life or safety.

In addition, there are no restrictions on programs that are provided to protect life and safety, including programs that provide:

- Mental illness or substance abuse treatment
- Medical, public health services and mental health, disability or substance abuse services necessary to protect life or safety
- Child and adult protective services
- Violence and abuse prevention, including domestic violence
- Short-term shelter or housing assistance (e.g., battered women's shelters)
- Other services necessary for the protection of life or safety

State health replacement programs

States can enact their own laws to provide health services to cover any groups of immigrants, whether "qualified" or "not qualified," if the programs are 100% funded by state or county funds. These state health programs are generally referred to as state health replacement programs. Since no federal funds are involved in these programs, there are no federal restrictions on which people the programs can cover.

Nationally, a majority of other states offer some type of health replacement program.[18] Some programs are limited in scope (for example, covering only prenatal care). Some states cover all immigrants (both documented and undocumented); others limit their programs to those immigrants who would have been eligible using the pre-1996 laws covering PRUCOL. Others provide state replacement programs only to qualified immigrants who are affected by the five-year bar. North Carolina does not have replacement health programs.

Recognizing that the state has very limited new resources at this time, the Task Force did not recommend that the state immediately implement a state health replacement program. However, the state should consider this in the future when the state's budget improves.

Recommendations

Specifically, the Task Force recommended that:

27. **The North Carolina General Assembly establish a health care program that would address the health care needs of uninsured low-income Latinos who would otherwise qualify for public insurance but who cannot because of federal immigration restrictions. Priority should be given to: coverage of children; prenatal care; and health conditions or diseases that are significant problems for Latino populations, as determined by the State Public Health Director.**

Workers' Compensation for Agricultural Workers

Workers' compensation helps pays for medical expenses, lost wages, rehabilitation expenses, permanent disability and death benefits for workers who suffer a work-related injury. Under North Carolina law, employees who work for firms with three or more full-time year round employees are generally covered by workers' compensation. Employees in certain hazardous industries are covered if there are one or more full-time-year-round employees. Farmers are only required to provide workers' compensation coverage to employees if they employ 10 or more full-time-year-round employees. However, under federal law, employers that hire H-2A workers must also provide workers'compensation, regardless of the size of the labor force.[19] Of the state's approximately 55,000 farms, 1,050 employ 10,000 H-2A guest workers.[20] Even if not required under state or federal law, farmers may provide workers' compensation coverage voluntarily. Farmers who do provide workers' compensation may also pay for coverage for themselves. One study suggested that farmers could benefit from this coverage, as 42% of all fatal agricultural injuries occurred to people working on their own farms.[21]

Workers' compensation is particularly important for agricultural workers, as agriculture is one of the state's most hazardous industries. On average, there are 4.3 fatalities per 100,000 workers in non-agricultural settings, but 23.9 in agriculture. Workers' compensation premiums are based on the type of farming operation, size of operation, and the claims made[22]. This provides an incentive for employers to improve the safety of the workplace so that fewer claims will be filed.

Agricultural workers who are injured on the job are unlikely to have alternative health insurance coverage that can help pay the health care bills. Because these workers earn relatively low salaries (on average $7.50/hour for H-2A workers; other farmworkers may only be paid minimum wage), they are unlikely to be able to pay for needed health care. This means that the costs of caring for these injured workers are shifted onto other paying patients, a form of indirect tax on other insured individuals.

Last year, Sen. Clodfelter introduced a bill (SB 1444) to remove the workers' compensation exemption for farmworkers. Under the bill, agricultural workers would be covered by workers' compensation if the farmer regularly employed three or more workers. The bill did not pass. The Task Force supports efforts to extend workers' compensation coverage to agricultural workers. Because few farmers hire workers for the entire year, the Task Force recommended that farmers be required to provide coverage if they have three or more full-time workers during their growing season. However, even if workers' compensation coverage is offered, additional protections must be provided to ensure that migrant and seasonal farmworkers can exercise their rights.

Similar to health insurance, being eligible for workers' compensation does not guarantee that migrant and seasonal farmworkers will actually utilize such benefits. Migrant and seasonal farmworkers may not know that they are covered by workers' compensation (even when offered), and may not understand how to exercise these rights. Depending on the particular circumstance, filing a workers' compensation claim can be very complex and time consuming, and the waiting time for eligibility to be determined can be long. As a result, some eligible farmworkers end up returning to Mexico or migrating to other areas before learning the outcome of the claim or before receiving benefits. Out of frustration, some farmworkers abandon their claims.

Some growers offer injured workers a sum of money up front to return home and seek treatment rather than pursue a workers' compensation claim. Farmworkers may not be aware that, under certain circumstances, they can obtain medical care and treatment in their home country and have the services covered by workers' compensation. Alternatively, immigrants who are in this country on H-2A visas may be able to get those visas extended to obtain needed medical care. However, these options are not fully understood by many agricultural workers. Immigrants working in other industries have similar problems, also lacking information about where to turn for assistance. The NC Industrial Commission has a Latino Ombudsman, and has translated many of the workers' compensation forms and informational brochures into Spanish. Still, the availability of these services is unknown to many Latino workers.

One way to improve outreach to the farmworker community would be to include information about workers' compensation in the weekly orientations that the NC Growers Association provides for incoming H-2A workers. The NC Industrial Commission could also provide trainings to NC agencies that provide health, social and other services to farmworkers in order to increase access to workers' compensation benefits.

The Task Force also heard testimony about "bad-faith denials," that is, some workers' compensation carriers initially deny the workers' compensation claims knowing that many of the injured workers will never appeal. This is a particular problem for migrant and seasonal farmworkers, many of whom are in the state for short periods of time. The Industrial Commission has the authority to reverse an initial denial, but cannot impose sanctions for bad-faith denials (aside from ordering the insurer to pay attorney's fees). As a result, there are no effective "checks" that could help discourage an unscrupulous insurer from routinely denying claims, especially for people with large medical bills.

Recommendations

To address these problems, the Task Force recommended that:

28. **The NC General Assembly extend workers' compensation to agricultural workers if they work for an employer who employs three or more full-time workers, working 30 or more hours/week at least 13 weeks in a year. The NC General Assembly should also change existing workers' compensation laws to give the Industrial Commission the right to impose monetary or other sanctions on workers' compensation carriers for a pattern or practice of bad-faith denials.**

    - **The Industrial Commission should be directed to conduct an educational campaign, through the Latino media, partnering organizations and existing outreach sources and programs, to explain how the workers' compensation system works, who is covered, how they can apply for benefits, and where they can go to seek assistance.**

The Commission should partner with Latino agencies, migrant/community health centers, NC Farmworker Health Program, farmworker health outreach programs, North Carolina Growers Association, NC Legal Services, and other agencies to disseminate information about workers' compensation to the Latino community.

Notes

1. Schur C. Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured. The Commonwealth Fund, May 2001.
2. *Ibid.*
3. Ninety-eight percent of the farmworkers who received services from the NCFHP in 2001 were uninsured. Generally, only dependents of farmworkers have some form of coverage, and this is limited to those who are eligible for Medicaid or NC Health Choice.
4. Poley S. Special data run from Cecil G. Sheps for Health Services Research. Using Current Population Survey data for 2000, 2001, 2002.
5. *Ibid.*
6. N.C.G.S. 58-2-161.
7. Means tested programs are programs that limit eligibility to those who are low and/or moderate income. To qualify, a person or family must meet certain income and/or resource standards in addition to other program rules.
8. To qualify as a battered spouse, the person has to be married to or have been married within the past two years to a citizen or lawful permanent resident and have filed to change their status on the basis of being a battered spouse.
9. Individuals who arrived in the United States before August 22, 1996, who later become "qualified immigrants" are not subject to the bar. However, if an immigrant arrives on or after August 22, 1996, then the bar starts on the day the immigrant becomes a "qualified immigrant," not on the date of entry into the United States.
10. Fix, Passell, and Zimmerman. The Integration of Immigrant Families in the United States. The Urban Institute, July 2001, p. 8.
11. Profile of the Foreign Born Population, 2000; http://www.census.gov/prod/2002pubs/p23-206.pdf
12. Ku L. Center for Budget and Policy Priorities. Analysis of March 2001 Current Population Survey. Personal communication, November 6, 2002.
13. Division of Medical Assistance. Special data run from the NC DHHS Data Warehouse during August 2002.
14. Griffin C. Attorney, Office of Civil Rights, US Department of Health and Human Services; Presentation to NCIOM Latino Health Task Force, September 17, 2002.
15. For US HHS and USDA guidelines regarding inquiries into citizenship, immigration status and Social Security numbers see www.hhs.gov/ocr/immigration/triagency.html.
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18. Guide to Immigrant Eligibility for Federal Programs. 2002. National Immigration Law Center.
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8 The Challenge of Health Promotion & Health Literacy in North Carolina's Latino Population

Introduction

As the NC IOM Latino Health Task Force worked to define the nature and extent of health problems and health care access issues facing the state's growing Latino population, its members confronted the fact that Latinos do not experience (and therefore do not interpret) the symptoms of ill health in ways similar to the majority white or African-American populations. Moreover, when Latinos (especially recent immigrants) seek formal medical care from US health care providers, their expectations are different, and therefore the satisfaction they take away from such encounters is likely to be different as well. The Task Force came away from this analysis with the clear notion that a major impediment to health and health care among this population is that recent Latino immigrants are relatively unfamiliar with the methods of how health care is provided in the United States and may not interact effectively with health care providers when seeking care in this country. Ineffective communication and interaction in such circumstances can lead to reduced access to needed services, the ineffectiveness of diagnostic and therapeutic interventions, lower satisfaction and adherence to prescribed medical regimen, and ultimately to the detriment of the health of North Carolina's Latino population.

These communication barriers are only partly related to language differences or to the cultural competency of health care providers. The larger rubric under which much of this problem was discussed is that of health literacy, a term gaining more attention within the professional health and medical care community in reference to the specific skills necessary for communication between health care providers and their patients. Health literacy assumes a basic understanding of medical terms, techniques and technologies, which is essential to assure that the patient can be a full participant in managing his or her medical care in conjunction with a physician or other health care provider.

Innovative Practice

Expecting the Best

Expecting the Best is a collaborative effort between the North Carolina Community College System, the Division of Public Health in the North Carolina Department of Health and Human Services, Coastal AHEC, and the North Carolina March of Dimes. The program is designed to teach adults about health and wellness through English as a Second Language (ESL) classes administered by the Community College. Classes focus on health care, nutrition, and exercise and fitness, and are intended to improve health literacy, functional literacy, and communication skills. The program was piloted at Cape Fear Community College and Centro Latino in Wilmington in the fall, 2002. The Community College System plans to offer this curriculum statewide by 2004.

The General Problem of Health Literacy in America

The problem of health literacy is not confined to the Latino population. Low reading levels are a major concern for the larger US population as a whole. The National Adult Literacy Survey, which provides the best national portrait of the literacy capacity of the population, estimates that 22% of the total population score at the lowest level (Level 1) and are unable to perform such tasks as to identify the expiration date on their personal driver's license or to read and understand the front page of a major newspaper. Thirty-two percent have difficulties interpreting and using a local bus schedule. Another 27% have difficulty distinguishing between the price of two items on the grocery store shelf. Forty percent of Americans are unable to understand the information and warnings contained on a common prescription bottle label. The consequences of low literacy in relation to health and health care can mean that, despite the availability of personal health care services, both the awareness of such availability and the effectiveness of services received can be significantly reduced (if not eliminated).[1]

The increasing complexity of health care information and the shift of a greater responsibility onto the patient to participate in health care decision making and manage their own diseases has meant that these health literacy problems have become much more daunting. Parker has shown how the situation has changed in 25 years with regard to the seemingly straightforward management of a patient with asthma.

> "Consider the task we set for a newly diagnosed asthmatic today, and compare that situation to the same situation 25 years ago. In 1975, a newly diagnosed asthmatic would see the doctor, get a prescription for theoplylline, be told how to take the pills, and be instructed to comply with follow-up. Today, in a clinical encounter likely to be much shorter than a 1975 encounter, the patient would be instructed in the use of multiple meters and inhalers that function differently, and the taking of different dosages of medication. The patient would be shown how to monitor his or her asthma, and how to keep records. Patients are shown how to take different doses of steroids for flares, how to avoid mental triggers, how to use - but not to overuse - the emergency room, their primary care physician, and their subspecialist. Altogether, asthma management today is much more complex, much more technologically sophisticated and has become very challenging to be a patient."[2]

The complexity of today's health care system is compounded for Latinos who cannot speak English well, or who may not have access to health care providers who speak Spanish. This is a prescription for system failure, and ultimately a situation of extremely high health risk.

The Seriousness of the Health Literacy Problem Among Latinos

Even ignoring the problem of language and cultural differences that may increase the seriousness of these problems for Latinos, we are becoming aware of the fact that as many as 50 percent of our US population (of any race or ethnic group) simply cannot participate at an effective level in the communication

process involved in obtaining formal health care in this country. By any standard, this is a "public health disaster!"[3] This means that in spite of well-recognized global leadership in medical science and health care technology in this country, there are large segments of the population for whom these benefits are out of reach, irrespective of their economic circumstances. For all our talk of giving patients the opportunity to express their preferences and to make their own decisions about health care, the fact that more than half of the people in the US, when offered this opportunity to participate in such decisions, simply lack the basic understanding of their diseases or health conditions or the range of treatment options available to them. "Shared decision making" with regard to these matters is without meaning, hence it is without any added value or benefit. We need to find ways of addressing this problem through a number of avenues, involving health care, educational, occupational and community development initiatives. But, first, we must find ways of at least talking about this huge and growing problem with American health care.

The problem may be growing more severe for Latinos as North Carolina has a higher proportion of Latino teenagers who have quit school - or bypassed it - than any other state, according to a new report from the US Bureau of the Census. Nearly 47 percent of Latino youth in North Carolina between the ages of 16 and 19 are not enrolled in school and lack a high school diploma.[4]

The NC IOM Latino Health Task Force has identified this as a problem of such proportions as to require substantial public and private sector intervention in the interest of ensuring the full participation of this growing segment of our state's population, a population on whom the very economy and vitality of our state depend.

The Challenge of Addressing the Health Literacy Problem

What is it about health literacy that makes this problem so difficult to address through sensible programs and planned interventions? First of all, we have to face the fact that basic literacy is not a problem limited only to health issues and concerns. The health care system cannot solve this problem alone.[5] Many of those who immigrate to our country in search of employment and a better way of life arrive with only limited literacy in their native languages. Many have only limited formal educational backgrounds. Most are accustomed to working for less than the US standard minimum wage in their own countries and are willing to work for only the minimum wage rates here in the US.

It is in the interest of employers, nationally and here in North Carolina, to help solve this problem, for it has much to do with the health and productivity of their work force. Similarly, the schools can do much about this problem, not only for the students who are their primary targets, but also for their families (parents, grandparents, aunts and uncles, etc.). Students taught the basics of health, or chronic disease management, can help a parent or grandparent who suffers from those diseases manage their conditions. Many of us have had the experience of learning how to do something on our computers, or with our VCRs, from our children. Hence, the power of intergenerational teaching and learning can potentially be harnessed for public health benefit.[6]

Second, we have to remember that illiteracy is a problem shrouded in secrecy, guilt and embarrassment. No one with a problem of illiteracy is anxious to have this problem revealed. Adults who are illiterate devise novel ways of disguising this inability to read or understand printed material. Because the inability to read, in any language, leads to insufficient understanding of complex information, the consequences of concealment and deception can confound problems of communication between the health care professional and client. Further, health care encounters can serve to increase the anxiety that many with low literacy skills feel day to day. As Frank McArdle has pointed out,

> "(low levels of health literacy) makes it harder for the patient and the medical professional to fully participate in the process of two-way communication. Commonly held expectations that patients read adequately and the implicit social stigma of not doing so, conspire to silence patients, inhibit them from disclosing their situation, and discourage patients from seeking information and asking for help."[7]

The fact that large numbers of enrollees in health care plans simply do not understand basic physician instructions, means that our efforts to target major health conditions in these populations is equivalent to "shooting blanks." Resources are being wasted and results are not achievable.

The Importance of Latino Cultural Beliefs and Health Care Practices

The Latino Health Task Force had to recognize and deal with a phenomenon not normally so important in other areas of health policy development in our state. This is the matter of Latino culture and belief systems with regard to health and health practices. These would not be major concerns were we talking about meeting the health and health care needs of the Latino population in their native countries, where both patients and their health care providers were from the same culture and spoke a common language. Even if language barriers could be reduced through the acquisition of Spanish language skills by US health care professionals and clerical personnel, there would still be differences in cultural beliefs that could lessen the potential effectiveness of health care services and interventions offered by health professionals to their Latino clients and patients.

As noted previously, it is important to recognize the there is considerable diversity within the Latino community; there are many Latino cultures, each with its own traditions and beliefs. Many Latinos in the US have never lived anywhere other than the United States and may not speak Spanish at all. Moreover, Latinos are racially and ethnically heterogeneous as well, while Latinos will often self-identify by their country of origin and not a particular racial or ethnic group.

Since health promotion efforts often have as their primary goal the changing of personal behaviors and attitudes, it is important to consider the culture-bound belief systems that may influence the health behaviors targeted by such intervention programs. It is clear that many Latinos are suffering from diseases and dying from causes that can be prevented; many of these are associated with

risky behaviors or environmental exposures. Many of the self-care strategies employed by Latinos in response to symptoms are not based on any scientific evidence and are supported only by cultural beliefs and folk remedies from other parts of the world. Some are based on very different causal frameworks used to explain the nature of human disease and the prospects for cure. US health care professionals who attempt to treat Latinos in times of ill health may or may not know about the countervailing influence of these cultural phenomena. This can lead to additional health risks or treatment ineffectiveness.

As noted previously (Chapter 3), Latinos may rely on traditional and folk healers, may not understand how to access or use the US health system, and may have different cultural expectations about the provision of health services. The Task Force has concluded that any attempt to intervene within the Latino community in the interest of population-based health improvement or increasing health care access should start from an understanding of these social and cultural factors pertinent to the Latino community.[8] Any meaningful and effective approach should therefore seek to build upon the strong family values and connections within the Latino community, recognize the cultural beliefs associated with health and illness within this community, seek to identify and work with indigenous persons and informal networks within the Latino community who are trusted and readily available sources of health advice, and address the problems of communication and understanding that may arise in conventional health care encounters between Latino immigrant populations and US health care providers.

Among the strategies for addressing these issues considered by the Task Force was the use of trained Lay Health Advisors, indigenous community members who are trusted sources of health and health care information and who can facilitate both access to care and understanding of health and illness symptoms and medical care advice received from professional health care providers. Lay Health Advisors work directly with individuals to provide health education, inform them about the peculiarities of the US health care system and how to access needed health services, and help link individuals to community resources. Lay Health Advisors can also help strengthen the capacity of Latino families to manage the consequences of illness and take positive steps to promote personal health status within the Latino community.

Recommendations

In its consideration of these social and cultural factors influencing the health behaviors and attitudes of Latinos, the NC IOM Latino Health Task Force offers the following recommendations intended to promote the positive health outcomes of Latinos now resident in North Carolina. The Task Force recommended that:

29. **The NC Community College system (Adult Literacy) take positive steps to address the problem of low literacy, including health literacy, among its Latino population. There is a need for a statewide initiative to address this problem across all population groups (not limited to Latinos).**

This initiative should include the participation of all human services sectors (health, behavioral health, dental and social services), law enforcement, public utilities, education community as well as non-profits, philanthropies, faith-based organizations, private business and industry.

30. **A statewide campaign be mounted, under the leadership of the North Carolina Area Health Education Centers, involving all types of health care professional membership organizations and health-related trade associations to elevate a concern for health literacy among those professions serving the needs of NC's population. This should include skill training for health professionals in methods of measuring and identifying low literacy problems in patients as well as interventional skills for overcoming the negative effects of low literacy in encounters with health and medical care providers.**

Model programs such as those developed by the American Medical Association, and programs like those piloted here in North Carolina and mentioned elsewhere in this report, should be used as models for such an initiative.

31. **The NC Department of Health and Human Services take the lead in convening a group of organizations who have developed and implemented lay health advisor programs. This group will help coordinate and strengthen lay health advisor programs, including developing training for lay health advisors and providing technical assistance to other organizations seeking to implement similar programs. The group should help identify possible funding sources from North Carolina and national philanthropies, with a priority given to communities and counties with large concentrations of Latino residents.**

The group should include, but not be limited to, the NC Primary Health Care Association, Cooperative Extension Services, and the Department of Health Behavior and Health Education within the UNC School of Public Health.

32. **The University of North Carolina System coordinate efforts to establish a Minority Health Research and Policy Center dedicated to advancing new and innovative public policy solutions toward more equitable and available health care. The center should seek to collaborate with such organizations as the Inter-University Program for Latino Research (IUPLR)[9] and the UNC-Chapel Hill Program on Ethnicity, Culture, and Health Outcomes (ECHO).[10]**

The mission of ECHO, the UNC Program on Ethnicity, Culture, and Health Outcomes, is to eliminate health status and health outcomes disparities through translatable, evidence-based research, multidisciplinary training and education, and culturally sensitive services to North Carolina communities.

33. **El Pueblo, the NC Institute of Medicine, and the NC DHHS create a health care consumer guide for Latinos modeled after NC Programs Serving Young Children and Their Families published in Spanish and in English for the benefit of Latino families and individuals, as well as health and social services organizations serving the Latino community in the state.[11]**

Some agencies throughout the state have already taken steps to educate Latino family members about services available throughout the community; however, more work in this area is needed.

Notes

1. Tuckson RV . Keynote Address. Proceedings of Conference on Health Literacy: Advancing Public Policy (2000). January 18-19. Washington, DC: Pfizer (www.pfizer.com/hml/literacy/hl2), pp. 4-6.
2. Parker RM. Update on health literacy. Proceedings of Conference on Health Literacy: Advancing Public Policy. January 18-19. Washington, DC: Pfizer (www.pfizer.com/hml/literacy/hl2), pp. 6-8.
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4. *Raleigh News & Observer,* November 4, 2002: 5B.
5. Lurie N. Opportunities for setting a health literacy agenda. Proceedings of Conference on Health Literacy: Advancing Public Policy (2000). January 18-19. Washington, DC: Pfizer (www.pfizer.com/hml/literacy/hl2), pp. 8-12.
6. Ibid.
7. McArdle F. (2000) Proceedings of Conference on Health Literacy: Advancing Public Policy. January 18-19. Washington, DC: Pfizer (www.pfizer.com/hml/literacy/hl2), pp. 13-17.
8. Some useful resources include: Karliner S, Crewe SE, Pacheco H, and Gonzalez YC. Latino Health Beliefs: A Guide for Health Care Professionals. National Council of La Raza. Washington DC: Sept. 1998. National Alliance for Hispanic Health. 2001. (Designed to help providers in clinical, prevention and social service settings to better understand and more effectively respond to the service delivery needs of the growing Latino population). Guidelines for the Care of Migrant Farmworkers' Children. American Academy of Pediatrics Committee on Community Health Services and the Migrant Clinicians Network. 2000. (The guidelines describe the unique characteristics of migrant farmworkers' children and when used appropriately, assist clinicians with the provision of care that is of high quality and tailored to the context in which children of migrant farmworkers live). Doty MM, Ives BL. Quality Health Care for Hispanic Populations: The Cultural Competency Component. Bureau of Primary Health Care, Health Resources and Services Administration, US Department of Health and Human Services (2002). Technical assistance is also available from the NC Primary Health Care Association and the NC Farmworker Health Program within the Office of Research, Demonstrations and Rural Health Development for North Carolina agencies interested in adapting their services to better address the unique health care needs of migrant and seasonal farmworkers.
9. Inter-University Program for Latino Research (IUPLR). Information available at: http://www.nd.edu/~iuplr/
10. The UNC-Chapel Hill Program on Ethnicity, Culture and Health Outcomes. Information available at: http://echo.unc.edu/index.cfm
11. Another example of this is: The Complete Guide to Immigration and Successful Living in the United States, Access USA, Inc. (1994). Millington, NJ, on sale for $60. The book is divided into 12 sections covering a variety of topics such as Immigration Law, Employment, Insurance, Health, and Education.

9 Conclusion & Priorities

Introduction

As noted throughout the report, Latinos are the fastest growing ethnic group in North Carolina. Between 1990 and 2000, the number of Latinos in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. Latinos now comprise approximately 5% of the state's population.

Latinos move to North Carolina for employment; they are more likely to be employed and in the workforce than any other population in the state. Latinos are often employed in the state's most hazardous industries—agriculture or construction—or in low-paying jobs that are less attractive to native North Carolinians. Because of their willingness to work in these industries, some North Carolina businesses actively recruit Latinos from Mexico. Latinos are major contributors to the North Carolina economy, contributing more than $2.3 billion in purchases in 1999.

The Latino community is one of tremendous diversity. North Carolina Latinos come from many different geographic backgrounds. Some are united as an ethnic group by a common heritage derived from Spanish language and culture, while others share cultural heritages unique to their countries of origin. Most Latinos in the state are of Mexican origin, but many come from Puerto Rico, or other Caribbean, Central or South American countries.

The growing Latino population has created new health care challenges for the state. Most North Carolina Latinos are recent immigrants; nearly two thirds are foreign-born. Because so many Latinos are recent immigrants coming directly from Mexico or other foreign countries, many still have language barriers. In addition, persons coming from other countries are accustomed to different health care systems. The number of Latinos has overwhelmed many public agencies, and the underlying issues of lack of insurance coverage, language bar-

riers, different cultural and health care beliefs, and general unfamiliarity with the US health care system have not been adequately addressed.

Major Health Issues Facing the Latino Community

The NC IOM Latino Health Task Force met for more than nine months with the goal of developing a consensus on the major health and health care problems facing the NC Latino community, and to identify public and private sector initiatives that can be undertaken to address these concerns.

Over the course of its deliberations, the Task Force identified eight key issues:

1. **Latinos are disproportionately likely to live in poverty and are more likely to go without health care. Despite these problems, Latinos in the state, especially recent immigrants, are relatively healthy as compared to whites or African-Americans. But as Latinos acculturate to the US lifestyle, their health status worsens. Thus, the state cannot afford to be complacent.**

North Carolina Latinos, especially recent immigrants, are generally healthy. Latinos have better birth outcomes and have lower age-adjusted death rates that whites or African Americans. There are several possible explanations for this. Latinos are a younger population than the state as a whole. North Carolina Latinos are also likely to be recent immigrants, and studies have shown that first-generation immigrants may be healthier that those who have lived in the country for longer periods of time. Strong family support systems, coupled with traditional diets that emphasize vegetables and grains rather than high-fat foods and low rates of smoking, may explain, at least in part, why recent immigrants as a group are healthy.

Nonetheless, there are some health problems of immediate concern. Latinos are more likely to die from alcohol-related motor vehicle crashes and to suffer occupational injuries. Latinos are more likely to be born with certain developmental disabilities; Latino children are more likely to have dental disease and untreated dental caries. Further, Latinos are also more likely to contract immunization-preventable communicable diseases such as rubella. While first-generation Latinos generally are healthy, if they follow the pattern of other Latinos across the country, their overall health status is likely to worsen as they acculturate to the United States. Already, we are seeing signs that Latino youth are acquiring some of the poor health behaviors that lead to chronic health problems. Latino youth look much like their white and African-American peers in the percentage that report being overweight or at risk of being overweight and leading sedentary lifestyles. One-fourth of Latino high school students report smoking; 10% report their health status as poor, a higher percentage than whites or African-American high school students. Absent culturally appropriate, effective interventions aimed at promoting healthful behaviors among the growing Latino population, Latinos are likely to suffer the same adverse health outcomes as other population groups.

2. **Immigrants coming to this country are accustomed to different health care systems and may have different health care beliefs. This can create barriers to the effective use of the US health care system. Health, behavorial health, dental, and social services providers must be aware of these different cultural beliefs.**

Health care systems differ across countries, as do ways of accessing health services. For example, injections are commonly used to treat a wide variety of infections and other illnesses in Mexico and other countries. Waiting until after tests results are available to determine the course of treatment may not make sense to a person who is used to getting immediate treatment including antibiotic injections. Rather than wait, some Latinos may feel more comfortable seeking out immediate treatment with vitamins and medicines that are familiar to them from a trusted community source. In addition, many Latinos have different understandings of the cause of illness than is customarily believed in the United States. Because of the influence of certain cultural beliefs and practices, many Latinos may simultaneously seek the help of both formal medical care and folk healers for either acute or chronic conditions. North Carolina health care practitioners need to understand these different cultural expectations in order to be able to communicate effectively with their Latino patients and establish a trusting relationship.

3. **Because many North Carolina Latinos are recent immigrants, many face language difficulties. This creates barriers when seeking health, behavioral health or social services in addition to barriers caused by poverty, isolation, cultural differences and lack of health insurance.**

According to the US Census, approximately half of North Carolina Latinos have Limited English Proficiency (LEP) or are unable to speak English very well. These language barriers can impair a Latino's ability to access needed programs and services. Title VI of the Civil Rights Act prohibits public and private providers who accept federal funds (including Medicaid, NC Health Choice or Medicare reimbursement), from discriminating on the basis of race, color or national origin. The failure to make services and programs linguistically accessible has been interpreted to violate Title VI provisions. In October and November of 2001, the Office of Civil Rights (OCR) of the US Department of Health and Human Services conducted a review of the NC Department of Health and Human Services and five of the local public health and DSS agencies. OCR found North Carolina to be out of compliance with Title VI by failing to provide adequate language assistance to groups who speak a primary language other than English. According to OCR, individuals with limited English proficiency were sometimes turned away because no interpreters were available, or were required to use their family members, including minor children, as interpreters. Not only does this violate the provisions of Title VI, it compromises the confidentiality and accuracy of communication between the clients and the agency personnel. The best way to ensure that services are linguistically and culturally accessible is to hire bilingual, bicultural staff, but in the absence of sufficient bilingual personnel, agencies and health care providers must ensure the availability of trained interpreters.

4. **Lack of "health literacy" causes additional communication barrier between Latinos and their health care providers.**

Health literacy assumes a basic understanding of medical terms, a basic ability to read medical instructions, and an understanding of health care technology that is essential to ensure that the patient can be a full participant in managing his or her medical care. Nationally, 40% of Americans are unable to understand the information and warning contained on a common prescription bottle. The increasing complexity of health care information and the shift of a greater responsibility onto patients to participate in health care decision making and manage their own diseases has meant that health literacy problems have become much more daunting. While the problem of health literacy is not unique to the Latino population, it is particularly acute for many Latinos because of their communication barriers, different understandings of the underlying factors that affect health, and lack of awareness of the US health care system.

5. **Latinos are disproportionately likely to be uninsured compared with other racial and ethnic groups. Latinos are more likely to work for small employers or industries that do not offer health insurance coverage to their employees. Because many Latinos are recent immigrants, they are unable to qualify for publicly-funded insurance, such as Medicaid and NC Health Choice. Some Latino adults are afraid of seeking assistance for their eligible citizen children, because of their fear that this would affect their ability to remain in the United State or obtain lawful permanent residence status.**

North Carolina Latinos are more likely to be uninsured than other groups. More than half (54%) of all Latino adults in North Carolina are uninsured, compared to 11% of non-Latino whites and 22% of African Americans. Nationally, a smaller percentage of Latinos are uninsured (37%) than in North Carolina. Similarly, Latino children in North Carolina are more likely to be uninsured (29%), compared to non-Latino whites (8%) or African-Americans (15%). Latinos are more likely to be uninsured for a number of reasons—they are more likely to work for employers or in industries that do not provide coverage, and are less likely to qualify for publicly-funded insurance, despite their relative poverty.

Federal laws in 1996 made eligibility for publicly-funded programs more restrictive for most immigrants. While federal law restricts coverage for many immigrants, the citizen children of these immigrants born in the United States may be eligible for assistance. However, many immigrants are afraid of applying for their child because they fear that they may be labeled a "public charge," making it more difficult later to qualify for lawful permanent resident status, or that they may be deported if they seek assistance from a governmental agency.

6. **Migrant farmworkers face additional barriers in accessing health services, and are generally thought to be in worse health than the general Latino population. In addition, many migrant and seasonal farmworkers are ineligible for workers' compensation if they are injured on the job.**

Migrants suffer all the same barriers faced by other Latinos in accessing the health care system, including different health care expectations, a lack of understanding of the US health system, language barriers, inability to take off work, and transportation problems. Further, migrants are even more likely to be uninsured than the general Latino population and have particular problems accessing publicly-funded health insurance programs. Because of the transitory nature of their work, migrant farmworkers may have little understanding of the local health care systems. Migrants are often isolated, living in remote rural areas, and may lack telephones and transportation.

Migrant and seasonal farmworkers and their families have different and more complex problems, many of which can be attributed to a mobile lifestyle and the environmental and occupational hazards of farmwork. Because of state laws, migrant and seasonal farmworkers, unlike most other employees, lack workers' compensation coverage. Thus, while they are working in a hazardous industry—agriculture—they have no form of recourse if they are injured on the job. Migrants, as a whole, are more likely to harbor infectious and other parasitic diseases. They are also likely to have a higher incidence of tuberculosis. Nationally, studies suggest that migrant farmworker women have poorer health outcomes; the infant mortality rate for farmworkers is 25-30% higher than the national average. Because of the isolation of many migrant and seasonal farmworkers, special outreach efforts by trusted members of the community are needed.

7. There are insufficient resources available to address the health, behavioral health and dental health needs of Latinos.

Because of financial and non-financial barriers, health, behavioral health and dental health services are generally more limited for the North Carolina Latino population than for other North Carolinians. As a result, the Latino population relies more heavily on publicly-funded programs or safety-net providers—that is, providers who are willing to treat low-income patients for free or on a sliding-scale fee basis. However, these resources are not available throughout the state, and even when available, they may be insufficient to serve all in need. Nationally, almost four fifths of all the people in the United States saw a doctor in the past year. However, the available data—albeit limited—suggest that there are many counties in the state where less than 20% of Latinos visited a primary care provider in the past year. Further, Latinos have particular problems accessing behavioral health services. Despite the evidence that Latinos are more likely to be born with developmental disabilities, and that Latino males may have a higher incidence of alcohol abuse, Latino use of publicly-funded mental health, developmental disabilities and substance abuse services is very low. While the state and many other public and private health care providers have implemented special outreach efforts to reach the Latino community, these are generally isolated initiatives. There have been limited state or local funds available to cover the costs of treating uninsured Latinos.

There are new federal funds available that can be used to provide primary care, dental and behavioral health services to Latinos and other underserved populations in the state. However, special efforts are needed to encourage and assist

communities in seeking these funds. Additional state and local funding is needed to help replicate successful pilot programs aimed at providing culturally appropriate and linguistically accessible primary care, immunization efforts, family planning, maternity services, behavioral health and dental services across the state.

8. The lack of health data specific to North Carolina Latinos makes it more difficult to measure health disparities and use of health services.

In the past, health data were not collected by race and ethnicity. More recently, some agencies and programs have started to collect these data, but it is difficult to establish baseline data or to make accurate comparisons across different Latino subcultures. In addition, private health care providers do not collect this information routinely, so it is difficult to measure the use of health services among North Carolina Latinos. State and local agencies and other health, behavioral health, dental, and human services providers should collect health, behavioral health, dental, and social services related data (including but not limited to utilization and health outcomes) by race and ethnicity. Data should be used to determine if Latinos are able to access needed health, behavioral health, dental, and social services and whether there are specific health disparities facing the Latino community.

Recommendations

The Latino Health Task Force made a total of 33 recommendations to improve the health status of Latinos and increase access to culturally and linguistically appropriate health, behavioral health, dental, and social services. Task Force members understand that there are limited governmental and private funding sources available to address these needs. Therefore, the Task Force developed 13 priorities that, if implemented, would have a significant positive impact on the ability of Latinos to access needed health, behavioral health, dental and social services which would ultimately lead to improved health status. Because of the immediate need of bridging the language and cultural gap, most of the priority recommendations are aimed at expanding the availability of bilingual and bicultural providers. In addition, the Task Force made recommendations to expand the availability of primary, behavioral health and dental resources; remove barriers that deter families from applying for Medicaid, NC Health Choice and other publicly funded programs; provide meaningful workers' compensation for migrant and seasonal farmworkers; develop leadership within the Latino community to address health issues; address the problems of health literacy, including the lack of understanding of the US health system; and ensure that the state has adequate data to monitor health disparities and health access of the Latinos living and working in the state.

To expand the availability of bilingual and bicultural providers, the Task Force recommended that:

1. The Department of Health and Human Service help local communities in their efforts to recruit and retain bilingual and bilcultural providers and to hire and train interpreters. The Department will take responsibility for identifying possible grant sources for these efforts, and will assist local com-

munities in seeking these funds. In addition, the Department should develop systems to maximize federal funds to reimburse providers and agencies for interpreter services. The NC General Assembly should appropriate funding to the NC Department of Health and Human Services to assist in recruiting bilingual and, if available, bicultural professionals and pay for interpreter services.

2. The NC General Assembly appropriate additional funds to the Office of Minority Health and Health Disparities (OMHHD) to expand the capacity of OMHHD to focus on Latino health issues. Specifically, the OMHHD should: expand its technical assistance; communicate with communities about funding opportunities; provide cultural diversity and interpreter training to local agencies, non-profits and community groups; and conduct research into the major health issues facing Latinos.

- As part of this effort, the OMHHD Hispanic Health Task Force should be expanded to include a broader collaboration of state agencies and other organizations to develop policies and programs to address the health care needs of Latinos. The collaboration should help support the development or expansion of local coalitions to address the health needs of Latinos.

- If no new funds are immediately available, the Department of Health and Human Services should explore state, federal and private grant sources to obtain additional revenues to support the work of OMHHD.

3. The Governor's Office and NC Department of Health and Human Services explore the issues around certification, credentialing and licensing of foreign graduates, and research what other states are doing to develop systems to enhance recruitment of bilingual and bicultural health, behavioral health and human services providers.

- Because of the immediate need for bilingual and bicultural mental health and substance abuse counselors, the NC Department of Health and Human Services should work with the NC Social Work licensure board, the NC Certification Board for Substance Abuse Counselors and the Office of State Personnel to facilitate the certification, credentialing, licensure and employment of bilingual and bicultural social workers and substance abuse counselors.

- The General Assembly should appropriate funds to the University and Community College system to provide course work tailored to foreign graduates to assist them in preparing for certification, credentialing, and licensure in social work, substance abuse, nursing and other allied health and human services professions to increase the recruitment of bilingual, bicultural providers.

4. The NC General Assembly appropriate funding to maintain and expand the AHEC Spanish Language and Cultural Training Initiative and the Office of Minority Health and Health Disparities interpreter training and cultural diversity training courses.

To expand the availability of health, behavioral health and dental services, the Task Force recommended that:

5. The NC Primary Health Care Association, in conjunction with the NC Office of Research, Demonstrations and Rural Health Development and other state agencies, encourage and assist communities in seeking new federal Community and Migrant Health funds to expand the availability of primary care, dental and behavioral health services. The NC General Assembly should appropriate funds to C/MHC to be used to support the federal grants.

6. The NC General Assembly establish a health program that would address the health needs of uninsured, low-income Latinos who would otherwise qualify for public insurance but who cannot because of federal immigration restrictions. Priority should be given to: coverage of children; prenatal care; and health conditions or diseases that are significant problems for Latino populations, as determined by the State Health Director.

To help remove barriers that deter families from applying for Medicaid, NC Health Choice, and other publicly-funded services, the Task Force recommended that:

7. The NC Division of Medical Assistance and Division of Social Services re-examine the Medicaid, NC Health Choice and other DSS applications, notices, and policies to make services more accessible to the Latino population.

- As part of this effort, the NC Department of Health and Human Services should help train Latino service organizations and other organizations to assist applicants in filling out Medicaid, NC Health Choice and other public assistance applications. Funding from private foundations would assist in supporting this work.

8. The NC Division of Medical Assistance explore methods to improve migrant families' access to Medicaid and NC Health Choice.

To ensure that migrant and seasonal farmworkers are covered by workers' compensation, the Task Force recommended that:

9. The NC General Assembly extend workers' compensation to agricultural workers if they work for an employer who employs three or more full-time workers at least 13 weeks in a year. The NC General Assembly should also change existing workers' compensation laws to give the Industrial Commission the right to impose monetary or other sanctions on workers' compensation carriers for a pattern or practice of bad-faith denials.

- The Industrial Commission should be directed to conduct an educational campaign, through the Latino media, partnering organizations and existing outreach sources and programs, to explain how the workers' compensation system works, who is covered, how they can apply for benefits, and where they can go for assistance.

To develop leadership within the Latino population to improve Latino health, the Task Force recommended that:

10. El Pueblo, in conjunction with AHEC and other organizations, create a Latino Health Institute dedicated to improving the health of North Carolina Latinos.

To address the problems of health literacy, including the lack of understanding of the US health system among many Latinos, the Task Force recommended that:

11. The NC Department of Health and Human Services take the lead in convening a group of organizations who have developed and implemented lay health advisor programs. This group will help coordinate and strengthen lay health advisor programs, develop training for lay health advisors and provide technical assistance to other organizations seeking to implement similar programs. The group should help identify possible funding sources from North Carolina and national philanthropies, with a priority given to communities and counties with a large concentration of Latino residents.

12. The NC Community College system (Adult Literacy) take positive steps to address the problems of low literacy, including health literacy, among its Latino population. There is a need for a statewide initiative to address this problem across all population groups (not limited to Latinos).

To ensure that the state has adequate data to monitor health disparities and health access of the Latinos living and working in the state, the Task Force recommended that:

13. The NC Department of Health and Human Services and other health, behavioral health, dental and human services providers should collect health, behavioral health, dental and social services-related data (including but not limited to utilization and health outcomes) by race and ethnicity, to determine if Latinos are able to access needed health, behavioral health, dental, and social services, and whether there are specific health disparities facing the North Carolina Latino community.