An Overview of Health Care Access in Ohio’s Hispanic Community
The Ohio Commission on Hispanic/Latino Affairs issued this report on July 20, 2017. The report was composed by:

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The Ohio Commission on Hispanic/Latino Affairs (“OCHLA”) put forth best efforts in gathering and providing accurate and current information. This report contains data from the latest research available. Upon request, OCHLA will provide any additional information or data available.

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I. Introduction

The expanding Latino demographic in Ohio and across the country presents unique challenges and opportunities for health care providers, policy makers and health care organizations. Accessing health care is problematic for many Hispanics who are more likely to be uninsured than all other racial/ethnic groups living in the United States. In 2015, 18 percent of Hispanic Ohioans lacked health insurance, compared to just 8 percent of African Americans and 6 percent of Caucasians1.

Certain obstacles such as high costs of health care, low-wage jobs that do not provide employer-based health insurance, language barriers and immigration status disproportionately impact the Hispanic community, thus hindering equal accessibility2. While the uninsured rate for Hispanics has significantly declined since the implementation of the Affordable Care Act, disparities in health care access remain3.

Nearly half of all immigrants are uninsured in the United States4, often leaving them one injury or hospitalization away from financial insolvency. Both documented and undocumented immigrants are often forced to rely on emergency room visits or religiously affiliated clinics for reduced-price medical care, leaving taxpayers responsible for the resulting financial consequences of uncompensated health care. Only 20 percent of Latinos living in Ohio were born outside the United States5, but Ohio’s immigrant population continues to rapidly expand, and has increased by 49 percent since the year 2000 to 504,000 individuals. Contrary to popular belief, most immigrants to Ohio hail from Asia and Europe6.

Mental and behavioral health care accessibility is an often undervalued yet critical component to ensuring a healthy well-being. While accessibility is a significant barrier for Latinos, there is also a long-standing stigma in the Hispanic community that often prevents individuals from seeking out mental health services. According to Mental Health America, only 27 percent of Latinos are likely to seek mental health treatment, compared to 40 percent of Caucasians7.

In this edition of the Latino Community Report, we investigate the barriers and opportunities related to health care access for Latinos in Ohio. We examine the services available to U.S. citizens and non-citizens alike, and highlight health care policy initiatives under consideration at the state and federal levels that would significantly impact the Latino community. A critique on mental health service accessibility will be provided, and opportunities to increase impact will be offered.

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II. Barriers to Accessing Health Care

The low average income and educational attainment of Hispanics in Ohio are key barriers to receiving high quality health care. On average, Hispanic Ohioans are more than twice as likely as their non-Hispanic white counterparts to be poor, and they are also less likely to hold a post-secondary degree. Individuals with low-incomes are less able to afford out-of-pocket costs, which may inhibit them from seeing a doctor even for important matters. Similarly, being less educated puts individuals at a disadvantage, as they may be less able to successfully navigate the complex, multifaceted American health care system. Low income and education levels are also associated with low rates of health insurance coverage and a lack of usual source of care.

Hispanics are disproportionately represented in the agricultural, construction, domestic and food services, and retail trades, which are less likely to offer employer-sponsored insurance. The Affordable Care Act (ACA), a comprehensive health care reform law implemented during the Obama administration, helped extend coverage to many uninsured workers via Medicaid expansion and the Health Insurance Marketplace. Ohio is one of 32 states including Washington DC that has implemented Medicaid expansion, which expands Medicaid to individuals earning up to 138 percent of the Federal Poverty Level (FPL). The Health Insurance Marketplace provides premium subsidies to certain individuals with incomes of up to 400 percent FPL. Uninsured rates in the Hispanic community have significantly declined since the implementation of the Affordable Care Act, however Hispanics remain twice as likely as whites to be uninsured.

Aside from income and educational barriers, the Hispanic community must also confront a unique set of social circumstances that impact access to health care. Language access, cultural differences, transportation and logistical challenges, and immigration status are serious barriers that are especially prevalent in the New American community. Approximately half of Hispanics in Ohio report speaking Spanish at home, and 20 percent of these individuals are not able to speak English fluently. Language barriers directly impact access to care, as communication is critical to the delivery of services and the development of provider-patient relationships. Studies show that “language barriers between providers and patients may result in excessive ordering of medical tests, lack of understanding of medication side effects and provider instructions, decreased use of primary care, increased use of the emergency department, and inadequate follow-up.” Similarly, the absence of a culturally responsive approach by

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8 Ibid. Ohio Hispanic Americans.  
12 Ibid. Ohio Hispanic Americans.  
13 Ibid. Hispanics and the Future of America
medical professionals may lead to a breakdown in communication. Every day, doctors, nurses, and other medical professionals must use subjective analysis when interpreting patient needs. The professionals that lack appropriate training in cultural and linguistic competence may have difficulty accurately evaluating the needs of patients from different racial or ethnic groups, as their analyses of patients may be subconsciously influenced by implicit biases.

The significant underrepresentation of Latinos in the health care field contributes to the lack of culturally and linguistically competent medical services that Latinos may experience. Of the practicing physicians in the United States in 2012, only 5.2 percent identify as Hispanic/Latino, even though Latinos comprise 17 percent of the nation’s population. Although the Latino population has grown over the past three decades, the proportion of Hispanic physicians in the United States has decreased, as there were approximately 135 Latino doctors per every 100,000 patients in 1980, but in 2010 there were only 105 Latino doctors per 100,000 patients.

Even in the absence of cultural and linguistic barriers, logistical challenges may hinder the ability of individuals to access the health services they need. Many low-income Hispanics, and especially immigrants, rely heavily on the public bus system or family and friends for their transportation needs, which provides less control over daily schedules making it difficult to attend appointments. Additionally, individuals may not have the time or financial capability to take time off work for a doctor’s appointment.

In spite of myriad barriers to accessing health care, Latinos still live longer than whites on average, a phenomenon commonly referred to as the Hispanic Epidemiological Paradox. Researchers have reasoned that good health at the start of migration, lower smoking rates and strong social networks may give Latinos a survival advantage over their white counterparts. The survival advantage is particularly evident among first generation Latino immigrants. While cultural factors likely play a role in longer life expectancies, a pattern known as the return-immigrant effect or “salmon bias” also provides an explanation for the paradox. The return-immigrant effect is a trend in which Latinos who are in poor health are more likely than their healthier counterparts to return to their country of origin, thus providing an inaccurate portrait of Hispanic mortality rates in the United States. Another theory posits that Hispanics have a slower biological aging rate than their non-Hispanic counterparts, as evidenced by epigenetic biomarkers of aging, which indicate that blood from Hispanics ages more slowly than that of whites and African Americans.

**Local Initiatives to Reduce Disparities**

With 18 percent of Latinos lacking health insurance in Ohio and 27 percent lacking a usual health care provider, more emphasis must be placed on breaking down barriers while promoting a healthy

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14 Deville, Curtiland; Hwang, Wei-Ting; Burgos, Ramon. *Diversity in Graduate Medical Education in the United States by Race, Ethnicity, and Sex, 2012*. *JAMA Internal Medicine*. 2012.
15 Rivero, Enrique. *Rate of Latino physicians shrinks, even as Latino population swells*. UCLA Newsroom. 10 February 2015.
18 Ibid. Q&A: Does the ‘Hispanic Paradox’ still exist?
19 Schmidt, E. *Latinos age slower than other ethnicities, UCLA study shows*. UCLA Newsroom. 16 August 2016.
lifestyle. Hispanic community organizations in Ohio have largely taken it upon themselves to help improve the community’s access to health care by offering services that seek to minimize logistical barriers while promoting a healthy lifestyle in a culturally competent manner. The Ohio Latino Health Coalition (OHLC), which existed from 1999 to 2009, laid much of the groundwork in addressing Latino barriers in health care occurring around the state. For ten years, the coalition was successful in carrying out initiatives aimed at promoting a healthy lifestyle, such as the creation of a bilingual aerobics video, bilingual cook book with low-fat Latino recipes, Spanish health novelas, statewide Latino health disparities conferences, as well as a statewide Latino health needs survey – all sponsored by the Ohio Commission on Minority Health. Although the coalition no longer exists as a formal entity, many of its member organizations, including the Ohio Latino Affairs Commission, continue to carry out its mission.

As recent as 2015, four Latino-serving social service agencies have joined forces to create The Latino Connection, a formal partnership with a goal to reduce health disparities and improve the overall health of Hispanics in Ohio. The Latino Connection is comprised of Executive Directors from the following social-service agencies: El Centro de Servicios Sociales de Lorain; Adelante, Inc. Latino Resource Center of Toledo; Ohio Hispanic Coalition of Columbus; and Su Casa Hispanic Center of Cincinnati. Current areas of focus for the coalition include improving medical interpretation services, organizing prevention programs, hosting health fairs and health summits, and expanding data collection to reflect a more accurate representation of the state of Latino health in Ohio.

Several other Latino organizations and its allies are working toward a similar goal. For example, in Northwest Ohio the Farmworker Agencies Liaison Communication and Outreach Network (FALCON) works closely with Advocates for Basic Legal Equality (ABLE) to conduct trainings for hospitals on the rights of migrant families under Title VI regulations. Similarly, the Nuestra Gente Community Projects organization works collaboratively with local health organizations to assess and address the Latino community’s health needs. The organization hosts a Free Health Screenings Program, Diabetes Support Program, Breast Cancer Support Program, HIV/AIDS Program, Minority Lupus Program and Mental Health First Aid Training Program. Cardio drumming classes through the Sofia Quintero Art and Cultural Center, and Nosotras-Healthy Pregnancy, Healthy Babies program at Adelante Inc. focus on maintaining a healthy lifestyle.

In Northeast Ohio, El Centro de Servicios Sociales assists in the interpretation and translation of medical and social service appointments, and disseminates bilingual health material to the Latino community. Nueva Luz in Cleveland works to lessen the impact of HIV/AIDS on the Cleveland Latino community by increasing awareness and access to resources. Programs of Nueva Luz create a compassionate environment for culturally competent case management services, STD testing, prevention education, counseling and spiritual support. Several area churches are also involved in Latino health initiatives, such as the Sagrada Familia Church, which offers health programs, screenings and health fairs in the Cleveland area.

Our Lady of Guadalupe Center in Central Ohio provides health screenings and nutrition classes to thousands of Hispanics each year. The Hispanic Latino Health Collaborative, hosted by Mount Carmel Healthy Living Center, convenes over 50 partners across Central Ohio to focus on increasing health equity by providing a forum to network and share information and resources. The Ohio Hispanic Coalition’s Baby and Me-Tobacco Free and Promotoras de Salud programs also provide important outreach strategies to promoting a healthy lifestyle. Promotoras de Salud (community health workers) is
a nationally recognized initiative in which trained individuals provide outreach, education and information on healthy lifestyles for people who speak Spanish as their primary language. Promotoras are the bridge between the Latino community and health providers. They host informational group meetings and perform health education and outreach directly in the community. Promotoras may also be responsible for patient follow-ups, assisting patients in understanding medication and treatments, calling patients, setting appointments and filing medical charts.

Santa Maria Community Services in Southwest Ohio offers health insurance enrollment assistance, bilingual health screenings, HIV prevention and education for Latino families. Su Casa Hispanic Center offers monthly health workshops, Yoga and Zumba classes, and health fairs. The Greater Cincinnati Latino Coalition leads many advocacy efforts in the area of health and operates as a network of agencies, professionals, advocates and community leaders. Similarly, the Latino Health Collaborative, which is hosted by the University of Cincinnati, offers an opportunity for health care advocates and experts to network and share information and resources in the Southwest region of Ohio. In Dayton, La Vanguardia Newspaper and Latinos Unidos de Dayton also serve Latino families primarily through media and community outreach efforts.

At the state level, the Ohio Commission on Hispanic/Latino Affairs is proud to support initiatives that improve health and promote a healthy lifestyle for Hispanic Ohioans. The Commission works closely with Latino-serving organizations from across Ohio to shift the community’s focus from a curative approach to health disparities to a preventative approach focused on building health equity. The annual Latino Health Summit is hosted by OCHLA and convenes health experts, service providers and community members to share best practices as it relates to the health and well-being of the Latino community. The Summit hosts a variety of exhibitors to provide a forum for the exchange of contacts and ideas, and for strengthening the cohesion of the Latino health care community in Ohio. OCHLA works closely with the Commission on Minority Health to promote healthy lifestyle habits in the Latino community and to collect data on the state of Latino health in Ohio through state funded grants. The grants have allowed OCHLA to update its health data and work with Latino organizations to devise healthcare priorities around the state.

In 2016, OCHLA was proud to partner with The Ohio State University Wexner Medical Center to host the first-ever Ohio Medical Interpreting Conference centered on improving language access and cultural competence in the healthcare field. The event provided a unique opportunity for interpreters, health providers and stakeholders to build synergy for better health outcomes through workshops and networking opportunities. In 2017, OCHLA partnered with the Ohio Department of Mental Health and Addiction Services (ODMHAS) and the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Hispanic and Latino Addiction Technology Transfer Center Network to gather information on the mental and behavioral health needs of Latinos in Ohio, and to build a strategy that results in culturally competent training programs for clinicians and other mental health service providers.
III. Health Care Considerations for Immigrants

Over the past three decades, the immigrant population in the United States has more than doubled from 19 million people to over 43 million people. Interestingly, 88 percent of children living in immigrant families are U.S. citizens by birth. Although the labor force participation rate of the foreign-born is higher than that of the native-born, the foreign-born are more likely to work low-wage jobs that do not provide employer-based health insurance. Immigrants are also less likely to be covered under public health insurance than the native-born (29 percent vs. 36 percent), and immigrants are more than three times as likely to be uninsured.

Access to adequate health care can be a challenge for many, but especially for immigrants, both the lawfully present and undocumented*. Health insurance coverage rates have improved for immigrants since the implementation of the Affordable Care Act (ACA), but establishing immigrant eligibility is complex and may vary within family units depending on immigration status, date of immigration, state of residency and other considerations. Nearly two-thirds of uninsured lawfully residing immigrants are eligible for assistance under the ACA, while all uninsured undocumented immigrants remain ineligible to participate in the Marketplace or enroll in Medicaid.

Like U.S. citizens, lawfully present immigrants are subject to insurance mandates and related tax penalties, and are eligible to enroll in Marketplace health insurance and may receive subsidies. Deferred Action for Childhood Arrivals (DACA) grantees, however, are ineligible for ACA benefits or public health insurance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), a welfare reform overhaul, established restrictions governing which categories of immigrants are eligible for public means tested benefits. The law separates immigrants into two categories, qualified immigrants and non-qualified immigrants. Lawful Permanent Residents, trafficking

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*For the purpose of this report the term undocumented refers to those individuals who lack legal permission to be in the country.

22 Ibid. Barriers to Immigrants’ Access to Health and Human Services Programs.
24 Ibid. Policy Dilemmas in Latino Health Care…
26 Ibid. Frequently Requested Statistics…
27 Artiga, Samantha; Damicco, Anthony; Young, Katherine; Cornachione, Elizabeth; Garfield, Rachel. Health Coverage and Care for Immigrants, Henry J.Kaiser Family Foundation. 20 January 2016.
survivors, refugees and asylees are examples of qualified immigrant statuses that may be eligible for public benefits. Non-qualified immigrants, such as undocumented immigrants, those permanently residing under the color of law, and those with temporary visas are not eligible for public assistance because of the nature of their immigration status. An important provision of the PRWORA states that qualified immigrants who arrive to the U.S. after August 22, 1996 are subject to a five-year waiting period before they may access public benefits. Certain immigrants such as refugees, asylees and military members and their families, are exempt from the five-year waiting period.

Exhibit 1 – Immigration Statuses Eligible for Marketplace Coverage

<table>
<thead>
<tr>
<th>Lawfully Present Immigration Statuses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketplace eligible status only</td>
</tr>
<tr>
<td>Individual with valid nonimmigrant status (includes worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau)</td>
</tr>
<tr>
<td>All aliens whose visa petitions have been approved and who have a pending application for adjustment of status</td>
</tr>
<tr>
<td>Individuals granted employment authorization</td>
</tr>
<tr>
<td>Temporary Protected Status (TPS)</td>
</tr>
<tr>
<td>Paroled into the U.S.</td>
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<tr>
<td>Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) are not considered lawfully present)</td>
</tr>
<tr>
<td>Deferred Enforced Departure (DED)</td>
</tr>
<tr>
<td>A child who has a pending application for Special Immigrant Juvenile status</td>
</tr>
<tr>
<td>Granted relief under the Convention Against Torture (CAT)</td>
</tr>
<tr>
<td>Lawful Temporary Resident</td>
</tr>
<tr>
<td>Family Unity beneficiaries</td>
</tr>
<tr>
<td>All of the Medicaid eligible statuses listed below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid eligible status (If 5-year bar is met)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawful Permanent Resident (LPR/Green Card holder)</td>
</tr>
<tr>
<td>Conditional Entrant</td>
</tr>
<tr>
<td>Paroled into the U.S. for 1 year or more</td>
</tr>
<tr>
<td>Battered Spouse, Child, or Parent who has a pending or approved petition with DHS</td>
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</tbody>
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<tr>
<th>Medicaid eligible status (5-year bar does not apply)**</th>
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<tbody>
<tr>
<td>Trafficking Survivors and their spouses, children, siblings, or parents</td>
</tr>
<tr>
<td>Lawful Permanent Residents who adjusted from a status exempt from the 5-year bar</td>
</tr>
<tr>
<td>Veterans or active duty military, and their spouses or unmarried dependents who also have a &quot;qualified non-citizen&quot; status</td>
</tr>
<tr>
<td>Refugee</td>
</tr>
<tr>
<td>Asylee</td>
</tr>
<tr>
<td>Cuban/Haitian Entrants</td>
</tr>
<tr>
<td>Granted Withholding of Deportation or Withholding of Removal</td>
</tr>
<tr>
<td>Member of a Federally-recognized Indian tribe or American Indian Born in Canada</td>
</tr>
<tr>
<td>Certain Amerasian Immigrants</td>
</tr>
</tbody>
</table>

For more lawfully present immigration statuses, visit: [www.healthcare.gov/immigrants/immigration-status/](http://www.healthcare.gov/immigrants/immigration-status/)

* Indicates lawfully present immigration statuses that are considered qualified non-citizen statuses for purposes of Medicaid eligibility

** Indicates lawfully present immigration statuses that are considered qualified non-citizen statuses for purposes of Medicaid eligibility and that are NOT subject to the Medicaid 5-year bar

Source: [Centers for Medicare and Medicaid Services](https://www.cms.gov)

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Overview of Immigrants’ Eligibility for SNAP, TANF, Medicaid and CHIP, U.S. Department of Health and Human Services. 27 March 2012.
Up until the passage of the PRWORA in 1996, lawfully present low-income immigrants were able to enroll in Medicaid coverage without a five-year waiting period. The Legal Immigrant Children’s Health Improvement Act (ICHIA), a provision of the 2009 reauthorization of the Children’s Health Insurance Program (CHIPRA), allows states the option to lift the five year waiting period for lawfully-residing immigrant children and pregnant women. In 2013, Ohio became one of 31 states to waive the five year ban for lawfully-residing children, and among 23 states to waive the ban for lawfully-residing immigrant pregnant women. Children up to age 21 whose parent’s annual incomes are no more than 206 percent FPL are eligible to receive coverage, and pregnant women with annual incomes of no more than 200 percent FPL are eligible for benefits during their pregnancies and up to 60 days after giving birth.

For the newly-arrived elderly immigrant population, Medicaid and Medicare benefits are not available for their first five years in the U.S. Access to Medicare benefits pose a greater challenge for newly-arrived elderly immigrants because they have not paid into the system for ten years and may not have a green card. Since 2014, elderly immigrants who are not eligible for Medicare or Medicaid may purchase guaranteed-issue private health insurance through the Marketplace, and they may be eligible to receive tax credits to offset the cost if their income is between 100 and 400 percent FPL and if they do not qualify for other insurance.

Undocumented immigrants are unable to purchase health insurance in the Marketplace or enroll in Medicaid, leading them to rely on safety-net health care providers such as free clinics and community health centers. All states, including Ohio, offer some type of Emergency Medicaid to undocumented immigrants and other non-qualified immigrants who do not meet citizenship requirements. In Ohio, non-qualified immigrants may be eligible for Alien Emergency Medical Assistance (AEMA), which provides coverage during an emergency medical condition regardless of insurance or immigration status. Applicants are not required to verify their citizenship status, but must meet the financial and residency requirements for Ohio’s Medicaid program. According to Ohio Administrative Code § 5160:1-5-06(B), an emergency medical condition is one that manifests itself by acute symptoms of sufficient severity, and if left alone could result in serious harm or death. Labor and delivery are included under this provision, however prenatal and postpartum care are not. Care and services related to an organ transplant are not covered under emergency Medicaid either. Individuals that have received treatment must apply for emergency medical assistance following their emergency episode through the County Department of Job and Family Services, hospital billing departments, or Ohio Benefit Bank.

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35 Can recent immigrants to the United States get health coverage if they’re over 65? Medicare Resources. 26 October 2016.
36 Ibid. Can recent immigrants to the United States get health coverage if they’re over 65?
37 Andrews, Sarah; Brown, David; Dee, Laurie Anne; et al. Emergency Medicaid for Non-Qualified Immigrants – Medical Coverage and Services for Immigrants. American University, Washington College of Law. 7 December 2016.
38 Ibid. Emergency Medicaid for Non-Qualified Immigrants…
In a 2015 national report published by UCLA, Ohio was ranked last in the country for having policies that support the health and well-being of undocumented immigrants. Five policy areas that affect the social determinants of health were taken into account for the study: public health and welfare benefits; higher education; labor and employment practices; driver licensing and identification; and the federal enforcement program, Secure Communities. The report recommends several steps states can take to promote a healthy lifestyle that is inclusive of the undocumented community, including instituting policies that grant access to higher education, health care and driver’s licenses. The report also recommends implementing programs that promote immigrant integration such as ESL classes, and instituting more universal labor and employment protections for all workers.

Source: UCLA Center for Health Policy Research

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39 Rodriguez, Michael; Young, Maria-Elena; Wallace, Steven. Creating conditions to support healthy people: State policies that affect the health of immigrants and their families. University of California Global Health Institute. 2015.
The immigrant community must confront a unique set of barriers that impact access to health care. Navigating a complex health care system and dealing with cultural and linguistic differences are among the most obvious barriers, but climates of fear and mistrust are also very real in deterring immigrants from accessing health care, especially as it relates to seeking public assistance. A study conducted by the U.S. Department of Health and Human Services found that common anti-immigrant rhetoric coupled with state legislation targeting immigrants contribute to the climate of fear and mistrust in the community. The study concluded that many immigrants fear mistreatment or deportation if they seek public assistance, or worry that public charge laws would render them ineligible for citizenship in the future. These misconceptions are pervasive throughout immigrant communities around the U.S., and outreach efforts to discredit such falsehoods are essential to enabling access to services.

40 Ibid. Barriers to Immigrants’ Access to Health and Human Services Programs.
**IV. Accessing Mental Health Services**

Hispanics are historically underserved in their ability to access mental health services as evidenced by low utilization rates and gaps in prevention and early intervention efforts. This poses a great challenge for today’s health care system, as Hispanics now comprise a large segment of the population that needs community-specific strategies to reduce disparities in behavioral health. Hispanics are no different than any other population group in their need for mental health services, and it is increasingly apparent for immigrants and their first-generation American children.

Moving to a new country is not easy. From saying goodbye to close friends and family to entering a new country with a different set of customs and language, the psychological toll on new immigrants can be immense. Many immigrants such as unaccompanied children and other refugees have endured trauma for years in their home countries, but may be forced to internalize the trauma as they focus on surviving in a new land. While immigrants must deal with the adjustment to a new country, their children are experiencing different stressors of their own. U.S.-born children in immigrant families often feel great pressure to assimilate into mainstream society, and navigating two cultures and adopting new social norms can adversely affect one’s mental health. A study published on Mexican immigrants in California validated these sentiments as immigrants recorded lower rates of mental health disorders than their U.S.-born peers. The study concluded that rapid assimilation to American culture is associated with negative mental health outcomes, and that the decline in health status of immigrants over time in the U.S. is associated with higher acculturation including changes in lifestyle, cultural practices, increased stress and adoption of new social norms.

For undocumented immigrants and individuals living in mixed immigration status families, stressors are compounded by the intense fear of deportation. These families live with constant exposure to serious stress because of the potential of a family member being deported, and the mental health effects can be particularly damaging. Many parents are afraid to leave their houses, and their children – who are mostly U.S. citizens – have anxiety over the thought of losing a parent(s).

Psychologist Kalina Brabeck, an associate professor at Rhode Island College, studies the effects of deportation on children and found that young children whose parents are undocumented tended to fare worse in school and experience more anxiety than other children. “They feel nervous and afraid and worry about things outside their control. What was interesting was that children of undocumented parents had fewer behavior problems and were less likely to be hyperactive. They sit still and are quiet, but they’re experiencing a lot of internal stress that might not be so apparent externally. They slip under the radar. They might not be recognized as needing help.”

When a parent is deported, the trauma of familial separation exacerbates the stress and anxiety. Children whose parents have been detained or deported can suffer severe mental health problems, such as PTSD, chronic depression and anxiety, and difficulties in school.

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41 Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.
Major mental health disorders such as schizophrenia and bipolar disorder exist in the Hispanic population, however depression and anxiety appear to be among the most prevalent. The Albert Einstein College of Medicine of Yeshiva University conducted the largest study ever on the mental health of Hispanics in the U.S. and found that 27 percent of Hispanics reported high levels of depression and anxiety. Hispanics between the ages of 45 to 64 were 21 percent more likely to have symptoms of depression than individuals ages 25 to 44, and women were twice as likely as men to experience high levels of depressive symptoms. A separate study found that anxiety and depression often led to substance abuse or suicide particularly among Latino youth. According to the CDC, suicide is the third leading cause of death for Hispanics between the ages of 10-34, and Latina adolescents in particular have the highest suicide attempt rate of all female adolescents at a rate of 15 percent.

The need for mental health services is evident, but only a small portion of the Latino population utilizes services. According to the Substance Abuse and Mental Health Services Administration (SAMSHSA) only 7.3 percent of Hispanics utilized mental health services from 2008-2012, compared to 16.6 percent of Caucasians and 8.6 of African Americans. Estimates of prescription medication use was 5.7 percent, a relatively low number considering 27 percent of Hispanics have reported high levels of depression. Hispanics over the age of 50 were more likely to seek mental health services compared to their younger counterparts.

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44 Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.
45 Largest Study of Hispanics/Latinos Finds Depression and Anxiety Rates Vary Widely Among Groups, Albert Einstein College of Medicine. 20 October 2014.
46 Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.
49 Racial/Ethnic Differences in Mental Health Service Use among Adults, Substance Abuse and Mental Health Services Administration. 2015.
Among Hispanic adults with an unmet need for services, cost or insurance (none or inadequate coverage) was the most commonly cited reason for not taking advantage of mental health services\(^\text{50}\). While many mental health services are offered on a sliding fee scale, cost still remains the most significant barrier to mental health care. Structural barriers such as a lack of reliable transportation or the inability to take time off work are significant barriers to accessing mental health services as well. Likewise, the underrepresentation of Latino mental health practitioners often leads to a lack of culturally and linguistically competent care.

Of all practicing psychologists in the American workforce, only 5 percent identify as Latino\(^\text{51}\), and the number of psychologists that offer services in Spanish is likely smaller. Language plays a critical role in the quality of mental health services that a client receives. When individuals are able to express their emotions and sentiments in their native language, it leads to a more positive therapy experience\(^\text{52}\). Bilingual therapy allows individuals to experience greater comfort and understanding in their sessions, while allowing their therapist to consider new perspectives and understand the client on a more personal level. Without linguistic competence, non-English speaking patients are more likely to be misdiagnosed, underdiagnosed, or as reported in studies concerning Latinos, “an exaggerated perception of psychopathy.”\(^\text{53}\) For example, some Latin American cultures may perceive supernatural phenomena such as hearing voices as part of a normal religious experience, and American clinicians with no cultural frame of reference could easily misinterpret the sentiments as evidence of schizophrenia or some other psychotic state\(^\text{54}\). Accordingly, a cultural frame of reference allows clinicians to understand normal variations in behavior or experiences that are specific to a person’s culture.

Even though high costs, structural barriers and lack of awareness of existing mental health services are significant barriers to accessing mental health services, stigma continues to be an important factor that deters Latinos from seeking mental health treatment. A study conducted by the UC Davis Center for Reducing Health Disparities found that Latinos largely associate mental illness with being “crazy”, and

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\(^{50}\) Ibid. Racial/Ethinic Differences in Mental Health Service Use Among Adults.


\(^{54}\) Ibid. Biennial Review of Counseling Psychology Volume 1.
thus do not seek out help because of shame and fear of being judged”\(^{55}\). As one study participant put it, “I think it [stigma] is true in the Latino community. I have an aunt with a lot of problems but she doesn’t want to go ask for help. She would rather just stay at home…suffering from depression than go out and look for help. It has to do with [her] not wanting other people to find out what she’s going through, and sometimes it has to do with not being told that you’re like crazy. It’s based on being labeled and how we are seen in other people’s eyes. We [Latinos] are scared of what other people have to say. We don’t like to be judged.”\(^{56}\)

The study also suggested that culture may influence how Latinos interpret psychological distress. Many study participants stated that cultural beliefs regarding faith, spirituality and religion are often used to explain mental illness as fate, and that mental illnesses are often caused by God’s will or evil done by others\(^{57}\). For example, some Latinos believe in the power of the *mal de ojo* (evil eye), and in the role of a shaman in curing these ailments. Masculinity or *machismo* is another cultural factor that may influence the likelihood of males accessing mental health services. Many Latino males in the study discussed the importance of appearing in control and strong for the family, and that seeking mental health treatment is perceived as a sign of weakness.

“Coming from a Latino family it’s always that traditional perspective where the male is the type of guy that has to be kind of be the head of the house…Being a kid and growing up in that certain perspective, it’s normal for the male to be like, ‘You know what? There’s no point in me looking for help. I can handle my own…I have to maintain my head up strong because if I show weakness, then they’re going to take advantage of me.’ I remember the man has to be the head of the household and if he has problems, he has to hold it in. He has to keep his head together because if he shows his weakness, then he shows his family’s weaknesses…”\(^{58}\)

Culturally competent community outreach and education strategies on mental health issues are important steps to combatting the barriers that prevent Latinos from seeking mental health care. Strategies that incorporate community leaders, Latino community organizations and service providers are critical to a successful outreach campaign. Locally, the Ohio Latino Connection and the Ohio Latino Affairs Commission are working to address mental health care barriers facing Latinos. A current initiative seeks funding for Mental Health Navigator programs in Ohio’s four major cities over the next three years. The concept of a Mental Health Navigator for the Latino community was devised and implemented in Lorain, Ohio, through a partnership between the Lorain County Board of Mental Health and El Centro de Servicios Sociales. Mental Health Navigators are licensed social workers/counselors who are fluent in both English and Spanish, and are tasked with providing mental health screenings, connecting clients to providers and scheduling interpretation for clients. Lorain County has experienced great success in overcoming cultural and linguistic barriers that Latino individuals often face through the navigator model. In its first year alone, El Centro provided service to 479 individuals -- 25 percent of whom required interpretation services. The expansion of the navigator model to other cities in Ohio will ease access for Latinos seeking mental and behavioral health services while improving the efficiency of services and reducing mental health disparities.

\(^{55}\) Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.

\(^{56}\) Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.

\(^{57}\) Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.

\(^{58}\) Ibid. Community-Defined Solutions for Latino Mental Health Care Disparities.
V. Health Care Policy Initiatives

Seven years ago, a comprehensive health care reform law was enacted with a goal to make health insurance more accessible for everyone. Since the Affordable Care Act (ACA) took effect, Latinos have experienced the largest decline in uninsured rates of any racial/ethnic group. The ACA expanded insurance coverage to millions of people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces that offer subsidies for certain individuals earning up to 400 percent FPL. The law also increases preventive care coverage and prohibits the denial of coverage to individuals because of pre-existing conditions.

Because of growing concerns over the affordability of health insurance and mandates set in place, Congress is seeking to repeal parts of the ACA. In May of 2017, the House of Representatives passed the American Health Care Act (AHCA), a partial overhaul of the health care system that would repeal ACA mandates, subsidies and standards for health plan actuarial values while retaining private market rules, including requirements to guarantee issue coverage, prohibit exclusion of coverage for pre-existing conditions (although states could seek waivers to allow insurers to charge more based on health status), and allow individuals up to age 26 to remain on their parents’ health insurance. The legislation would eliminate Medicaid expansion over the next few years, and eventually convert federal Medicaid funding to a per capital allotment.

In June of 2017, the Senate proposed its own draft of the bill titled the Better Care Reconciliation Act (BCRA) of 2017, which would also repeal ACA mandates and cost sharing subsidies while retaining private market rules relating to pre-existing conditions and age limits. The bill, which was revised in July, includes a provision that would allow certain insurers to sell non ACA-compliant “bare bones” plans that would not be mandated to cover broad benefits like maternity care, emergency room visits, hospitalization, outpatient care, etc. Medicaid expansion would still be phased out under the legislation, however the phase-out would occur over a longer period of time than the House version. According to a cost estimate of the original Senate version by the Congressional Budget Office, the BCRA would increase the number of people who are uninsured by 22 million over the next decade, but reduce the federal deficit by $321 billion over the same period – an amount that is $202 billion more than the estimated savings under the House version.

In early July 2017, the Senate version of the bill appeared to be “dead”, as the Senate reportedly lacked the votes to pass the legislation. Senate leadership may soon decide to reopen negotiations on the bill, or attempt to take up the 2015 Affordable Care Act repeal bill, which does not include a replacement plan. The future of the Affordable Care Act remains unknown.

At the state level, legislators are also addressing health care policy. Most recently, the Ohio legislature attempted to freeze Medicaid expansion enrollment after July 1, 2018, however Governor Kasich vetoed

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61 Ibid. Compare Proposals to Replace The Affordable Care Act.
62 Congressional Budget Office Cost Estimate. 26 June 2017.
the provision citing the need to preserve health care access for Ohio’s most vulnerable citizens. The legislature has until the end of the current legislative session to override the Governor’s veto. Other potential veto overrides include a provision that would limit the administration’s ability to cover new, optional groups under Medicaid and require that Ohio seek federal approval to charge premiums to Medicaid recipients.

Another proposal would require certain health care professionals to receive training in cultural competency to gain or renew a professional license. Senate Bill 16, introduced by Senator Charleta Tavares, states that dentists, registered nurses, licensed practical nurses, optometrists, pharmacists, physicians, psychologists and social workers must obtain instruction or continuing education in cultural competency in order to receive or renew their professional licensure. Likewise, licensing boards would be required to adopt rules that consider race and gender-based disparities in health care treatment decisions, while also consulting with outside professional organizations. Senate Bill 16 presently awaits consideration from the Senate’s Health and Human Services Committee.

Several State of Ohio agencies are also working to eliminate healthcare disparities through targeted initiatives. The Ohio Department of Mental Health and Addiction Services (MHAS) created the Disparities and Cultural Competence (DACC) Advisory Committee, which is comprised of MHAS program staff and external community members, with a goal of eliminating disparities and moving towards health equity. The Latino Affairs Commission is a member of this committee whose objectives include developing a business case for cultural and linguistic competency, and creating a cultural and linguistic competence plan for all human services. The Latino Affairs Commission is also part of the advisory council for the Ohio Department of Health, Preventive Health and Health Services Block Grant, which awards approximately $7 million in federal funding to local organizations each year. The program allows grantees to utilize funds to respond to emerging health issues and to fill funding gaps in programs that target chronic disease and injury prevention. Finally, the Ohio Commission on Minority Health (OCMH) also works to address health disparities in the state by funding projects that are innovative and culturally sensitive in their approach to promoting health and wellness in minority communities.

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65 Siegel, J. Kasich says legislature has left Medicaid 1.4 billion short. Columbus Dispatch. 6 July 2017.
VI. Conclusion

Despite increasing access to health care for Hispanics, disparities remain as Latinos continue to underutilize services and are more likely to be uninsured than other racial/ethnic groups. Community outreach and engagement is critical to ensuring Latinos are aware of the services available to them and to overcoming barriers and stigmas.

Likewise, education and outreach to health care professionals is important to develop and strengthen relationships with the Latino communities they serve. Developing a culturally competent workforce is critical to successful health outcomes, and promoting the recruitment of Latinos in the health and mental health care field should be prioritized to diversify a sector that is vastly underrepresented by Latinos. Collaboration with universities, high schools, community leaders and Latino organizations would be beneficial to developing a career pathway to the health care industry.

The Ohio Latino Affairs Commission continues to make progress in these areas through our partnerships, educational initiatives and participation on boards focused on reducing health disparities. We stand ready to assist the State of Ohio in improving access and health outcomes for Latinos and the New American community, and are committed to equipping state leaders with key information on Ohio’s Hispanic communities. Latino Community Reports are part of the Commission’s work to fulfill its statutory mandate to advise Ohio’s government on issues affecting their Hispanic constituents.