North Carolina Latino Health, 2003
A Report from the Latino Health Task Force

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THE FACE OF NORTH CAROLINA is changing rapidly, with a growing Latino population in every city, town, and hamlet. Between 1990 and 2000, the North Carolina Latino population grew by almost 400%, more rapidly than in any other state in the country. Latinos were estimated to constitute at least 5% of the state's population in 2000, and with ongoing immigration and a high birthrate the number of Latinos is expected to continue to grow.

Latinos, like other immigrants, come to our country to work. North Carolina Latinos are more likely to be in the workforce and more likely to be employed full-time than whites or African Americans (Table 1). In the past, Latinos were heavily concentrated in rural areas, working primarily in the agriculture industry. Over the past decade, more Latinos have immigrated to North Carolina or settled out of the farm stream. Although Latinos work in all sectors and industries, they are still one of the mainstays of the agricultural workforce, and they are disproportionately employed in hazardous industries, such as construction, or in low-paying jobs that are less attractive to native North Carolinians.

> *During the most significant and unparalleled immigration period in the state of North Carolina, my administration is committed to ensuring that immigrants have the opportunities they need to succeed. Access to quality healthcare services is critical for all people in our state and the work of this Task Force will go far in ensuring that our Hispanic and Latino population is well served.*
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> *—Governor Michael Easley, February 7, 2003*

North Carolina Latino residents are making a substantial contribution to the economic well-being of the state. Not only are Latinos hardworking—helping to produce North Carolina products—but they pay taxes and spend money in the state. A study by the Selig Center for Growth at the University of Georgia estimated that Latinos had a buying power of more than $8.8 billion in North Carolina in 2002.[1] In addition to their labor and financial contributions, Latinos, like other ethnic groups, help contribute to the cultural richness of our state.

Along with these benefits, however, this recent immigrant population also presents many challenges to those addressing its healthcare needs. Almost two-thirds of North Carolina Latinos (64.2%) are foreign-born, with almost half reporting that they do not speak English very well.[2] Over half of the Latinos in the state are noncitizens (58.3%), although it is important to note that this does not mean that they are all here "illegally." Latinos may be residing, working, or studying in the state under special work visas, or they may be here with a tourist or student visa. Thousands of Latino noncitizens serve in the military. Citizenship is not required to live in this country legally.

Most North Carolina Latinos are recent immigrants from Mexico (65.1%), but others come from Puerto Rico, Cuba, and other Central and South American countries. The Latino community in our state is one of tremendous diversity. Some of its members are united by a common heritage based on the Spanish language and culture, while others have cultural backgrounds that are unique to their country of origin. Those recently arrived may be accustomed to different healthcare delivery and financing systems, which can affect their health-seeking behaviors once in the United States. Further, Latinos are also more likely to be uninsured and thus need to rely on safety-net providers for their healthcare.

The North Carolina Institute of Medicine, in conjunction with El Pueblo, Inc., a statewide Latino advocacy and

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Table 1. Comparison of North Carolina Latinos, non-Latino whites, and African Americans on selected socioeconomic characteristics (2000)

	Latino	*Non-Latino White*	*African American*
Employment status			
In the labor force	74.8%	67.0%	64.6%
Employed full time	69.1%	63.4%	57.8%
Unemployed	3.3%	2.5%	5.9%
Employment occupation			
Production/Transportation	36.7%	15.8%	26.7%
Construction/Maintenance	24.8%	11.3%	6.9%
Farming/Fishing/Forestry	7.9%	0.5%	1.7%
Sales/Office	8.6%	25.9%	22.3%
Service	14.3%	11.8%	22.6%
Management/Professional	7.7%	34.7%	19.8%
Income			
Median family income	$30,529	$51,951	$30,529
Percent living in poverty	27.4%	8.5%	25.0%

Source: Poverty data from US Census. Census 2000 Supplementary Summary Tables. P114, P115. Employment data from US Census. Census 2000 Supplementary Summary Tables. PCT 048. Occupation data from US Census. 2000 Supplementary Tables. PCT 049. Median income from US Census. Census 2000 Summary File 3 (SF-3) Sample Data. P155B, H, I. Median Family Income 1999.

public policy organization, convened a Task Force to study the healthcare needs of the growing Latino population and the ability of the state's healthcare system to meet this need. The work of the Task Force was underwritten by grants from The Kate B. Reynolds Charitable Trust and The Duke Endowment. The Honorable Mary Easley, First Lady of North Carolina, was the Honorary Chair of the Task Force. Carmen Hooker Odom, Secretary of the NC Department of Health and Human Services, and Felix Sabates, Chairman of FSS Holdings in Charlotte, were Co-Chairs. The 48-member Task Force included representatives of private and public healthcare sectors, state and local health agencies, behavioral health and human service agencies, legislators, Latino service and advocacy organizations, private industry, nonprofits, and faith communities. The Task Force met for approximately nine months, April 2002 to January 2003. This article gives an overview of the Task Force's guiding principles (Sidebar), findings, and principal recommendations. A full copy of the Task Force's report can be found on the NC Institute of Medicine's web page at: www.nciom.org.

Major Healthcare Issues Facing the Growing Latino Population

The Task Force studied several health issues facing Latinos in the state, including the current health status of this population; their different healthcare expectations; language difficulties; lack of health literacy; financial barriers due to lack of health insurance; inadequate state resources to address the health, behavioral health and dental needs of the growing but largely uninsured Latino population; barriers facing the migrant population; and inadequate data to monitor the Latino population's health status and access to care and services. Each is discussed more fully below.

***Health status*:** Latinos are disproportionately likely to live in poverty (Table 1). Further, many Latinos are noncitizens, and studies show that noncitizens are more likely to go without healthcare.[3] Despite these issues, Latinos, especially recent immigrants, are relatively healthy as compared to whites or African Americans. For example, Latinos are much less likely to start receiving prenatal care in their first trimester, yet having less prenatal care does not translate into poorer health outcomes. Latinos, especially Mexicans, are less likely to have low birthweight babies (6.1%) than whites (6.6%) or African Americans (15.0%), and their infant mortality rate is comparable to that of whites. Further, Latinos have lower age-adjusted death rates than whites or African Americans (See the article by Paul Buescher on p. 97). National studies suggest that first-generation immigrants may be healthier, in part because of certain protective behaviors (low rates of smoking and traditional diets low in fats) and selection bias; that is, only the healthiest individuals successfully migrate because of the difficulties inherent in migration.[4]

While Latinos have a generally positive health status, there are some areas of immediate concern. Latinos are more likely to report drinking five or more drinks per month and more likely to die from alcohol-related motor vehicle crashes. Latino children are more likely to be born with certain birth defects, including neural tube defects, anotia/microtia and Down syndrome, and are more likely to have untreated dental disease. Migrant and seasonal farmworkers have greater health problems than the Latino population as a whole. Further, Latinos are more likely to die from occupational injuries than whites or African Americans. While Latinos have low infant mortality rates and lower overall death rates than other population groups, national studies suggest that the health of immigrants worsens as they acculturate to the United States.[5] Already, there are signs that Latino youth are engaging in some of the unhealthy lifestyle behaviors that lead to chronic diseases. Latino youth look much like their white and African American peers in the percentage who report being overweight and leading sedentary lifestyles.

Healthcare expectations: People coming from other countries are accustomed to different healthcare systems, financing mechanisms, healthcare providers and treatment regimens. The services offered, their availability, and the training of the healthcare providers vary depending on country of origin. For example, antibiotic injections are commonly used to treat a wide range of infections and other illnesses in Mexico and other Latin American countries. Latinos are also able to obtain over-the-counter from local pharmacies many of the same medicines that require doctor's prescriptions in the United States. Further, Latinos sometimes obtain care from traditional healers such as *curanderos* (folk healers), *yerberos* (herbalists), and *sobadores (*masseuses). There is also a strong belief in some communities that the sun, moon, and earth play a role in health outcomes. These pre-existing healthcare beliefs can affect health-seeking behaviors in the United States. Latinos are not always accustomed to a healthcare system that requires a prescription for medications or requires a doctor's visit to get a prescription. A patient may feel more comfortable seeking out immediate treatment with familiar vitamins and medicines from a trusted community source. For example, some Latinos rely on vitamins and unregulated medications available through some *tiendas* (local food stores) in North Carolina. Some of the *tiendas* have been found selling drugs that either have been banned (such as Matamizole), are restricted because of potential severe side effects (Lincocin, Lincorex), or are only allowed for use in animals (Butazolidin).[6] It is important for health, behavioral health, dental, and social services providers to be aware of these different health-seeking behaviors and of the availability of medications in some *tiendas* across the state.

Language difficulties: Because many North Carolina Latinos are recent immigrants to this country, many do not have complete facility with the English language. Approximately half the Latinos in North Carolina are unable to speak English very well. This language barrier compounds their problems in understanding and accessing needed health services. Language barriers work both ways: they also make it difficult for healthcare providers to understand and communicate with their patients. Effective two-way communication is needed to understand patients' underlying healthcare problems, provide health education, and prescribe necessary care.

Federal regulations that interpret Title VI of the Civil Rights Act of 1964 require all organizations, institutions, or healthcare providers that receive federal funds to make their services linguistically accessible.[7] Title VI applies to state and local health departments, area mental health programs, and departments of social services, as well as to hospitals and private healthcare providers who receive Medicare, Medicaid, or other federal payments. With the rapidly growing Latino population in this state, complying with Title VI has become a major issue for both public and private providers.

Principles That Guided the Work of the Task Force

1. Latinos residing in North Carolina are making a substantial contribution to the economic, social, and cultural enrichment of the 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.

2. Language barriers to needed healthcare, behavioral healthcare, or social services should no longer be acceptable. The most effective way to increase access to these services is to hire bilingual and bicultural providers who can provide for 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 long-term 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.

3. Care should be compatible with patients' cultural health beliefs and practices. Staff at healthcare 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.

4. Public and private health, behavioral health, dental, and social services providers; nonprofits; foundations; and churches can play an important role in meeting the healthcare needs of the growing Latino population. Private employers and industries that recruit Latinos from other countries have a special responsibility to meet the healthcare needs of all members of this vulnerable population in their employment.

Table 2. Health insurance coverage for Latinos, non-Latino whites, and non-Latino African-Americans

	Noncitizen Latinos (NC)	*All Latinos (NC)*	*All Latinos (US)*	*Non-Latino Whites (NC)*	*Non-Latino African Americans (NC)*
Adults (18 or older)					
Group health insurance	31%	35%	44%	66%	56%
Medicare	0%	2%	8%	14%	13%
Medicaid	2%	3%	33%	2%	5%
Uninsured	64%	54%	37%	11%	22%
Children (0 - 17)					
Group health insurance	26%	27%	40%	70%	52%
Medicaid/SCHIP	19%	32%	30%	9%	27%
Uninsured	48%	29%	26%	8%	15%

Source: US Census. Current Population Survey (2000, 2001, 2002). Totals do not equal 100% because Champus, private non-group insurance, and Medicare (for children) are excluded from the chart. Special data run from the Cecil G. Sheps Center for Health Services Research.

Compliance with Title VI requires that federal fund recipients provide linguistically and culturally competent services. The US Department of Justice interprets Title VI to include a balancing test, which takes into consideration the number of people likely to be affected, the nature of the services provided, the resources available to the grantee, and the costs involved. This is meant to balance the need for meaningful access, while not imposing undue burden on small businesses, nonprofits, or local governments.

Healthcare providers, especially hospitals that provide emergency services, are likely to be held to a higher standard because of the nature of the services provided and the potential impact of access barriers on a person's health. Compliance with Title VI generally requires federal fund recipients to identify individuals in need of language assistance, provide competent and trained interpreters, translate vital documents, and conduct ongoing monitoring to assure the accessibility of programs or services. Public and private agencies that receive federal funds are not allowed to require individuals to supply their own interpreters, as the use of untrained family members can compromise the confidentiality and accuracy of communications.

***Lack of health literacy*:** Language difficulties are exacerbated by a general lack of health literacy among many new immigrants. Health literacy assumes a basic understanding of medical terminology, the healthcare system, and treatment modalities so that people can be full participants in managing their own healthcare. This problem is not limited to the Latino population. The National Adult Literacy Survey showed that 40% of Americans are unable to understand the information and warnings accompanying a common prescription medication.[8] The problems associated with poor health literacy become even more daunting as the healthcare system seeks to shift greater responsibility for disease management onto patients themselves.

***Lack of public or private insurance coverage*:** North Carolina Latinos are more likely to lack health insurance coverage than other ethnic or racial groups (Table 2). Fewer Latino adults in North Carolina have private, employer-based coverage than whites or African Americans, and most are ineligible for public insurance. Noncitizen Latinos are even more likely to be uninsured, and less likely to have private or public health insurance than other Latinos. North Carolina Latinos are less likely to have group or publicly-funded insurance than Latinos nationally.

Although many Latinos are poor and could otherwise qualify for Medicaid or NC Health Choice, many are ineligible because of federal immigration laws. Federal laws passed in 1996 made it more difficult for immigrants to qualify for means-tested public programs (such as Medicaid, NC Health Choice, Food Stamps, or SSI). With certain limited exceptions, immigrants are ineligible to receive Medicaid or NC Health Choice assistance for the first five years after receiving their green card (authorization to live and work in the United States). While these laws restrict coverage for many adults—especially those who are here in the country without proper documentation—their children may be eligible if they are born in this country. However, some Latinos are afraid to apply for their children because they are afraid either that they may be labeled a "public charge"—making it more difficult for them to qualify later for lawful permanent resident status—or that they may be reported to the Immigration and Naturalization Service and deported.

Table 3. Counties with greatest unmet primary care needs

	Less than 20% of Latinos in county seen in C/MHC or health department	*20%-50% of Latinos in county seen in C/MHC or health department*
Access problems for adults and children	Alamance, Beaufort, Burke, Catawba, Craven, Cumberland, Iredell, Lincoln, Macon, New Hanover, Randolph, Rowan, Wayne	Bladen, Chatham, Duplin, Harnett, Lee, Robeson
Access problems greater for adults	Alleghany, Franklin, Gaston, Granville, Hoke, Hyde	Davie, Tyrrell

Source: Health department data from Division of Public Health. NC Department of Health and Human Services. HSIS Data. July 2000-June 2001. C/MHC data from: NC Primary Healthcare Association, Uniform Data System. 2001.

***Lack of resources to address the health, behavioral health, and dental health needs of the Latino population*:** Because Latinos are so much more likely to lack health insurance coverage and have lower family incomes, they are more likely to rely on certain safety-net providers for their needed health services. These include community and migrant health centers (C/MHC), health departments, hospitals, rural health clinics, free clinics, and area mental health programs. Many of these providers have a special mission to serve Latinos or underserved populations, but none receives sufficient funding to cover the healthcare needs of all of those seeking services. Community and migrant health centers receive some funding from the federal government to underwrite care to the uninsured, but federal grants cover only 20%-40% of a center's costs. Similarly, health departments do not receive funds to cover all of the care provided to Latinos. In 2000, 68 local health departments in the state reported a total of more than $7 million in uncompensated prenatal care services to pregnant uninsured Latinas. Under the federal Emergency Treatment and Active Labor Act (EMTALA), hospitals are required to screen and stabilize everyone who seeks care in the emergency room—regardless of whether individuals have a source of payment. Thus, hospitals have become a major source of care to the Latino population.

To get an idea of the extent of potential access barriers, the Task Force examined available data to determine the proportion of the Latino population being served by either C/MHC or health departments, two of the primary sources of healthcare for Latinos. The Task Force calculated the percentage of Latinos seen by these providers in comparison to the Latino population in the county, concentrating on counties that had the highest percentage or largest number of Latinos (5%, or 5,000 or more people). On average, 83% of all people in the United States and 73% of Latinos used ambulatory healthcare services in 2000.[9] More than half of all people (51%) had a visit to a primary care physician in 2000. The available health department and C/MHC data suggest that there are many counties in the state where less than one-fifth of Latinos have visited a primary care provider during the year (Table 3). In some counties, there are access barriers for both Latino adults and Latino children, as there are few public providers in the community serving this population. However, in other counties, the access barriers are limited to the adult population, as the health department is providing comprehensive services to children.

The Task Force recognized that this analysis is crude at best, since data were not available from all sources of care. Further, there is no way to get an unduplicated count of the number of Latinos in a county seen in either the health department or the C/MHC. Despite these caveats, the Task Force used these data to get an idea of the communities with the largest unmet primary care needs.

The Task Force also examined other systems of care available to Latinos. In addition to some primary care, local health departments provide immunizations, and many offer well-child and maternity care services, as well as treatment of sexually transmitted diseases. There is also a network of 73 nonprofit organizations that operate close to 100 dental clinics or vans that provide ongoing dental care to low-income Medicaid and/or uninsured persons. While none of these systems is sufficient to meet all of the healthcare needs of the growing Latino population, the greatest access barriers were in the areas of mental health, developmental disabilities, and substance abuse services. State data showed that the Latino population's use of publicly funded mental health, developmental disabilities, and substance abuse services is very low, despite their recognized need for these services (Table 4). Statewide, North Carolina's area mental health programs served 11.5 Latinos per 1,000 Latinos, compared to 39.0 per 1,000 people overall.

Access barriers facing migrant and seasonal farmworkers: Migrant and seasonal farmworkers are generally in worse health than other Latinos, and face greater barriers in access to services. Migrant and seasonal farmworkers and their families have more complex problems, many of which can be attributed to their mobile lifestyle and the environmental

Table 4. 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	0.2	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.

and occupational hazards of farm work. For example, they are more likely to have HIV infections, tuberculosis, and communicable diseases than the national average. Studies suggest that birth outcomes may be less positive for farmworkers,[10] and that farmworkers may be more likely to experience violence than the general population.[11] Furthermore, agriculture is a dangerous industry. On average, there are 4.3 fatalities per 100,000 workers in non-agricultural settings, but 23.9 in agriculture. In addition to job-related injuries, farmworkers may be exposed to pesticides or may experience heat-related illnesses, dermatitis, respiratory illnesses or musculoskeletal problems.

Although farmworkers have greater health needs, they also experience added barriers in accessing services. Farmworkers often live in isolated areas, lack transportation, and may be fearful of seeking services. Migrant farmworkers may be in the state or community for only a short time, making it more difficult to apply for and qualify for publicly-funded services such as Medicaid or NC Health Choice. Moreover, migrant and seasonal farmworkers are generally ineligible for workers' compensation, even if they are injured on the job. Most employees are covered by workers compensation if they work for firms with three or more full-time, year-round employees. Agricultural workers, in contrast, are covered by workers compensation only if they work for a farmer who employs 10 or more full-time, year-round workers or hires H-2A guest workers.

Outstanding data needs: The Task Force used all available data to assess the health status and outstanding healthcare needs of the growing Latino population in the state, including data collected by state agencies as well as studies undertaken by other agencies. However, data were not available to answer all of the questions raised by the Task Force. In many instances, the state lacked health data specific to North Carolina Latinos, although some national data were available. In the past, health data were not collected by race or ethnicity. More recently, some datasets have started to collect this information, but collection methods are not uniform, and the data, where they exist, may not cover enough years to identify trends. This lack of reliable data makes it difficult to fully assess the health status, health risks, utilization, and accessibility of health services.

Recommendations

The Task Force made 33 recommendations to improve the health status of Latinos and to increase access to culturally and linguistically appropriate healthcare, behavioral healthcare, dental care, and social services. To focus limited public and private resources, the Task Force identified 13 priority recommendations, which, if implemented, would have a significant positive impact on the health and healthcare access of North Carolina Latinos. Because of the immediate need to bridge cultural and language gaps, many of these 13 recommendations focus on expanding the availability of bicultural and bilingual care providers for health, behavioral health, dentistry, and social services. Other recommendations are to expand the availability of primary, behavioral, and dental healthcare resources; to remove barriers that deter families from applying for Medicaid or NC Health Choice; to provide meaningful Workers' Compensation coverage for migrant and seasonal farmworkers; to develop leadership within the Latino community to address health issues at the state and local level; to address problems of health literacy; and to ensure that the state has adequate data to monitor health disparities and access to healthcare among 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 bicultural providers and to hire and train interpreters. The Department should 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 NC Department of Health and Human Services to assist in recruiting bilingual and, if available, bicultural professionals and pay for interpreter services.

In order to make health, behavioral health, dental, and social services linguistically and culturally accessible to the Latino population, it may be necessary in the short term to rely on trained interpreters. In the longer term, priority should be on recruiting bilingual, bicultural providers. Further, public and private providers who accept federal funding are under

an obligation to ensure that their services are linguistically accessible. The Task Force recognized that this requirement would create additional costs to both public and private providers. Therefore, the Task Force recommended that the Department take the lead in helping communities recruit bilingual and bicultural providers, and to identify funding sources to help pay for interpreters.

2. The NC General Assembly appropriate additional funds to the Office of Minority Health and Health Disparities (OMHHD) within the NC Department of Health and Human Services 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, nonprofits, and community groups; and conduct research into the major health issues facing Latinos.

Historically, OMHHD has led the NC Department of Health and Human Services efforts to shape health policy for racial and ethnic minorities, and has worked with AHEC to expand interpreter training courses and training for local agencies on cultural competence. The Task Force recommended that OMHHD expand its mission in light of the Task Force report and seek out additional partners both within and outside the Department to ensure implementation of the Task Force recommendations.

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 dire need for bicultural and bilingual professionals in the areas of mental health and substance abuse (behavioral health) , priority should be placed on the certification and credentialing of social workers and substance abuse counselors.

There are a number of health, behavioral health, and human services professionals currently living in North Carolina who received their training in a Spanish-speaking country. It is difficult for them to practice in the state because of state licensure and/or certification requirements. Many of these professionals may be competent to practice in North Carolina and could help to address the gaps in the availability of bicultural and bilingual providers. The Task Force recommended that this issue be studied further, with the first priority given to the credentialing of foreign-trained social workers and/or substance abuse counselors.

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.

The NC Area Health Education Centers Program (AHEC) received funding from The Duke Endowment to create the Spanish Language and Cultural Training Initiative. The initiative includes five components: language training for health professionals and students, interpreter training, instructor training in basic medical Spanish, language training for mental health and substance abuse service providers, 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 OMHHD. This effort has received national recognition, but is scheduled to run out of grant funding by the end of December 2003. The Task Force strongly supported continued funding for this initiative.

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

5. The NC Primary Healthcare 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.

Under the Bush Administration's Health Centers Presidential Initiative, there are new federal funds available to expand the availability of services provided by community and migrant health centers. Most of the federal funding is targeted at expanding the services provided by existing health centers, but some of the funding can be used for new centers. Outreach is needed to identify communities interested in applying for these federal funds. Further, state funding is needed to augment the federal grants, as the federal funds are insufficient to cover all the costs.

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.

States are limited by federal immigration laws in the services and programs they can provide under the Medicare, Medicaid, and S-CHIP programs to undocumented immigrants, or to those who have been in the country for less than five years. However, states can enact their own laws to provide health services to cover any group of immigrants if the programs receive no federal funding. These are called "health replacement" programs. A majority of other states offer some type of health replacement program, typically limited to immigrant children or prenatal care services. The

Task Force recommended that the state establish a health replacement program to cover prenatal care, children, and/or other critical health needs facing the Latino population.

◆ 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 (DMA) and Division of Social Services (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.

There are many Latinos who would qualify for publicly-funded programs—either for themselves or for their children—if they were to apply. However, many are afraid to apply because of fears that the application will somehow affect their ability to remain in this country. Local DSS eligibility workers do not always understand program rules and sometimes discourage immigrants from applying. Therefore, the Task Force recommended that the NC Department of Health and Human Services review existing applications, policies, and notices to ensure that services are accessible, that eligibility workers be trained on an ongoing basis to ensure they understand the program rules as they apply to immigrants, and that Latino organizations be trained to understand basic program rules and application forms, so that they can act as advocates for Latino families and help them fill out Medicaid, NC Health Choice, and other public assistance applications.

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

Migrant and seasonal families face unique barriers applying for Medicaid and NC Health Choice. Once obtained, coverage is portable across NC counties, but not across state lines. Migrants in the state for only short periods of time may find that the regular application processing time is too long to provide meaningful coverage. Further, it is more difficult to count farmworker income to determine program eligibility because of the sporadic nature of their employment and wages. The Task Force recommended that the Division of Medical Assistance examine ways to make these programs more accessible to the farmworker population.

◆ 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.

Agricultural workers who are injured on the job are unlikely to have alternative health insurance that can help cover healthcare expenses. Further, these workers earn relatively low salaries (on average $7.50/hour or less), so they are unlikely to be able to cover needed health services out-of-pocket. This means that the costs of caring for injured workers are shifted onto the healthcare providers, who in turn shift the costs to other paying patients. The Task force recommended that agricultural workers be provided the same Workers' Compensation protections as other workers in North Carolina. Outreach is needed to ensure that migrant and seasonal farmworkers understand their rights, and that carriers do not purposely create barriers which prevent workers from exercising their rights.

◆ 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. 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 the state. The Task Force recommended that El Pueblo take the lead in creating a Latino Health Institute that would help establish a cadre of Latino health leaders who would work to meet the health needs of Latinos across the state.

◆ To address the problems of health literacy, including the lack of understanding of the US healthcare 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.

Latinos do not always understand how to access or use the healthcare system, and often have different cultural expectations about the provision of health services. Lay health advisors, indigenous community members who are trusted

sources of health and healthcare information, have been shown to be effective tools of communicating health information to the Latino population. Lay health advisors can help explain the US healthcare system, teaching Latino families how to access needed services. They have also been helpful in traditional health promotion, disease prevention activities, and teaching Latino families to manage their own health problems.

12. The NC Community College System 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).

The Community College System has already piloted a curriculum to promote health and wellness among Latinos through English as a Second Language (ESL) classes. The program, called "Expecting the Best," focuses on healthcare, nutrition, exercise, and fitness and is intended to improve health literacy, functional literacy, and communication skills for immigrant populations. Piloted at Cape Fear Community College, it is expected to be offered statewide by 2004.

◆ 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

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 NorthCarolina

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 services in these areas, and whether there are specific health disparities facing the North Carolina Latino community.

Although this recommendation was part of the Latino health report, the Task Force recognized the need to collect health data for all racial and ethnic groups. These data will help to identify racial and ethnic disparities and access barriers. Data should be collected from public and private health, behavioral health, dental, and social services providers.

The fact that this Task Force report was one of the first comprehensive examinations of the health status and unmet needs of the Latino population does not mean that communities, government, healthcare providers, philanthropies, nonprofit and faith based organizations, and private industry have done nothing to address these needs. To the contrary, the Task Force learned of many innovative efforts by public and private organizations at the state and local level. The full report highlights many of these efforts. Nonetheless, it was clear from the Task Force's work that the outstanding problems will necessitate further public and private sector action. In many ways, North Carolina is at the very beginning of its efforts to ensure that Latinos can have access to services so that they may continue to be vital and productive contributors to the future of the state.

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