



Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Health Needs and Access to Health Care

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Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Health Needs and Access to Health Care

This is the second report in a two-part series on the profile of the DACA-eligible population in California. This report describes the common sources of care, barriers to care, and health needs for DACA-eligible Californians, and presents potential solutions for health care providers, community-based organizations, and private and public funders to improve health and access to care. A [companion report](#) describes health care coverage of DACA-eligible Californians and presents potential policy solutions to expand their coverage options. Both reports can be found on the UC Berkeley Labor Center [website](#).

Executive Summary

This report describes the health needs, common sources of care, and major barriers to health care access for teens and young adults in California who are eligible for the Deferred Action for Childhood Arrivals (DACA) program, which provides temporary work authorization and relief from deportation for qualified undocumented immigrants. It is the second of two reports that collectively describe the findings from the California Health Interview Survey (CHIS) data and key informant interviews. This second report also describes findings from focus groups with DACA-eligible young adults in California.

The majority of DACA-eligible Californians are low-income and are more likely to lack private health insurance than their U.S.-born counterparts, as shown in the CHIS data from the [companion report](#) in this series. These teens and young adults constitute a subset of the approximately one million undocumented immigrants who are not eligible for federal coverage options under the Affordable Care Act (ACA), though low-income Californians granted DACA are eligible for Medi-Cal (California's Medicaid program) under state policy.

Further analysis of CHIS data shows that DACA-eligible Californians are more likely to report poor health than their U.S.-born counterparts. They have similar rates of being overweight and obese, but are less likely to report having asthma than their U.S.-born counterparts. DACA-eligible individuals are also less likely to have a usual source of medical care, or to have had a doctor or emergency room visit in the past year.

To provide further context to the CHIS data, focus groups conducted with DACA-eligible young adults in urban areas of Los Angeles and the Bay Area revealed that they tend to either avoid care completely or seek care outside of the mainstream medical system, except in instances of serious health need. Focus group participants and key informants identified the following key barriers to accessing care: cost, lack of health care literacy, difficulty navigating the health care system, and fear and mistrust of the health care system and its providers. Key informant interviews were also conducted to validate and expand upon focus group results.

The focus groups indicated that mental health issues are highly prevalent within the DACA-eligible community due to trauma and stress related to participants' undocumented status. In addition, participants noted that given the financial stressors, competing demands for their time, and general mistrust of health care providers, it has become culturally normative for DACA-eligible individuals to delay seeking care for physical and mental health issues.

Many DACA-eligible young adults are currently unaware of their eligibility for state, county, and private health care and health insurance programs. This lack of information reflects the complexity of the network of programs through which they can seek care, in addition to the limited transfer of information about how to access and utilize the health care system from their parents, families, and other community members, many of whom lack health care access and insurance.

This report highlights the health needs and gaps in access to health care for a significant number of young Californians who are not eligible for the benefits of the Affordable Care Act due to their immigration status. Focus group participants, as well as key informants interviewed in this study, made a number of recommendations for ways to improve health and health care access for DACA-eligible Californians. Some of the top priorities included:

- Supporting efforts to educate Californians with DACA about their health coverage options, enroll them in available programs, and assist them in navigating the health care system;
- Disseminating information about health care options and coverage programs through trusted sources, including peer networks, families, advocacy organizations, Spanish-language media, and social media; and
- Improving the way that health care services are delivered so that they are more culturally and linguistically accessible to diverse immigrant populations.

Removing barriers to timely preventive and primary care would improve overall population health and potentially reduce avoidable hospitalizations. Movement toward achieving these two central goals of the ACA would be bolstered by healthy DACA-eligible Californians, who are and will continue to be important contributors to the state and its economy.

Introduction

Limited data has been available on the demographics and health care experiences of the population eligible for the Deferred Action for Childhood Arrivals (DACA) program.

The purpose of this study is to provide information on the health-related experiences of these young California immigrants and inform providers, stakeholders, and policymakers in developing solutions in California and nationally that would improve access to health care for DACA-eligible teenagers and young adults. This report is based on research conducted by a team of University of California researchers between May and October 2013 involving analyses of data from the California Health Interview Survey (CHIS), focus groups with DACA-eligible young adults in California, and interviews with key informants.

In this report, the second in the two-part series, we describe the health status and health care use of DACA-eligible Californians based on CHIS data. Using focus groups conducted with DACA-eligible Californians, we also present participants' perspectives on existing sources of care, barriers to care, and health care needs. Finally, we present potential solutions suggested by key informants and DACA-eligible youth that would improve health and access to care for these young California immigrants.

The [companion report](#) in this series provides background on the DACA program and ineligibility for federal Affordable Care Act programs for individuals granted DACA, in addition to describing health care coverage of DACA-eligible Californians and presenting potential policy solutions to expand their coverage options.

It is worth noting that, concurrent to this project, the UCLA Labor Center conducted a study on health care access in which immigrant youth surveyed 550 of their peers throughout California, including undocumented youth and youth granted deferred action. The survey results were published

in a February 2014 report entitled [Undocumented and Uninsured: A Five-Part Report on Immigrant Youth and the Struggle to Access Health Care in California](#).¹ The UCLA Labor Center report helps fill the same information void on the health care experiences of DACA-eligible young adults as does our report.

Summary of Methods

We used data from the 2007 and 2009 California Health Interview Survey (CHIS) to examine the demographic characteristics, health status, health care access and utilization, and health insurance of DACA-eligible individuals in California. (For details on methodology see Appendix A.) We conducted focus groups with 61 DACA-eligible young adults in California. Additionally, 28 key informants were interviewed either in person or by phone. Informants included policy experts, advocates, health care providers, DACA-eligible young adults, funders, government officials, and representatives from community-based organizations serving the immigrant community in California (Appendix B). An advisory board of stakeholders in immigration advocacy and health policy guided the design of this study and provided valuable input in the interpretation of results.

Characteristics and Health Care Use of DACA-Eligible Californians

CHIS data presented in the [companion report](#) in this series showed that more than one-third (34 percent) of DACA-eligible Californians had no reported source of insurance coverage, a significantly higher rate than that of their U.S.-born peers of the same age (18 percent). However, coverage among Californians granted DACA could expand significantly because of their eligibility for Medi-Cal (California's Medicaid program) under state policy. The vast majority (93 percent) of DACA-eligible teens between the ages of 15 and 18 and nearly two-thirds (62 percent) of DACA-eligible young adults ages 19 through 30 are estimated to

be eligible for Medi-Cal, according to analyses of CHIS data presented in the [companion report](#).

In this section, the health status and health care use of DACA-eligible individuals are compared to those of U.S.-born individuals ages 15 to 30 living in California, using CHIS data. Comparisons among all immigration categories, including naturalized citizens, lawful permanent residents, those with temporary legal status, and undocumented individuals unlikely to be eligible for DACA, are provided in Appendix C.

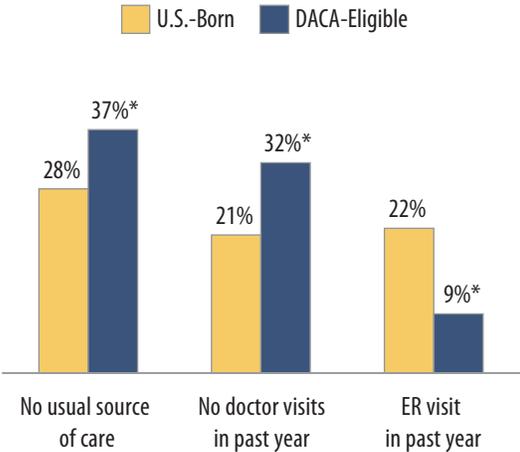
Access to Health Care

A higher share (37 percent) of DACA-eligible individuals report not having a usual source of care than their U.S.-born counterparts (28 percent). Consistent with less access to a usual source of care, DACA-eligible individuals are more likely to have had no doctor visits in the past year (32 percent) than U.S.-born individuals of the same age (21 percent; Exhibit 1). Despite less access to primary care, DACA-eligible Californians are also less likely to have had an emergency room visit in the past year (9 percent) than U.S.-born individuals (22 percent). The barriers to access to care for these individuals were explored in the focus groups described later in this report.

Health Status and Risk Factors

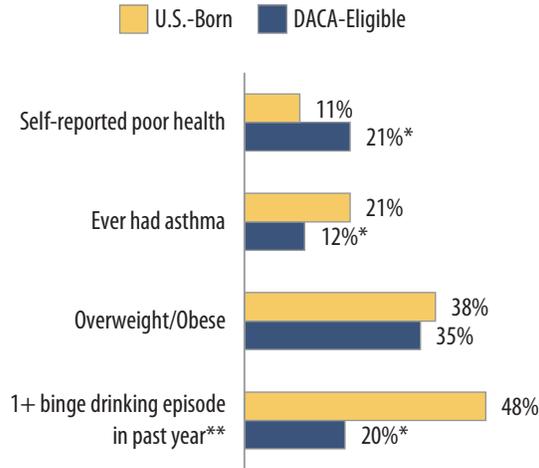
DACA-eligible individuals are nearly twice as likely as U.S.-born individuals to report being in poor health (21 percent and 11 percent respectively; Exhibit 2). Despite reporting poorer health, DACA-eligible individuals report lower rates of having asthma compared to U.S.-born individuals (12 percent and 21 percent respectively), possibly reflecting limited access to care and diagnosis, and similar rates of being overweight or obese (35 percent and 38 percent respectively). DACA-eligible individuals, ages 19-30 are also significantly less likely to report having had a binge drinking episode in the past year (20 percent) than U.S.-born individuals of the same age (48 percent).

Exhibit 1: Access to Care of DACA-Eligible and U.S.-Born Individuals, Ages 15-30, California, 2009-07



Source: California Health Interview Survey, combined 2009 and 2007 data
*Significantly different from the U.S.-born population (p < 0.05)

Exhibit 2: Health Status and Risk Factors of DACA-Eligible and U.S.-Born Individuals, Ages 15-30, California, 2009-07



Source: California Health Interview Survey, combined 2009 and 2007 data
*Significantly different from the U.S.-born population (p < 0.05)
**Includes ages 19-30 only

The poorer self-reported health, lower reported rate of asthma, and limited access to care identified in the above analysis indicate potential unmet need for preventive and primary care among DACA-eligible individuals in California. Poor health and limited access to health care can have negative consequences for this group and the public's health in general. Lack of a usual source of care and annual physician visits are highly correlated with low receipt of preventive health care services, such as flu shots, cancer screenings, and birth control and other reproductive health care.² Delays in receipt of preventive care are also generally associated with higher likelihood of avoidable hospitalizations and emergency room visits in the long run.³ Lower rates of emergency room utilization among DACA-eligible Californians in particular may reflect fear of discrimination or deportation as noted by focus group participants later in this report.

Common Sources of Care

Mirroring CHIS findings, DACA-eligible focus group participants and key informants described that for all but the most serious and life-threatening health care needs, these young adults tend to either avoid care completely or seek care outside the mainstream medical system.

Home Remedies, Over-the-Counter Medications, and Traditional Healers

Many focus group participants reported that they seek health information online in an effort to self-diagnose and self-treat. Participants also reported asking family members for medical advice and using home remedies or *remedios*, such as teas, provided by parents and other family members. Some participants also reported sharing prescription drugs that had been given to another family member with similar symptoms. In addition, participants described self-medicating with over-the-counter medications from drug stores, although those without driver's licenses were limited in their ability to purchase certain over-the-counter

medications, such as cough syrup and Plan B, due to the need for an acceptable form of identification. Participants also spoke about using traditional healers, such as *curanderos* and *sobadores*, who were well known within their communities.

Clinics, School Health Centers, and Bodega Clínicas

Participants mentioned a variety of clinics as sources of medical care. Public and private non-profit clinics, including federally-qualified health centers, were most commonly reported by participants. Among those attending college, participants reported turning to their school health center, though this option varied by institution. One key informant noted that a common source of care for uninsured, undocumented Latinos is *bodega clínicas*, which are storefront offices located in immigrant communities in the Bay Area and Los Angeles that are open on evenings and weekends, accept cash, and have Spanish-speaking providers and staff. These *bodega clínicas* are generally operated by unlicensed providers trained outside of the United States. Although they are widely used, information about the quality or outcomes of care at these clinics is very limited.

Barriers to Accessing Care

While there are some health care programs available for DACA-eligible Californians, access to health insurance coverage and health care services remains challenging due to cost, concerns about deportation or consequences for future immigration status, limited health care literacy, difficulties in navigating the health care system, fear and mistrust of providers, and the complex role of family in this population.

High Cost

The high cost of health care services was the single most common barrier to health care identified by both focus group participants and key informants. This population lacks access to health insurance and, consequently, often has to pay out of pocket

for health care received. These costs often compete with other basic needs, such as food, shelter, and school tuition. As a result, DACA-eligible young adults frequently forgo health care in all but emergency situations. Cost also impedes access to care due to DACA-eligible young adults' fear of burdening their family with medical expenses. This was the case even for some participants who had health insurance: "I had insurance from my dad growing up. But, even then, you know, you still had to pay five bucks. . . . Five dollars is five dollars; nowadays that could help in the house. And like they say, I avoided going to the emergency room. And I tried avoiding going to the doctor or getting medicine because it's so expensive." Lastly, several participants voiced worry about the large bills they would receive after seeking medical care and expressed fear of acquiring or having a record of medical debt that could be made available to immigration authorities. As one key informant put it, "My worst fear is getting sick, not having enough money to pay for it, being sent to collections, and then the government would find out about it. A lot of people I know fear collections."

Low Health Care Literacy

Lack of health care information was another major barrier to care mentioned frequently by both focus group participants and key informants. Focus group participants reported a lack of information about what health insurance options they are eligible for and where to seek the appropriate health care services or advice. As one participant said, "DACA recipients didn't grow up with insurance so they might not know how to use it or might not know if they have access." Several participants expressed that discussing health care and insurance is uncommon in undocumented and immigrant communities. Some key informants explained that many in these communities do not know that federally-qualified health centers (FQHCs) will serve any person who walks through the door, regardless of ability to pay or immigration status. Focus group participants reported that improving health care

literacy is important if greater inroads are to be made in health care delivery to this population.

"My worst fear is getting sick, not having enough money to pay for it, being sent to collections, and then the government would find out about it. A lot of people I know fear collections."

Misinformation regarding coverage options and health care services available to DACA-eligible young adults also limits access to health care. This misinformation may come from family members and peers, as well as from some eligibility workers who perpetuate inaccuracies regarding program requirements. One key informant reported that these inaccuracies may be due to deliberate discrimination towards undocumented immigrants or an unintentional lack of training during a time when significant changes in health care are occurring with the implementation of the ACA.

Finally, a lack of information about what health care services one needs and what services would be covered by insurance was common among focus group participants, regardless of insurance status. As one focus group participant noted, "Some of us have health insurance and we don't have no idea what it actually covers." Participants expressed that the lack of information was often intergenerational, since many of their parents were undocumented and had little experience using health insurance or the health care system. One participant explained, "I did have health insurance, and I didn't access it because I didn't know what services were available to me, or the co-payment and how that worked, or I was just really not informed on that. Because my parents, previously, they didn't have anything, so they . . . didn't give me direction in that."

Difficulty Navigating the Health Care System

A third major barrier to access was the difficulty of navigating the health care system. Many participants reported working part-time or full-time in order to pay for school and help support their families, while simultaneously attending classes. With these competing demands on their time, participants reported that they often do not have time to seek medical care. In addition, the lack of the legal right to apply for a driver's license prior to receiving DACA contributed to difficulty in obtaining transportation to medical care, although this is now changing with the passage of recent state laws allowing undocumented Californians and those granted DACA to obtain driver's licenses.⁴

“I did have health insurance, and I didn't access it because I didn't know what services were available to me, or the co-payment and how that worked. . . . I was just really not informed on that.”

Participants also identified a variety of systems-level barriers to care including the burden of paperwork, delays in getting appointments, long wait times, and language barriers. Multiple key informants explained that the safety net system of clinics and public hospitals is over-capacity, and focus group participants expressed frustration with facing these challenges as patients: “You have to deal with the long lines, with scheduling appointments two or three weeks in advance.” Another recalled, “They kept bouncing me from place to place to place before I actually even got to anybody to actually treat it. So it was just a couple of hours bouncing back and forth, filling paperwork at every part of the way.” While a number of these issues may be commonly experienced by a broader range of low-income populations, the experiences of the DACA-eligible young adults were further compli-

cated by the concern about potential deportation and discrimination with each new interaction with the health care system.

Mistrust of the Health Care System and Providers

Fear and mistrust of the health care system and its providers were also reported as barriers to accessing health care services. Participants shared experiences of discrimination in health care settings, including profiling based on race and documentation status. One participant reported distrust towards health care providers due to discrimination: “I think it's related to how we're brown, and we're undocumented, and we're low-income, you know? . . . They're going to treat you differently.”

In the context of these negative experiences, participants also expressed concern that doctors were only motivated by money and lacked an understanding of their immigration status and cultural experience. One participant reported a widely-held sentiment: “Doctors don't really sympathize with you, and they're just not culturally sensitive to Latinos or to our [immigrant] community.” These concerns were increased by a fear that disclosing their documentation status to a provider could jeopardize their safety and put their families at risk for deportation. After a negative experience with a clinician, one participant explained, “I can't go back to the [mental health] specialist. . . . And even if I would share my story, they won't understand. You know, they're doing it for a business. . . . They're not doing it to listen to you.” Based on these types of experiences, participants expressed fear and mistrust of providers, which discouraged them from seeking care. In addition, because the majority of DACA-eligible young adults lack a regular provider, they have little opportunity to develop a trusting and continuous relationship that might increase their level of comfort with the health care system.

Lastly, participants talked about avoiding medical care out of fear that major health problems would be discovered, leading to uncertainty about how

this would impact their immigration status or opportunities for citizenship in the future. Many also feared the potential financial repercussions of a new diagnosis: “If you go to the doctor for a cold, he might be like, ‘Oh, you also have this wrong with you and this wrong with you.’ It’s kind of good if you can get preventive care, but if you can’t afford to be treated that way then, that’s bad. So, there’s that fear that holds a lot of people back.” In this way, avoidance of medical care is used, in part, as a mechanism to delay receiving health diagnoses which would further complicate the already challenging lives of DACA-eligible young adults.

Family Members’ Health Care Experiences

Many focus group participants described how their family members’ experiences dealing with health problems, particularly mental health issues, and their failure or refusal to seek care, caused them to see this as the status quo. As a result, these young adults tended to normalize their health problems and avoided using the health care system. As one participant explained, “Everyone else in my family is tired. Everyone else in my family is stressed. Everyone else has trouble sleeping. . . . These health issues become normalized, so then when you bring it up, it’s just kind of like, ‘Tough it out,’ right?” Focus group participants also described a particular stigma in Latino families

about mental health care, inhibiting participants from seeking care and contributing to the pattern of normalizing the lack of mental health care.

Health Issues and Health Care Needs

Focus group participants identified a wide variety of health concerns and health care needs among DACA-eligible young adults, ranging from mental health problems to unmet need for primary and specialty care. They also identified how their immigration status has, in some ways, helped build their resilience and led them to be cautious about high-risk behaviors.

Mental Health Care is the Largest Unmet Health Need

Mental health issues represented the largest category of health problems reported by DACA-eligible young adults. Participants reported high rates of depression, anxiety, trauma, and stress in themselves and their peers. Mental health issues, while prevalent in this community, often go unrecognized. One participant explained, “I think a lot of things get normalized, so stress, anxiety, working 80 hours a week—that’s normalized, right? I think a lot of folks are in deep depression, but don’t know they are, or don’t realize it.” Among the focus group participants, nearly one in four

Expanding Coverage to Support Mental Health Needs

Potential policy options for expanding coverage for DACA-eligible Californians were discussed in the [companion report](#). Expanding eligibility for federal health programs would increase access to mental health services, specifically because mental health and substance use disorder services are among the ten essential health benefits that must be offered by individual market plans both inside and outside the Marketplaces under the Affordable Care Act. As discussed in the [companion report](#), California is unique in that residents granted DACA are eligible for Medi-Cal under state policy. Increasing enrollment in Medi-Cal would also improve access to mental health services because an expanded array of mental health and substance use disorder services are being offered under the Medi-Cal Expansion in 2014.⁵ Additionally, some of the county-based indigent care programs include mental health services. Health plans offered by small employers are also required to offer essential health benefits, including mental health services. While expanding coverage could improve access to mental health services, other barriers to accessing care and the underlying circumstances such as trauma may remain.

reported feeling so depressed that nothing could cheer them up within the past month.⁶

Participants associated widespread depression and anxiety in the DACA-eligible community with a variety of factors, including negative stereotypes of immigrants, financial stress, trauma, and limitations in education and employment options due to their immigration status. One participant described the impact of stereotypes: “There’s a lot of people here, you know, they think wrong of illegal immigrants and . . . if you think about it yourself, you’re kind of bringing yourself down.” Even after being granted DACA, participants reported that these problems did not go away: “Now they have DACA, but those years of having that depression and that low self-esteem are not going to disappear just because now you have a Social Security number.”

*“Everyone else in my family is tired.
Everyone else in my family is stressed.
Everyone else has trouble sleeping. . . . These
health issues become normalized, so then
when you bring it up, it’s just kind of like,
‘Tough it out.’”*

Trauma Due to Separation from Support Systems

Participants described how their undocumented status during childhood resulted in trauma and separation from support systems during the immigration process and long after settling in the U.S. One participant recalled, “There’s so much trauma in our community . . . like the idea of family. When other people talk about family, I don’t know those feelings because my experience of having a family is that I had a really big family. They all loved me, and when I was nine years old, I had to leave, and I never got to see them again.” Other participants

reported traumatic experiences of family separation due to deportation of parents and loved ones after being in this country for an extended period.

The Stress of Transition to Adulthood

While mental health challenges often began early in their lives, participants reported that the highest risk period for depression, anxiety, and stress for undocumented young adults was during the transition from high school to college or adult life. Many participants reported no knowledge of their documentation status until finding out they were not eligible for a driver’s license, legal employment, or federal financial aid for college. Participants’ inability to obtain a legal identification card in this phase of life also left them socially isolated, highlighting their separateness from their friends with documentation and preventing them from accessing public spaces where proof of age is required. Participants described this phase of life as “hitting the wall,” characterized by limited opportunities despite their years of dedicated studies: “You’re kind of led to believe that if you work really hard and you give it your all everything else kind of will work itself out. And it’s not like that, and it hits you right on the face. And it’s just kind of hard not to fall down.”

During this transition, many participants reported struggling with the decision to either pursue their educational goals without the assistance of federal financial aid or work to support their families, many of whom were living in poverty without legal work permits. One participant explained how being caught between two worlds was stressful and led to contemplating suicide: “They tell you, ‘Oh, let’s focus on college.’ . . . I thought it was hopeless. I had these suicidal thoughts. It was worse when I got home because even though I got into the colleges I wanted to, my parents said, ‘No, you have to work.’ So these thoughts grew and grew until I finally . . . I really thought I was going to do it.” Participants frequently expressed similar feelings of hopelessness and thoughts of suicide as they confronted the financial challenges limiting their

educational pursuits and the legal challenges impeding their ability to attain adult milestones like employment and driver's licenses.

“Now they have DACA, but those years of having that depression and that low self-esteem are not going to disappear just because now you have a Social Security number.”

DACA Application Associated with Stress and Identity Issues

Participants reported high levels of emotional and financial stress related to the DACA application process. One participant recalled, “You have no peace in mind because these people are tracking you your whole life, your grades, your life. I submitted everything since I [immigrated here until] now, like all my life. . . . And I’m just giving it to someone I don’t know . . . the vulnerability of that, you know. Or what if my parents get deported because of this information?”⁷ While some participants reported that being granted DACA decreased their stress, others reported anxiety and difficulty planning their lives due to DACA’s limited duration: “Tell . . . any other young person graduated from high school or in this age group that their numbers are just legit for two years, you know? What kind of job are you going to pursue? What kind of future are you going to plan?” one participant asked.

The process of obtaining DACA also raised complex identity issues for these young adults. As youth who grew up without documentation, many participants reported feeling like outsiders, and obtaining DACA only heightened their identity struggles. One participant reported that she grew up with “this identity that has been imposed on you . . . of being an undocumented. And then, you

become—you have some form of temporary legal status. . . . So where am I at right now? It’s like an inner struggle.”

Many participants reported that after receiving DACA, their stress simply transitioned into worry about family members: “I’ve noticed the difference between myself prior to DACA to now. It’s like I’m not looking out for myself anymore. . . . I’m worried about my parents now.” Another participant described how his family members are undocumented and that as a DACA-recipient, he has needed to work multiple jobs to support them and, as a result, has inadequate time to care for himself.

Use of Tobacco, Alcohol, and Drugs

The study methods produced mixed findings regarding substance use. Focus group participants reported that untreated depression, anxiety, and trauma leave some DACA-eligible young adults vulnerable to unhealthy coping mechanisms, such as smoking, alcohol, and drug use. “I see that a lot in our community . . . folks have a lot of, you know, stress, a lot of pain going on in their lives and . . . they start drinking. They fall into depression, and they drink. Or they do other drugs. And it’s just their way out,” reported one participant. Alcohol and tobacco use was discussed in all focus groups, with 62 percent of participants reporting binge drinking within the past year. However, rates of binge drinking among DACA-eligible young adults reported in CHIS (20 percent) were lower than those reported by focus group participants. The difference in results could be related to the non-random selection of focus group participants.

DACA-eligible Californians have a lower rate of binge drinking compared to their U.S.-born peers of the same age, according to CHIS data (Exhibit 2, page 7).⁸ Focus group participants’ self-reported current rate of smoking (10 percent) appears to also be lower than the proportion for the broader young adult population documented in other studies.⁹ These lower substance use rates among DACA-eligible Californians may be due to a

hesitancy, discussed by some focus group participants, to engage in behaviors that could lead to medical bills or jeopardize their immigration status, as discussed later in this report.

Access to Healthy Life Style and Preventive Health Care

In addition to significant mental health issues, participants reported a variety of other health concerns among DACA-eligible young adults. Many participants reported unhealthful changes in their behavior after immigrating to the U.S. One participant recalled that when he was living in Mexico he always played soccer outside. “But once we came here, I don’t know if it was fear of getting caught by the police . . . we became so used to watching TV at least five, six hours a day. There was nothing else to do.”

“I would like to receive all of the same benefits that all the other women would receive under the ACA.”

Other participants were aware of interactions between their mental and physical health: “For me, it’s like a slippery slope because, when I get sad, I want to eat. When I want to eat, there’s no money to eat something good. So it’s fast food. So it’s just like a chain of things that just lead to poor health.” Many participants explained that the stressors common to DACA-eligible young adults, including cost, competing demands for their time with work and school, and the need to provide for undocumented family members, limited their time and opportunities to engage in healthy eating and exercise. Financial need also compelled some DACA-eligible young adults to take jobs in manual labor that took heavier tolls on their bodies and led some to experience conditions such as chronic back pain. These patterns were also noted by participants who discussed the negative experiences and harsh impact on their parents, who often

worked in challenging manual labor. Focus group participants expressed that their ability to continue their education would help them avoid such jobs, and, in turn, avoid common physical problems that they witnessed in their communities.

The DACA-eligible young adults in this study wanted to be able to engage in preventive health care, such as annual health care visits, vaccinations, and regular reproductive health care. “I would like to receive all of the same benefits that all the other women would receive under the ACA,” one participant said. In addition, participants reported particular challenges accessing dental and vision care, citing the absence of these services at most free clinics. Participants reported a similar desire to utilize health services such as nutrition counseling, surgical care, specialty medical care, physical therapy, and emergency care.

Resilience and Caution with Risky Health Behaviors

Young people who are eligible for DACA, by definition, have successfully pursued some educational goals in spite of the social, financial, health, and other challenges related to their immigration status. This alone indicates a remarkable resilience among this population. One participant explained, “I think, in general, we’re all very self-sufficient people. I needed to find a way to progress pretty much on my own. . . . I feel more empowered, like I did it by myself.” One participant explained simply, “I have to excel. I have to be the best I can be so I can prove that I belong here.”

Although DACA-eligible young adults were clearly at risk for mental and physical health issues, their immigration status also promoted some protective factors. Participants reported that the desire to maintain deferred action under DACA along with the fear of deportation prompted many DACA-eligible individuals to be cautious about behaviors that could jeopardize their health and wellbeing. Some noted that their own DACA status placed their family members at potentially increased risk

of deportation, leading them to employ even greater prudence. As one participant noted, “We’ve always had to be careful. It’s not a matter of choice. You can’t drink . . . you can’t be out partying too much. I don’t think it’s going to go away just because I get an ID.” Another participant explained

access to care for these young adults by decreasing transportation barriers for themselves and their families, as well as by reducing the stress they experienced from driving without a license. Lastly, focus group participants and key informants both shared that young adults granted DACA felt an increased sense of safety and security with their new status, even if it was temporary. Some participants also reported that being granted DACA, and the benefits of having a social security number and an ID increased their willingness to interact with the health care system. One participant explained how he benefitted from “just having ID so that, when you go see a doctor . . . you don’t have to explain why you don’t have a Social number.”

“I have to excel. I have to be the best I can be so I can prove that I belong here.”

that even with DACA “we’re kind of being watched still by officials and stuff. We’re not permanently here. You know? I think that’s one of the reasons why we’re very careful with what we do with these IDs, where we get ourselves into and the things we do.” Participants also discussed a hesitancy to engage in unprotected sex in order to avoid contact with the medical system and subsequent medical bills. One participant summarized this issue by explaining, “I don’t have the same space to take that kind of risk.”

Impact of DACA on Access to Care

In addition to discussing the DACA program’s impact on Medi-Cal eligibility, focus group participants and key informants reported that DACA will confer a number of other benefits that directly or indirectly improve access to health care among individuals granted DACA, while also acknowledging that many challenges remain. For example, both focus group participants and key informants mentioned that broader job opportunities resulting from DACA were perceived as allowing these young adults to choose work that does not endanger their health, that pays higher wages, and that increases the likelihood of obtaining employer-based health insurance. Higher earnings were also seen as potentially reducing the cost barriers to seeking health care. The ability to obtain a California driver’s license was also seen by both participants and key informants as helping to increase

Potential Solutions for Improving Health and Health Care Access

More than two dozen key informants were asked to identify potential solutions that would improve the health and health care access of DACA-eligible Californians. In addition, focus group participants were asked about the best ways to provide them with information about health care and coverage options. Many of the solutions address one or more of the key barriers to access identified by the focus group participants.

Improve Health through Immigration Policy Changes

Providing a path to citizenship for DACA-eligible Californians and others in their families and communities, in addition to adopting other immigration policies that keep families together, would reduce the stress and trauma caused by the fear of deportation and separation of family members. An example of a state policy contributing to the goal of keeping families together is the Trust Act (California Assembly Bill 4), signed in October 2013, which limits detention in local jails solely for deportation purposes. By reducing DACA-eligible

individuals' fear of deportation for themselves and their families, immigration reform is likely to increase this population's willingness to apply for health care coverage and utilize medical services, rather than avoid or delay care.

Ensure Adequate Public Funding for and Capacity of Safety Net Providers

As discussed in the [companion report](#), many DACA-eligible Californians and their family members will continue to remain uninsured. These Californians will rely on safety net providers that primarily serve the uninsured and public program enrollees, such as public hospitals, community clinics, and federally-qualified health centers (FQHCs). While some key informants were optimistic that revenue for safety net providers could improve under the ACA as Californians gain coverage through Medi-Cal and Covered California, others were concerned about upcoming funding reductions for safety net providers planned under the state budget and the ACA.¹⁰ Given that three to

four million Californians are predicted to remain uninsured under the ACA,¹¹ some key informants noted the importance of maintaining adequate state and county funding for safety net providers.

Several key informants also expressed concern that provider capacity at these clinics may be inadequate to handle the increased demand for care as more Californians gain health insurance under the ACA, potentially increasing wait times and hindering access. Adequate capacity is partially dependent on adequate funding, but capacity can also be increased by altering how care is provided and the roles of existing health care providers and workers.¹²

Improve Service Delivery and Accessibility

With the array of sometimes negative experiences with health care providers that a number of the DACA-eligible young adults reported, it is important to consider how clinics can improve service delivery and accessibility of health services

Increasing the Number of Immigrant Health Care Professionals

One suggested way to improve cultural and linguistic competency is to increase the number of doctors and providers who are or were previously undocumented themselves. One key informant said that having doctors from these communities could improve trust and quality of care because these providers would be more familiar with the needs of the undocumented community. Pre-Health Dreamers, a national organization of over 150 undocumented students who are pursuing careers in science and health, is contributing to this goal by providing peer support and information to assist individuals granted DACA or undocumented students interested in pursuing health careers.

Another program, the Welcome Back Initiative, serves participants from more than ten counties in the state, including

San Francisco, Los Angeles, San Diego, and Imperial. The initiative works with foreign-trained health professionals to overcome barriers to their re-certification and integration into the health workforce in the U.S., including limited language proficiency, limited financial resources and time, a lack of familiarity with the U.S. health care system, and limited credit given by educational institutions for their foreign education. Participants receive support in developing a career pathway plan that builds on their education, experience, and skills; in obtaining appropriate professional credentials and licenses for their profession; and in exploring relevant educational programs, job and volunteer opportunities, and alternative career options.

for this group. Given the variety of health needs, from prevention to physical and mental health issues, a trusted network of providers is critical if young people are going to avail themselves of services. Local health care clinics can make care more accessible with additional appointments that are “school and work friendly” for young people whose schedules make it difficult to take time off for health care. In addition, delivery models that lessen patient waiting times as well as efforts to integrate behavioral and primary care services in a “one-stop shopping” setting would begin to ameliorate many of the negative experiences DACA-eligible Californians (and other low-income or undocumented populations) have experienced in the past.

Improve Providers’ Cultural and Linguistic Competency

Focus group participants and key informants highlighted the importance of providing more culturally and linguistically sensitive care in order to improve quality and increase DACA-eligible Californians’ trust in the health care system. Key informants suggested ensuring adequate training and certification of medical interpreters and more training for health care professionals on providing culturally sensitive care. Focus group participants suggested educating front desk clerks, intake and clinic staff, physicians, and other practitioners about the health care needs and public coverage options available to individuals granted DACA and undocumented immigrants so that their recommendations for care can take into account available resources for this population.

Support Community Health Resources

In addition to suggesting reforms to current delivery systems, key informants highlighted programs that were specifically designed to meet the needs of the immigrant communities they serve. For example, the Street Level Health Project in Oakland strives to improve the health and

well-being of underserved immigrant communities through a screening clinic and referrals to health care resources in the community, providing temporary assistance for those with basic needs in food, clothing, and social support, and offering programs that empower and support low-wage immigrant workers. The Project also serves as a community center which offers a computer lab, a knitting circle, and dance classes.

Collective Resilience through Community Led Empowerment, also known as the CIRCLE Project, is another example of an innovative program meeting the health and well-being needs of young undocumented immigrants. Developed and managed by the Dream Resource Center at the University of California, Los Angeles, the CIRCLE Project promotes collective healing for undocumented immigrant youth, many of whom are DACA-eligible. The project includes Community Talking CIRCLES in which immigrant youth come together to talk about their experiences growing up undocumented and to support each other in a safe space that is also facilitated by immigrant youth. Key informants recommended that innovative programs such as these be supported and expanded.

Assist with Enrollment and Build Health Literacy

Lack of awareness of potential eligibility for Medi-Cal and lack of health care literacy among the DACA-eligible population were frequently mentioned as barriers to health care in the focus groups and key informant interviews, but many solutions were suggested for these problems.

Key informants and focus group participants recommended the creation of large-scale outreach and education programs to enroll Californians granted DACA into Medi-Cal, and to enroll individuals not yet granted DACA into any other health programs for which they are eligible. Due to many DACA-eligible young adults’ inexperience using health insurance, key informants also suggested that after enrolling in coverage these young adults

could benefit from education on how to fully utilize their insurance benefits. As DACA-eligible populations represent the beginning of a new intergenerational cycle of health system knowledge, key informants suggested that it would be beneficial to educate DACA-eligible Californians about the health resources available to their parents, siblings, and other family members. Otherwise, the strong family connections among DACA-eligible youth could result in feelings of guilt when accessing health care to which their family members do not have access. Providing a more comprehensive education on available health resources would ease the way for these young adults by helping them help their family members gain access to care.

Community-based organizations (CBOs) are often trusted entities which will be central to reaching this immigrant population. They can bolster health insurance enrollment efforts by providing guidance on how to navigate the enrollment process, as well as by providing referrals to health care providers who are “immigrant friendly.” It is important that CBOs identify community health services that provide care for DACA-eligible Californians as well as their undocumented community members. Counties may be willing to partner with CBOs on outreach and enrollment efforts, since the counties have a financial incentive to maximize the number of individuals with DACA enrolled in Medi-Cal, which is funded by state dollars, rather than spending county dollars on indigent care.

Several specific ideas for disseminating information were described by key informants. One suggested the creation of a toll-free hotline for California immigrants that would provide information about health care eligibility and resources. Another key informant described a program already in place at Worksite Wellness LA, in which staff travel to the Los Angeles worksites of low-income, medically-underserved families, many of whom are immigrants, to offer information and assistance with enrollment into pertinent coverage programs and to provide referrals to health care resources.

Other key informants suggested educating providers about eligibility so that they can better inform their patients. Well-informed and trusted outreach workers, including *promotoras/os* and patient navigators, working in a variety of community settings, may help to educate families regarding the eligibility requirements for different community programs for DACA-eligible young adults as well as other family members. One key informant also suggested integrating health and health care information into existing outreach efforts around food, housing, and other social service programs.

Focus group participants reported that they receive most information about health and health care from their parents, friends, schools, and DREAMer advocacy and support organizations. They suggested that providing information through these channels would be the best way to reach them and their peers. They also shared that trusted media sources including social media (i.e., Facebook and Twitter), as well as Univision, could be further engaged in providing relevant information to DACA-eligible teens and young adults.

Finally, focus group participants indicated that many DACA-eligible Californians are unaware of their eligibility for DACA or do not know how to apply. Some key informants suggested that programs that assist with applications for DACA (for example, immigration lawyers and immigration rights groups) provide information on health care programs at the same time that they assist with DACA applications. Several key informants highlighted that the DACA program is currently associated with employment opportunities and protection from deportation, but not typically with health coverage. Building greater awareness among young low-income immigrants and their families about the impact of being granted DACA on Medi-Cal eligibility could improve access to care for this population and may increase the rate of DACA applications. This in turn could also increase access to job-based coverage because of the wider employment opportunities available to individuals granted DACA.

Peer-to-Peer Education

Focus group participants reported that their peers were a main source of information on health and immigration issues. In fact, many participants shared that they learned about DACA from their peers and felt they would more readily trust information that was provided by their DACA-eligible peers about health insurance options and where to seek health care. Peer-to-peer education programs could be an effective way of increasing health literacy among DACA-eligible Californians. Promotoras Comunitarias, a program run by Planned Parenthood of Los Angeles, is an example of a well-established *promotora* model using peer educators in the Latino community to provide information on a variety of health topics. The program has reached more than 150,000 Los Angeles County residents since it started in 1990.¹³ Peer Advocates, another program directed by Planned Parenthood of Los Angeles, trains high school students to educate their peers about preventing teen pregnancy and sexually transmitted diseases. Building the capacity of these peer community workers and others to include information regarding the importance of health insurance coverage and the options available within their communities could be instrumental in increasing the number of DACA-eligible young adults enrolled in programs for which they are eligible.

Promote a Culture of Coverage and Health

Some key informants noted that the ACA creates an opportunity to expand coverage to DACA-eligible Californians because it is anticipated to spur a shift to a broader “culture of coverage,” in which coverage is more accessible and having insurance is expected. The hope is that this cultural shift will lead more Californians, including those who are DACA-eligible, to find out which programs they are eligible for and to enroll and seek services. A cultural change promoting coverage is also expected to occur at county human services agencies which determine eligibility for Medi-Cal and other programs.¹⁴ One key informant emphasized

the importance of creating a culture of health care within communities of color, where even people with access to health care often do not utilize it because care-seeking is outside the cultural norm. Promoting utilization of preventive care has the potential to be particularly effective in the setting of the ACA’s mandate for coverage of preventive services, including certain screening, counseling, and women’s health care services, in all plans including Medicaid. These initiatives impact the health and well-being of all young adults, including those who are DACA-eligible.¹⁵

Summary and Conclusions

The California DACA-eligible population faces numerous challenges when it comes to health. DACA-eligible Californians are more likely to report poor health, lack a usual source of care, and to have not visited a doctor or emergency room in the past year.

Focus groups in California revealed experiences specific to individuals shifting from being undocumented to being granted deferred action. Many DACA-eligible young adults do not want to jeopardize their deferred action status by engaging in high-risk behaviors. They feel scrutinized and exposed because of the intrusive nature of the application process and temporary nature of deferred action under DACA. In addition, the shift in their documentation status is also associated with internal struggles with identity, new responsibilities in their families, and an uncertainty about how to plan for their futures with only a two-year temporary reprieve from deportation.

DACA-eligible young adults have unique needs, but they also represent a subset of the more than two million undocumented immigrants in California, and some of their needs overlap with the broader undocumented population. Fears of deportation and discrimination continue after young adults are granted DACA status, and result in hesitancy to interact with the health care system even when they have a temporary reprieve from

deportation. They also have fears that health care expenses will result in debt or financial burden for family members, or limit their future immigration status options. Lack of health care literacy, which is likely common to other undocumented immigrants, limits their ability to effectively participate in the health care system.

The DACA program will partially and temporarily address some of the difficulties described in this report for select California teens and young adults, though many challenges to good health remain. Programs should be created to educate Californians granted DACA about their health coverage options, enroll them in available programs, and assist them in successfully navigating the health care system. Health care system reforms should also be put in place to improve the way that care

is delivered and to make it more accessible for DACA-eligible teens and young adults.

The California legislature is considering legislation to extend health coverage to all Californians. The state policy providing Medi-Cal eligibility for low-income individuals granted DACA provides insights into the best practices for and challenges of addressing health needs of undocumented immigrants. By taking steps to understand the health needs of DACA-eligible individuals and by working to break down the barriers to health care access for this population, local providers, community-based organizations, private and public funders, and young people themselves living in California can guide the way forward to securing good health for immigrants throughout our state and nation.

Appendix A: Methodology

The research procedures were approved by the Institutional Review Board of the University of California, San Francisco.

California Health Interview Survey (CHIS)

We used data from the 2011-12, 2009, and 2007 California Health Interview Surveys (CHIS). We obtained the estimates of the undocumented population and those eligible for DACA from the latest available CHIS cycles (2011-12). However, we used the combined 2009 and 2007 surveys to examine the demographic characteristics, health status, health care access and utilization, and health insurance of DACA-eligible individuals in California due to the limited sample size of the 2011-12 data.

CHIS is a landline and cell phone survey of the state's non-institutionalized population and is representative of multiple racial/ethnic populations in California. CHIS is conducted in six languages to include populations with limited or no English proficiency. This data source is especially well-suited to identify and analyze characteristics of the undocumented and DACA populations because it contains multiple questions on nativity and immigration status.

The overall population was divided into four immigration status categories—U.S.-born, naturalized citizens, lawful permanent residents/temporary legal status, and undocumented. The undocumented population in California was estimated using statistical modeling techniques among individuals without a green card or those who reported being naturalized but who had not lived in the U.S. long enough to be citizens under most circumstances.

The population eligible for DACA was identified from within the undocumented population based on the current criteria for DACA, including: 1) arrival in the U.S. prior to 16 years of age; 2) at least a high school diploma or equivalency for respon-

dents ages 19-30; and 3) assuming all respondents 18 years of age and under were currently enrolled in school. Information on other criteria for DACA eligibility could not be identified in CHIS, including: 1) current enrollment in a program working toward placement in post-secondary education, job training, or employment; 2) honorable discharge from the U.S. military; 3) lack of a criminal record; and 4) continuous physical presence in the U.S. since June 2007.

The method of identifying DACA-eligible individuals is likely to overestimate the number of teens 18 years of age or younger because some may have dropped out of high school without receiving a GED. These methods may also overestimate eligibility for those who had criminal records or were not continuously present in the U.S. Our methods are likely to underestimate eligibility among individuals 19-30 year-olds who may be actively pursuing a post-secondary or vocational degree. Of these limitations, underestimation of those pursuing further education and overestimation of individuals who had dropped out of high school to work may have the largest impact on our estimates. Significance tests were conducted to compare differences across immigration categories in the population ages 15-30.

An estimated 2.2 million undocumented immigrants are living in California, according to CHIS data from 2011-12. An estimated 9 percent, or 188,000 individuals, are between the ages of 15 and 30, have lived in the U.S. since the age of 15 or younger, and are currently enrolled in a high school program or have a high school diploma or equivalent certification. These individuals are potentially eligible for DACA, assuming that they meet all of the program requirements.

The CHIS-estimated number of potential DACA-eligible individuals in California is lower than in other studies. For example, the Immigration Policy Center estimates that 298,000 Californians were eligible for DACA in 2012.¹⁶ The lower CHIS estimate

is due to the limitations of survey data in assessing eligibility status.¹⁷ For example, CHIS does not capture student status of individuals 19-30 years of age who are pursuing a post-secondary or vocational degree. Other reasons for underestimation of the DACA-eligible population may be lower response rates of young populations in statewide surveys such as CHIS. Despite such limitations, CHIS is the premier source of population-based health information in California and these data are the most representative data available on the profile of the undocumented population in general and the DACA-eligible population specifically.

Focus Groups

Focus groups were conducted in July and August 2013 in the Los Angeles and Bay Areas. Participants were recruited from a variety of community settings, including legal aid clinics, immigrant advocacy groups, schools, libraries, farmers' markets, parks, and churches. Outreach was conducted in person by researchers including two DACA-eligible research interns, as well as via email, social media, phone, flyers, and word of mouth. Eligibility criteria for participation included being Latino between 18 and 31 years old, meeting eligibility criteria for DACA, and being comfortable participating in a focus group conducted in English. Due to resource limitations, focus groups were limited to Latino young adults living in urban areas, as Latinos comprise the largest population of DACA-eligible people in California and nationwide. More than half (51 percent) of the 119 DACA-eligible individuals who were recruited and screened for the study participated in the focus groups.

Nine focus groups were held (five in LA and four in the Bay Area) with a total of 61 participants, ranging in age from 18 to 31. Overall, 36 participants were women and 25 were men, with nearly all having graduated from high school (95 percent). Nearly three-quarters were currently students (72 percent) and most were employed (75 percent) at the time of the study. More than half of participants were uninsured, 39 percent had private

insurance, and 8 percent had public insurance. Consistent with California's immigrant demographics, 87 percent of participants were born in Mexico. Almost three-fourths of the participants (72 percent) identified themselves as activists for immigrant causes. Although honorably discharged military veterans are eligible for DACA, none took part in this study.

Focus groups lasting approximately two hours were conducted by experienced moderators who obtained verbal informed consent from each participant on the day of the study. Focus groups were held at community sites and conducted in the afternoons and evenings to accommodate the participants' employment and educational obligations. All participants completed a brief written questionnaire asking for a few background elements, such as the individual's insurance status and place of birth, prior to the start of the focus groups. Topics discussed in the focus groups included the health status, behaviors, and needs of this population; experiences accessing health care; and the impact of DACA on the health and well-being of DACA-eligible young adults. Each participant received a \$20 discount store gift card and a meal as compensation for his or her time. Participants also received a resource guide to health, social service, and educational programs in their communities for which they would be eligible. Three members of the research team completed a thematic analysis of focus group transcripts.

Key Informants

Twenty-eight key informants were interviewed either in person or by phone. Informants included policy experts, advocates, health care providers, DACA-eligible young adults, funders, government officials, and representatives from community-based organizations serving the immigrant community in California (Appendix B). Interviews lasted approximately 30 to 90 minutes and involved questions intended to validate and contextualize quantitative and focus group results, understand key concerns, describe existing resources and

programs, and identify potential solutions for improving health and health care access for DACA-eligible young adults in California.

Following completion of these methods, the research team shared preliminary results with the study's Advisory Board and other key stakeholders who supported the validity of the study's findings and overall consistency with their experiences working with the DACA-eligible community. Thus, these sources of information provide a nuanced and in-depth profile of DACA-eligible Californians.

Appendix B: Key Informants Interviewed

The following individuals participated in key informant interviews:

- Harrison Alter, MD, MS, FACEP, Research Director, Department of Emergency Medicine, Alameda Health System—Highland Hospital
- Sonal Ambegaokar, JD, Senior Attorney, National Health Law Program (formerly with National Immigration Law Center)
- Isabel Becerra, Chief Executive Officer, Coalition of Orange County Community Health Centers
- Mario Chavez, Director of Community Relations, St. John’s Well Child & Family Center
- Marlon Cuellar, Program Manager, The California Endowment
- Crispin Delgado, MPP, Program Officer, Health Care and Coverage, Blue Shield of California Foundation
- Mark Ghaly, MD, MPH, Deputy Director for Community Health, Los Angeles County Department of Health Services
- David Hayes-Bautista, PhD, Professor of Medicine and Director, Center for the Study of Latino Health and Culture at the School of Medicine, University of California, Los Angeles
- Kanthalak Latthivongskorn, Intern, DREAM Summer
- Jirayut New Latthivongskorn, Co-Founder, Pre-Health Dreamers
- Laura López, Executive Director, Street Level Health Project
- Arlette Lozano, Intern, DREAM Summer
- Louise McCarthy, MPP, President and Chief Executive Officer, Community Clinic Association of LA County
- Gary Mendoza, JD, Founder and Chief Executive Officer, iPaseo Health Partners
- Hector Alessandro Negrete, Statewide Coordinator, California Immigrant Youth Justice Alliance
- Luis Pardo, Executive Director, Worksite Wellness LA
- Nora E. Phillips, Staff Attorney (admitted in Illinois), formerly with CARECEN
- Imelda S. Plascencia, Project Coordinator of Health Initiatives, Dream Resource Center, UCLA Labor Center
- Natalia Rodriguez, Workplace Justice Organizer, Restaurant Opportunities Center of Los Angeles
- Seth Hernandez Ronquillo, Co-Chair, IDEAS at UCLA
- Vanessa R. Saavedra, JD, Assistant Director of Legal Affairs and Policy, California Primary Care Association
- Cary Sanders, MPP, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network
- Reshma Shamasunder, Executive Director, California Immigrant Policy Center
- Suzie Shupe, JD, Executive Director, and Anna Hasselblad, Communications and Operations Manager, California Coverage & Health Initiatives
- Meng L. So, MA, Director, Undocumented Student Program, UC Berkeley
- Celinda M. Vázquez, Vice President of Public Affairs, Planned Parenthood Los Angeles
- Anthony Wright, Executive Director, Health Access California
- Lucien Wulsin, JD, Executive Director, Insure the Uninsured Project

Appendix C: Health Status and Access to Care by Immigration and Citizenship Status, Californians, Ages 15-30, 2009-07

	U.S.-Born	Confidence Interval	Naturalized Citizens	Confidence Interval	Authorized Immigrants	Confidence Interval	DACA-Eligible	Confidence Interval	Other Unauthorized	Confidence Interval	P-value*
Demographics											
Total	6,562,000		618,000		523,000		188,000		610,000		
No doctor visits in past year	21%	20-22%	27%	20-35%	33%	28-38%	32%	24-40%	41%	36-47%	<.0001
No usual source of care	28%	26-30%	28%	23-33%	42%	37-47%	37%	29-46%	51%	45-57%	<.0001
Self-reported poor health	11%	10-12%	8%	6-11%	18%	14-22%	21%	14-30%	23%	18-27%	<.0001
1+ binge drinking episode in past year**	48%	46-50%	35%	28-43%	31%	25-36%	20%	12-33%	22%	17-27%	<.0001
Ever had asthma	21%	19-22%	12%	9-15%	7%	5-11%	12%	7-20%	4%	2-6%	<.0001
ER visit in past year	22%	21-23%	12%	9-16%	16%	13-20%	9%	5-15%	14%	10-21%	<.0001
Overweight/Obese	38%	36-40%	30%	25-36%	38%	34-44%	35%	27-44%	50%	44-57%	<.0001

Source: California Health Interview Survey, combined 2009 and 2007 data

*P-values indicate overall differences in rates by immigration status.

** Includes ages 19-30 only.

Endnotes

- 1 Plascencia IS, Leyva A, Jaimes Pena MY, & Waheed S. Undocumented and Uninsured: A Five-Part Study on Immigrant Youth and the Struggle to Access Health in California. UCLA Labor Center Dream Resource Center. <http://undocumentedanduninsured.com/>
- 2 Blewett LA, Johnson PJ, Lee B, & Scal PB. When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services. *Journal of General Internal Medicine*. Volume 23, Number 9, pages 1354-60, 2008. DeVoe JE, Fryer GE, Phillips R, and Green L. Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care. *American Journal of Public Health*. Volume 93, Number 5, pages 786-91, 2003. Bindman AB, Grumbach K, and Vranizan K. Primary Care and Receipt of Preventive Services. *Journal of General Internal Medicine*. Volume 11, Number 5, pages 269-76, 1996.
- 3 Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Lurie N, Billings J, & Stewart A. Preventable Hospitalizations and Access to Health Care. *JAMA: the Journal of the American Medical Association*. Volume 274, Number 4, pages 305-11, 1995. McCaig LF & Nawar EW. National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 2006.
- 4 Californians with DACA status have been eligible for driver's licenses since January 1, 2013, under California Assembly Bill 2189, and in October 2013 Governor Brown signed California Assembly Bill 60, which makes undocumented California residents eligible for driver's licenses by January 1, 2015 or sooner.
- 5 According to the Department of Health Care Services, "The following mental health benefits will be available through Medi-Cal managed care plans or the fee-for-service delivery system: Individual and group mental health evaluation and treatment (psychotherapy); Psychological testing when clinically indicated to evaluate a mental health condition; Outpatient services for the purposes of monitoring drug therapy; Outpatient laboratory, drugs, supplies and supplements; Psychiatric consultation; Specialty mental health services currently provided by County Mental Health Plans will continue to be available." <http://www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx>
- 6 The sample size was not large enough in CHIS data to compare depression rates between DACA-eligible Californians and their U.S.-born counterparts. No other research was found to use as a comparison point for U.S.-born young adults; the only related research found was for adolescents.
- 7 According to U.S. Citizenship and Immigration Services (USCIS) policy, information submitted as part of a DACA application "... is protected from disclosure to U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and Border Protection (CBP) for the purpose of immigration enforcement proceedings unless the requestor meets the criteria for the issuance of a Notice To Appear or a referral to U.S. Immigration and Customs Enforcement under the criteria set forth in USCIS's Notice to Appear guidance (www.uscis.gov/NTA). Individuals whose cases are deferred pursuant to the consideration of deferred action for childhood arrivals process will not be referred to ICE. The information may be shared with national security and law enforcement agencies, including ICE and CBP, for purposes other than removal, including for assistance in the consideration of deferred action for childhood arrivals request, to identify or prevent fraudulent claims, for national security purposes, or for the investigation or prosecution of a criminal offense. The above information sharing policy covers family members and guardians, in addition to the requestor." USCIS also states, "This policy, which may be modified, superseded, or rescinded at any time without notice, is not intended to, does not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable by law by any party in any administrative, civil, or criminal matter." USCIS. Frequently Asked Questions. <http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process/frequently-asked-questions>
- 8 CHIS data indicated a binge drinking rate of 48 percent among U.S.-born young adults ages 19-30. A prior study found rates of binge drinking among 18 to 25 year-olds at 41.8 percent in the past month with no annual data available, making direct comparisons about alcohol consumption difficult. Mulye TP, Park MJ, Nelson CD, Adams SH, Irwin Jr. CE, & Brindis CD. Trends in Adolescent and Young Adult Health in the United States. *Journal of Adolescent Health*. Volume 44, pages 8-24, 2009.
- 9 A prior study found that 36.2 percent of 18 to 25 year-olds of all racial/ethnic groups and 29.5 percent of Hispanic young adults smoked cigarettes in the past month, compared to 10 percent of focus group participants who reported currently smoking at least some days. Mulye TP, Park MJ, Nelson CD, Adams SH, Irwin Jr. CE, & Brindis CD. Trends in Adolescent and Young Adult Health in the United States. *Journal of Adolescent Health*. Volume 44, pages 8-24, 2009.
- 10 The 2013-2014 California state budget began reducing county Realignment funds for indigent health care on January 1, 2014, and funds will be further reduced in subsequent years. Also, beginning on October 1, 2015, the Affordable Care Act amended by the Bipartisan Budget Act of 2013 will reduce Medicaid Disproportionate Share Hospital payments, which are a significant source of revenue for safety net hospitals in California.
- 11 Lucia L, Jacobs K, Dietz M, Graham-Squire D, Pourat N, & Roby DH. After Millions of Californians Gain Health Coverage Under the Affordable Care Act, Who Will Remain Uninsured? UC Berkeley Center for

Labor Research and Education and UCLA Center for Health Policy Research. September 2012.

12 One example of a solution recommended for maximizing providers' time was e-Consult, a system in which a primary care provider can consult with a specialty physician electronically. The system reduced unnecessary face-to-face visits with specialists and reduced the wait time for those needing specialty care appointments when it was implemented by community clinics in Los Angeles County. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Electronic Specialist Consultations Reduce Unnecessary Referrals and Wait Times for Specialty Appointments for Uninsured and Underinsured Patients. July 17, 2013. <http://www.innovations.ahrq.gov/content.aspx?id=3915>.

13 Planned Parenthood of Los Angeles. Promotoras Comunitarias. <https://www.plannedparenthood.org/los-angeles/promotoras-comunitarias-42236.htm>

14 The County Welfare Directors Association of California has sponsored a Customer Service and Culture Change Best Practices Project to "enhance local agency culture to effectively promote health care coverage and access to vital human services for all eligible persons." Child and Family Policy Institute of California, under the auspices of the County Welfare Directors Association of California. A Framework for Advancing a Culture

of Customer Service in Health and Human Services. April 1, 2013. <http://www.cfpic.org/pdfs/Framework-for-Advancing-a-Culture-of-Customer-Service-Final.pdf>.

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16 Immigration Policy Center. Who and Where the DREAMers Are, Revised Estimates. October 16, 2012. <http://www.immigrationpolicy.org/just-facts/who-and-where-dreamers-are-revised-estimates>.

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