

5 Systems of Care

INTRODUCTION

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

PRIMARY CARE

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

Community and Migrant Health Centers

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

Exemplary Practices

Piedmont Health Services

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

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

Exemplary Practice

Harvest Family Health Center

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

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

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

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

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

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

State-funded Rural Health Clinics

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

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

Public Health

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

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

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

Free Clinics

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

Hospital Emergency Rooms and Outpatient Clinics

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

Innovative Initiatives

Immigrant Health Initiative at Chatham County Hospital

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

NC Farmworker Health Alliance

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

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

Other Private Providers

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

Programs Serving Migrant and Seasonal Farmworkers⁸

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

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

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

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

Portable Health Records Project

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

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

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

Outstanding Primary Care Needs

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

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

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

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

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

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

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

NC Latino Health 2003

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

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

Source: C: US Census Bureau. 2000 Census. FA: Faith Action, 2002 Latino Estimates. Health Department data from: Division of Public Health. NC Department of Health and Human Services. HSIS Data. July 2000-June 2001.¹⁵ Community/Migrant Health Center data from: NC Primary Health Care Association. Uniform Data System. 2001.

- * County is listed as a primary care provider for the Carolina Access program for all ages.
- φ County is listed as a primary care provider for the Carolina Access program for children.
- ♦ County is listed as a primary care provider for the Carolina Access program for pregnant women.
- ∇ County is listed as a primary care provider for the Carolina Access program for adults.
- + The health center, clinic, or health department receives federal funding as a migrant health center or as a NC Farmworker Health Program contract site.
- FC: Free Clinic.
- NA: Not Available.
- ¥ Greene County Community Health Center serves a large number of migrants who are not counted in the Census.

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

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

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

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

Tiendas

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

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

Recommendations

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

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

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

The Task Force recommended that:

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

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

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

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

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

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

- **As part of this effort, the OMHHD Hispanic Health Task Force should be expanded to include a broader collaboration of state agencies and other organizations. This collaboration should help support the development or expansion of local coalitions to address the health needs of Latinos.**
- **If no new state funds are immediately available, the Department of Health and Human Services should explore state, federal, and private grant sources to obtain additional revenues to support the work of OMHHD.**

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

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

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

REPRODUCTIVE HEALTH

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

Maternity Services

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

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

Innovative Initiatives

Catawba Centering Model

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

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

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

Family Planning¹⁷

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

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

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

Lee County Cambios

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

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

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

Teen Pregnancy Prevention Programs

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

Recommendations

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

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

The Task Force recommended that:

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

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

Maternity Services:

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

Family planning:

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

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

Teen Pregnancy Prevention:

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

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

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

CHILD AND ADULT IMMUNIZATIONS

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

Innovative Practices

Vacunas Para Todos

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

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

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

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

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

Recommendations

The Task Force recommended that:

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

As part of this strategy, the Department should:

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

DENTAL

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

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

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

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

Innovative Practices

Lee County Health Department Dental Clinic

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

Innovative Practices

NC Baptist Hospitals

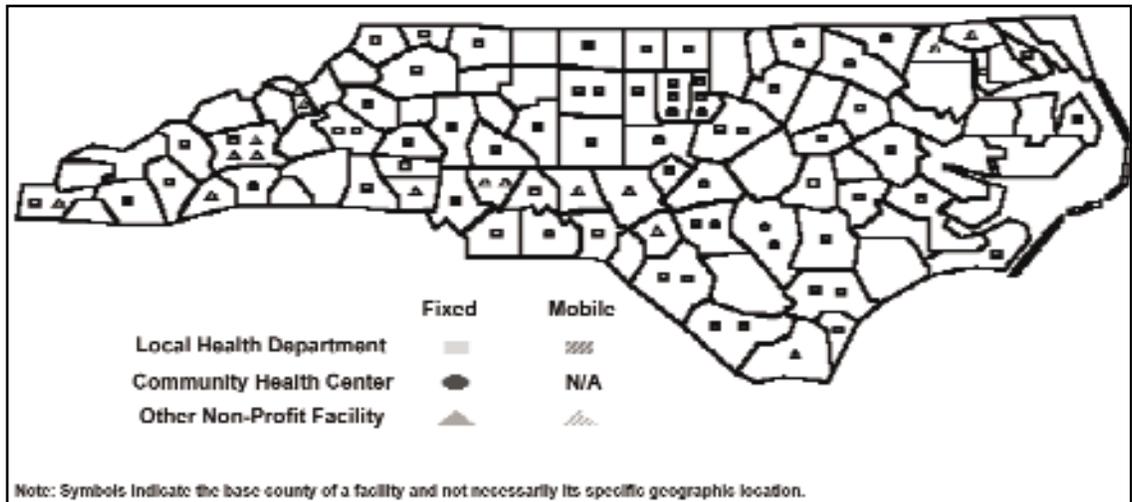
NC Baptist Hospitals has two dental centers and a mobile dental unit that offer services to underserved populations of all ages, including Latinos. The Mineral Springs Dental center is located, by design, in a largely Latino neighborhood. The office coordinator is bilingual. The Cleveland Avenue Dental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

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

Map 5:1

Dental Care Safety Net Facilities as of 2002

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



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

Recommendations

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

The Task Force recommended that:

8. **The General Assembly appropriate additional funds to increase access to culturally and linguistically accessible dental services for Latinos.**
- **These efforts should include, but not be limited to additional funds to recruit bilingual dental professionals, increasing Medicaid reimbursement rates, and funding dental care coordinators.**
 - **In addition, the NC Department of Health and Human Services should continue and expand existing programs that provide dental services to Latinos by providing technical assistance to local organizations to help establish dental safety-net programs, expanding the provision of preventive school-based services, and continue funding the *Into-the-Mouths of Babies* program.**

Specifically, the General Assembly should:

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

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

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

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

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

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

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

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

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

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

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

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

Innovative Practices

Neuse Area Program

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

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

Casa Cosecha / Harvest House

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

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

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

State Mental Health Plan

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

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

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

Recommendations

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

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

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

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

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

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

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

OUTREACH TO LATINOS DURING EMERGENCIES

The ice storm that spread across North Carolina in early December 2002 affected millions of residents. Power outages lasted for several days in many communities and cold temperatures drove people to use extreme measures to heat their homes. Many residents attempted to use their charcoal grills and other heating devices designed for the outdoors to warm themselves inside their homes.

Latinos, in particular, made up a majority of persons seeking treatment from resultant carbon monoxide poisoning at Durham, Orange, and Wake county hospitals. At least two Latinos died from carbon monoxide poisoning during the weeklong period following the storm.²⁶ After the ice storm, the power outages affected many Latino organizations as well as prominent Spanish radio stations. Officials turned to door-to-door canvassing to spread alerts. Even so, Latino residents without power had difficulty locating emergency shelters and could not understand or navigate county emergency telephone lines.

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

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

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

Recommendations

To address this problem, the Task Force recommended that:

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

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

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

NOTES

1. Kaiser Family Foundation. Immigrants' Health Care Coverage and Access. Kaiser Commission on Medicaid and the Uninsured: Key Facts. March 2001.
2. National Association of Community Health Centers. 2000 Access to Health Care: North Carolina. Spring 2001.
3. Bruton S. Executive Director, NC Primary Health Care Association. Presentation to the NC IOM Latino Health Task Force. May 7, 2002. There are resources available for new and existing health centers:
 - \$650,000 is available for new starts (e.g., for communities without an existing C/MHC. These C/MHC must assure that they can provide or contract for dental and mental health services. In addition, they must be operational within 90 days of when the grant is funded. The time constraint means that some things must be in place prior to the granting of funds: facility, staff. The lack of facility and staff is preventing some communities from applying for federal funds. The center must eventually see at least 3,000 patients.
 - \$550,000 is available for existing centers that wish to open a new primary care, dental or mental health site. The new site must eventually be expected to see 3,000 new patients.
 - \$600,000 is available for existing centers that want to expand medical, dental, or mental health services at an existing site. For example, a clinic that has mammogram screening can seek funds to add cervical cervical screening.
 - Additional funds are available for special needs, including black lung victims, public housing residents, healthy school programs and the homeless. However, the Bureau of Primary Health Care is not seeing many applications for special needs or migrant health funding categories.
4. MacCracken S. Women and Children's Health Section. Division of Public Health. N.C. Department of Health and Human Services. Personal communication. February 2002.
5. Howell E. State Center for Health Statistics. Special Data Run from SFY00-01 Health Services Information System. April 2002.
6. Division of Medical Assistance. Carolina Access Primary Care Providers. April 2002. 25 provide primary care to individuals of all ages, 8 to children only, one to pregnant women only, 1 for women only, and 4 for pregnant women and children.
7. 42 USC 1320a-7b
8. Stephanie Triantifillou, Elizabeth Freeman Lambar, and Andrea Radford contributed to the research and writing of this section.
9. The federal government's definition for seasonal and migrant farmworkers varies slightly depending on the program. The federal definition of farmworkers for health-related programs is more restrictive compared the definition for education-related programs. The definition in the health field describes migrant and seasonal farmworkers as:

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

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

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

11. The CHCs that receive targeted federal funding include: Goshen, Tri County Community Health Center, Greene County Health Care, Harvest, Blue Ridge, Robeson Health Care Corp., and Piedmont Health Services. Of these seven CHCs, four receive significant federal migrant dollars directly from the Bureau of Primary Health Care and four receive migrant funding from the North Carolina Farmworker Health Program in the Office of Research, Demonstrations and Rural Health Development.
12. The Migrant Fee-for-Service Program does not keep data on the number of patients served, only on claims paid.
13. National Center for Health Statistics. Health United States. 2000. <http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf#Ambulatory>, Table 72
14. Data on the percentage of Latinos seen by health department clinics are available through the Division of Public Health's Health Services Information System (HSIS). While information is available about the number of Latinos seen in each of the health departments, there are no data about whether the health department provides comprehensive primary care. Historically few health departments provided comprehensive primary care services, focusing instead on preventive screenings, prenatal care, and immunizations. More recently, some health departments have started offering primary care to some population groups. The health departments that participate as primary care providers for the Medicaid Access program were identified as having the capacity to provide full primary care, although whether they were providing comprehensive primary care to uninsured Latinos was unknown. Information about the percentage of Latinos seen by Community and Migrant Health Centers was an extrapolation from data submitted by each C/MHC on the Uniform Data System (UDS) to the Bureau of Primary Health Care. The UDS data include total users and percent Latino that was used to calculate an approximate number of Latinos served. Some of the centers provided information on the counties included in their service area. The Task Force took the approximate number of Latinos served in each C/MHC and divided it by the total number of Latinos in each health center's service area in order to get a rough estimate of the Latino penetration rate for each C/MHC.
15. The HSIS data are submitted at the clinic level (i.e., a local health department may see Latinos in their adult health, maternal health, child health, or epidemiology clinics.) Each health department also submits data on the unduplicated number of Latinos served during the year. The Task Force calculated an estimate of the penetration rate by dividing the number of Latinos seen by the health department, divided by the total Latino population in that county.
16. Work D. Executive Director. NC Board of Pharmacy. Presentation to NC IOM Latino Health Task Force. October 2002.
17. Ellen Wilson contributed to the research and writing of this section.
18. NC Institute of Medicine. Task Force on Dental Care Access. April 1999.
19. Venezie R. Oral Health Section. NC Department of Health and Human Services. Presentation to the NC IOM Latino Health Task Force. June 12, 2002.
20. NC Office of Research, Demonstrations and Rural Health Development. NC Department of Health and Human Services. Dental Safety Net Providers Database. January 2002.
21. North Carolina Association of Free Clinics (2002). <http://www.ncfreeclinics.org/> (accessed February 2002).
22. NC Migrant Health Program. Contracts for Migrant Dental Health Funds for FY 02-03.
23. There is also a shortage of dentists in North Carolina. North Carolina ranked 47th in the number of dentists per 100,000 population (1998). The North Carolina General Assembly just passed legislation to authorize dentists and dental hygienists from other states with a requisite number of years of practice to practice in North Carolina (called licensure by credentials). While this legislation will hopefully help improve the dental supply, it would not necessarily address the maldistribution problem.
24. Kurtz B. Presentation to the NC IOM Latino Health Task Force. July 9, 2002. Data from the FY 00-01 MHDDSA client statistical report.
25. A Spanish language version was made available to people in all area programs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services received 195 usable surveys from people who identified themselves as Latinos, of which 110 were received on the Spanish language survey forms.

26. *Raleigh News and Observer*, December 11, 2002.
27. Available at: <http://www.ayudate.org/ayudate/emergencias.html>

