EXPLORING LATINO HEALTHCARE SERVICE PROVISION IN A PRE-EMERGING IMMIGRANT GATEWAY STATE

by

James Thaddeus Dixon

A dissertation submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in
Geography and Urban Regional Analysis

Charlotte

2014

Approved by:

_____
Dr. Heather A. Smith

_____
Dr. Owen J. Furuseth

_____
Dr. Qingfang Wang

_____
Dr. Maren J. Coffman

ABSTRACT

JAMES THADDEUS DIXON. Exploring Latino healthcare service provision in a pre-emerging immigrant gateway state. (Under the direction of DR. HEATHER SMITH)

As Latinos continue to grow in population and impact, both nationwide and in the U.S. South, so too must the appropriate and equitable provision of services. Healthcare service provision is particularly important to Latinos as research shows they face significant barriers to healthcare access and suffer from negative health outcomes as a result of such access disparities. While North Carolina *metropolitan* areas have been identified as pre-emerging immigrant gateways, in what ways are experiences and challenges in *all* new Latino destinations in North Carolina similar or different? Do new immigrant gateway destinations have similar or unifying issues in healthcare service, or might a continuum of experiences based on scale and place exist? This study addresses such a research inquiry by comparatively examining healthcare service provision across gateway North Carolina communities that fall at different points along the rural to urban continuum. Research questions are explored primarily through a qualitative-based methodological design utilizing key-informant interviews with healthcare providers. In addition to its focus on provider experience and perspective, the contribution of this study encourages discussion on expanding the contextual definition of Latino gateways to a broad and multi-scalar array of places including non-metropolitan areas. Additionally, this research expands upon place-based relationships between Latino health access and service provision networks by providing case studies from three North Carolina counties that have experienced rapid Latino population growth; Mecklenburg, Chatham, and Greene.

ACKNOWLEDGEMENTS

First, I would like to thank my advisor Dr. Heather Smith for her continued support and encouragement throughout this process. Particularly, I would like to thank her during the most challenging elements, which seemed overwhelming at times. Second, I would like to thank Dr. Owen Furuseth for his advice and mentorship. In addition to this, I would like to thank the remaining dissertation committee members, Dr. Maren Coffman and Dr. Qingfang Wang, for their support and encouragement and agreeing to serve in the first place. Third, I want to thank the faculty and staff of the Department of Geography and Earth Sciences, as well as fellow graduate students that have been wonderful professional colleagues and great friends. Fourth, I want to thank the Department of Family Medicine at Carolinas Healthcare System, for providing me with years of incredible practical and theoretical experience that served so importantly in conducting this research. In particular, I would like to thank Brisa Hernandez, Dr. Michael Dulin, Dr. Hazel Tapp, Dr. Thomas Ludden, and Patricia Sanchez. Fifth, I would like to thank bedrock friends that provided support as well as escape when needed. In particular, I would like to thank Mike and Laura Simmons, Paul McDaniel, Lauren Mowrer, Ramon Concepcion Torres, Claire Schuch, Derek and Elizabeth Morrell, and Koshilie Gunadasa. Fifth, I would like to thank all of the wonderful healthcare providers that participated in the study and contributed to this research. Finally, I want to thank my family including: my mother, Connie Mandacina; my sister and brother-in-law, Laura and Derek Shroyer; my brother, Adam Dixon; and my aunt, Lacy Jackson. Without your patience, love, support, encouragement, and again, patience, I would never have come this far. I love you all.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1: INTRODUCTION

This study examines healthcare service provision by healthcare providers to the Latino population in three distinct North Carolina communities through the three-dimensional lens of: (1) health and place, (2) the perspectives and experiences of healthcare providers and (3) the context of pre-emerging immigrant gateways.

1.1 Health and Place

Explorations of geography in health and healthcare research have been present since the nineteenth century. However, an increase in studies that include explicit investigation of the role of place in health and healthcare has occurred significantly since the 1990s. At this time, geographers primarily in Great Britain and other parts of Europe were establishing and critically discussing an ideological move from 'medical geography' to 'health geography'. Health geography is a way of examining issues of health from a humanist, social place perspective and deviates from traditional medical geography topics primarily focused on disease pathogens and pollution ecologies. In other words there is more of a focus on the importance of people in their places, and how people impact and are impacted by that place (see Kearns 1994; Dorn and Laws 1994; Kearns and Moon 2002).

The effect of place on healthcare or health services provision is difficult to measure and analyze simply because places and the factors that contribute to their creation are so complex. Places can be understood as real or material (buildings, trees,

etc) or subjective, meaningful (a 'dangerous' neighborhood, a 'good' school). Drawing from the work of Macintyre et. al. 2002, three primary categories were utilized in this dissertation to help explain place's role in health related variations across a range of urban and non-urban places: compositional; contextual; and collective.

> "Compositional explanations draw our attention to the characteristics of individuals concentrated in particular places; contextual explanations draw our attention to opportunity structures in the local physical and social environment; collective explanations draw our attention to socio-cultural and historical features of communication" (Macintyre et. al. 2002).

These place categories are not mutually exclusive yet are often studied separately. It is the contention of this study that one cannot understand compositional explanations of characteristics of individuals in a place without input from collective explanations of cultural and social positions and understanding of contextual opportunity structures.

1.2 Provider Perspective

It is also the contention of this study that research on place effects on health and healthcare often overlook the perspective of providers whose work is directly shaped and impacted by the compositional, collective and contextual characteristics of the places in which they practice. Whereas many previous studies have focused on healthcare issues based on the population being served (Arcury et. al. 2004), this study addressed a suite of place based research questions by exploring the experiences and perceptions of service providers. Health disparities can differ across places that seem similar in place-based characteristics (Villalba et. al. 2006). One element of difference flows from the providers and their distinctive approaches. With that said, "…Current directions in health professionals' practice, which increasingly take account of the links between society and the health of individuals and groups, and a greater reliance by health care systems on

community care suggest that there are many potential points of convergence in the quest for developing knowledge and managing health in rapidly changing societies," (Dyck 1999). Therefore, to more fully understand points of convergence and divergence in health care provision and outcome, and to determine place's role in those, it is important to study service provider experiences based on the intersecting compositional, collective and contextual characteristics of the places in which they provide care.

1.3 Immigrant Gateways and Latinos in North Carolina

Such a task is particularly important in the "rapidly changing societies" of newly formed immigrant gateways. Immigrant gateways are most commonly discussed and researched in the context of cities. And while established Latino gateways have existed in places like Miami, New York, and Los Angeles for quite some time, new immigrant gateways have been identified in the South; including three metropolitan areas in North Carolina alone (Charlotte, Greensboro-Winston-Salem, and Raleigh-Durham). These 'pre-emerging' gateway cities, as defined by Singer (2004), had high rates of foreign-born population growth between 1990 and 2000 and are places with little experience incorporating and providing services to foreign-born populations. Effective service delivery is very important to Latino populations in these new gateways in terms of incorporation and the long-term health of this population. However, new gateways likely experience extensive service-delivery challenges to their newly arriving foreign-born populations due to culturally inappropriate or insufficient service infrastructure and network capacities (Singer 2004). It is important to examine the state and conditions of service delivery in new gateways as they are the primary receiving areas (and likely long

term settlement locations) for foreign-born populations whose expectations and needs may differ significantly from those of the more established communities.

Due to larger economic restructuring, changing federal and state level immigration policies, and many other factors, the U.S. South has experienced large and sustained rates of immigrant population growth over the past twenty to thirty years. Latinos from the collective countries of Mexico, Central and South American comprise the clear majority of these foreign-born newcomers. As the Latino population in southern communities grow, access to services including; housing, education, and health care, have been strained due to a lack of initial resources and the growing population itself which places increasing pressure on established resources (Drever, 2006). Healthcare service provision is particularly important to Latinos as research shows the Latino population across many places faces significant barriers to healthcare access and suffers from negative health outcomes as a result of such access disparities (Kuchar et. al. 2005).

Between 1990 and 2000, North Carolina had the largest rates for Latino population growth in the U.S. South, and has continued sustained growth through 2010. North Carolina is the location of an increasing and diversifying set of new Latino communities within both metropolitan and non-metropolitan places. And while North Carolina metropolitan areas have been identified as new gateways, in what ways are experiences and challenges in all new Latino destinations in North Carolina similar or different? Do new gateway destinations have similar or unifying issues in healthcare service, or might a continuum of experiences that might be similar or different based on scale and place exist in new gateway places? This study addressed such a research inquiry by examining healthcare service provision across North Carolina communities

that differ in scale and location but share some compositional, contextual and collective place-based characteristics with specific respect to their Latino populations.

1.4 Research Questions and Approach

Through a comparative study of three distinct North Carolina places all experiencing similar rates of Latino population growth over a similar time period this study posited three core research questions:

1) What challenges and opportunities do providers face providing healthcare to the newly arrived Latino population and how are they adapting to/overcoming challenges?
2) How do these challenges vary across different destinations that are different in location, scale and place-based dynamics?
3) What are the impacts of understanding these differences towards improving healthcare service provision for Latinos*?*

The study areas in question represent three North Carolina counties that have experienced significant percent Latino population growth since 1980, and have similar Latino percent of the total county population. These counties are; Mecklenburg, Chatham, and Greene. Importantly, these counties range across a spectrum of urban-to-rural. Mecklenburg County is the largest in the state of North Carolina and contains the city of Charlotte, which is also the largest in the state. Chatham County is a small-urban county that is at the edge of the Raleigh-Durham MSA. It contains Siler City, a former location of three chicken processing plants, which was a primary source of Latino in-migration in the 1980s and 1990s (Cravey 1997). Greene County is a rural county located in the Eastern part of North Carolina. It is an agricultural state, formerly known for large

tobacco crop production. For many decades, Latino temporary and migrant laborers have come through Greene County during harvest (Torres et. al. 2003). While the study areas share similarities in Latino population growth and percent total county population, in many ways their local economies, place-based characteristics, and reasons for Latino in-migration are very different. As such, we would expect to see different dynamics and perspectives related to health care provision across the three countries.

To test this expectation and answer the specific research questions noted above, a qualitative methods design was utilized through semi-structured key-informant interviews. Healthcare providers were asked to discuss their perceptions and experiences of Latino health care provision and describe demographic, socioeconomic, health incidence and prevalence, and spatial factors for the Latino population in each study area. Further supportive and descriptive research was conducted through field observations, provider surveys, and secondary demographic/health databases to bolster and confirm qualitative analysis. It is through this process that the researcher aimed to disseminate a thorough and moving picture of the state of healthcare service delivery in places of different scale and location but with similar rates of Latino immigrant arrival and settlement.

Among the contributions of this study is encouraging discussion on expanding the contextual definition of Latino gateways beyond the metropolitan scale – specifically to broad and multi-scalar array of places including rural and other non-urban areas. Many studies of Latino immigrant experience in the U.S. South have identified and expanded upon the 'Latinization' of places where significant Latino migration and settlement have changed social, cultural, and spatial dynamics (Mohl 2003; Cravey and Valdivia 2011).

Other terms often used by immigration scholars are the 'Nuevo' South (Smith and Furuseth 2006) or simply the new Latino South. Importantly, these studies examine Latino experiences in urban and rural environments. And while the pre-emerging gateway concept has to date only been applied to metropolitan areas (Singer, 2008), the results of this study suggest the expansion of the pre-emerging immigrant gateway concept to a more fluid multi-scalar framework. Similar to Mecklenburg providers, Chatham and Greene providers are keenly aware of the socioeconomic, demographic, and cultural characteristics of their patients and the Latino population living in their counties in general and while the contextual, composition and collective details of these places differs – they appear to be unified by a common experience of population based change leading to similar pressures on service needs and similar responses to address those needs.

This research also expands upon current knowledge with respect to place-based relationships between Latino health access and service provision networks by providing evidence from three study areas as gleaned from the often overlooked perspective of the providers working to provide the best possible access and quality of car

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

2.1 Understanding Immigrant Settlement Patterns

2.1.1 Immigrant gateways

The United States is a country of immigrants. With a population surpassing 300 million and an age of less than 250 years, the U.S. has relied on immigrants to propel its economic engine and shape its cultural diversity. Throughout U.S. history, people from all over the world have immigrated for myriad reasons reflecting both push and pull factors. The promise of a better life and freedom to pursue individual expression remain as core values motivating immigrants to reside in the U.S. Historically, the most common places in the U.S. where immigrants have initially settled are cities, or as they've come to be known, gateways. In the literature, gateways have been referred to as immigrant gateways, urban immigrant gateways, or simply gateways. At its simplest definition, a gateway is a place (most commonly city) that represents the initial destination point for a substantial immigrant population (Price and Benton-Short 2008). Even that simple definition contains subjective qualifications such as immigrant or 'substantial' immigrant population. In fact, gateways represent such a broad range of immigrant settlement experience, community incorporation challenges, and relationships/interactions between immigrants and destination communities that simple conceptualizations are problematic. This issue is discussed in the passage below by Benton-Short and Price in their attempt to define gateways:

> "The term 'gateway' is increasingly found in sociology, history, and geography literature in reference to major urban immigrant destinations. The meaning of this ubiquitous term is assumed rather than systematically developed or conceptualized…our definition of an urban immigrant gateway recognizes that these cities are not only settlement points for immigrants but also critical entry and are nodes for the collection and dispersal of goods, capital, and people. Yet these gateways are often socially and spatially segregated places. For many immigrants, these cities are not endpoints but turnstiles, with migrants moving into and out of them" (Benton-Short and Price 2008).

The most common example of an immigrant gateway city is New York City, which through Ellis Island, was a primary reception point for the majority of European immigrants throughout nineteenth and twentieth centuries (Foner 2008). New York has supported continuously high levels of immigrants (during each immigrant wave) with varied ethnic backgrounds since the early nineteenth century. And while New York City can certainly be classified as a quintessential immigrant gateway, the causes and consequences of that migration on immigrant communities and the city itself are contextual and unique.

Gateways cannot be discussed without also discussing the complex intricacies and connections between immigrants and receiving communities, and how those relationships have represented themselves spatially. Traditionally, immigrants would settle into ethnically-similar neighborhoods in a gateway central-city. These neighborhoods were characterized as having large concentrations of one ethnic group with social and economic interactions occurring primarily within the spatially-defined space. These neighborhoods or places have been referred to as enclaves, ghettos, and barrios. Spatially, these 'enclave' neighborhoods were relatively small within the gateway they accompanied (Singer 2008). However, the complex interactional and acculturative environments these neighborhoods created have lasting consequences in how the

American population, both native and foreign-born, understands theories of immigrant settlement. In other words, New York is established as a gateway on a city scale, but the interactions between immigrants and the incorporating community occur at micro-level scales in neighborhoods within the city (Singer 2008).

At the midpoint of the twentieth century almost half the immigrant population in the United States lived in just four cities; New York, Los Angeles, Chicago, and Miami (Singer 2008). Because of the large proportion of initial immigration as well as immigrant population, it is in these gateways that the majority of immigrant experience research was conducted prior to the late twentieth century. These stories of collective immigrant experience include, but are certainly not limited to, the Cuban population increase and transformation of Miami, Hispanic and Asian population concentrations in Los Angeles, Eastern European neighborhoods in Chicago, and Puerto Ricans in New York. In sum, generalized understanding of immigrant gateway research has been formed through research conducted in a few of the largest cities in the United States where, historically, initial immigration has been concentrated. Immigration flows are showing that a larger percentage of initial immigration is being directed towards non-traditional immigrant cities and even rural areas (Singer 2004). However, one of the most notable recent changes in immigration settlement patterns is that from the central-city gateway destination to emerging gateway cities and suburban destinations.

2.1.2 Stability, Flux, and Economic Restructuring

Traditional ethnically-concentrated neighborhoods (often called enclaves) in gateway cities both facilitated and hindered political, economic, and social mobility of both the immigrants residing in those neighborhoods and the neighborhoods themselves.

This dualism of immigrant experience can be explained through the processes of 'stability' and 'flux';

> "Enclave neighborhoods represent both 'stability' (that is, a constant presence that 'institutionalizes' the immigrant experience) and 'flux' as continuous waves of newcomers enter the neighborhood and use its services and structures at the same time that others are moving out to better opportunities elsewhere" (Singer 2008).

It is through the concepts of stability and flux that we have began to understand the emergence of 'new' immigrant gateways and how they are conceptually different from traditional gateways. Traditionally, opportunities for social and economic interactions and transactions for new immigrants were primarily limited within gateway city neighborhoods with similar ethnic backgrounds and make-up. And while this provided stability for new immigrants, capacity for improvement was limited and more established immigrants would eventually move to other neighborhoods or cities if they had the resources to do so. The key is that the immigrant/enclave neighborhood was a spatially-defined transition point through which the majority of immigrants travelled. This trend began to change in the latter-half of the twentieth century due to national scale economic restructuring which shifted the U.S. economy from being primarily industrial and manufacturing based to being based on knowledge-information technologies and the financial/banking industry. The geographical ramification of this economic restructuring was that new cities in new regions became targets of economic and population growth. Examples of these cities include; Atlanta, Georgia, Phoenix, Arizona, Dallas, Texas, and Charlotte, North Carolina.

One characteristic of these new economic growth centers is that they had limited experience with immigrant incorporation compared to traditional gateway cities. And

where New York offered enclaves for most ethnic backgrounds, cities like Atlanta and Dallas did not. In these cities, immigrants have in-large by-passed traditional center-city neighborhoods in favor of settling in less-densely settled suburban neighborhoods that are closer to jobs and offer lower rental prices. At a smaller scale, immigrants are also flowing directly from their home countries to rural areas that offer job opportunities in agriculture and agribusiness (one example being meat processing plants), and occupations surrounding resource extraction (i.e. oil drilling. However, the rapid rates of initial immigration into suburban and even rural destinations have facilitated research surrounding 'new immigrant gateways'.

2.1.3 New Immigrant Gateways

Singer (2004) identified different classifications of immigrant gateways in an attempt to revise and update policies in receiving communities across America. As a framework, Singer clarifies the traditional notion (or "typology") of a gateway around central cities. This typology fits with the idea of 'enclaves' in the central cities of New York or Chicago. It is against this framework of traditional gateway that Singer creates new gateway classifications; as a response to contemporary immigration patterns that are highly diverse across space and ethnicity of immigrant. On a methodological note, all of the metropolitan areas studied had a population of at least one million or higher. Singer's six gateway categories are listed and defined in Table 4.

TABLE 2.1: Gateway definitions*

Gateway Type	Definition	U.S. Cities (examples)
Former	Above national average in percentage foreign-born 1900-1930, followed by percentages below the national average in every decade through 2000.	Baltimore Philadelphia Detroit St. Louis
Continuous	Above-average percentage foreign-born for every decade, 1900-2000.	New York Chicago Boston San Francisco
Post-World War II	Low percentage foreign-born until after 1950, followed by percentages higher than national average for remainder of century.	Los Angeles Miami Houston San Diego
Emerging	Very low percentage foreign-born until 1970, followed by a high proportion in the post-1980 period.	Atlanta Dallas Las Vegas Washington, D.C.
Re-Emerging	Similar pattern to continuous gateways: Foreign-born percentage exceeds national average 1900-1930, lags it after 1930, then increases rapidly after 1980	Denver Phoenix Portland, OR Tampa
Pre-emerging	Very low percentages of foreign-born for the entire 20th century.	Charlotte Greensboro-Winston-Salem Raleigh-Durham Austin

*Chart is extracted from Singer (2004)

The justification behind gateway classifications is the notion by Singer that immigrants are simultaneously travelling to the largest, most traditional cities as well as new, smaller cities. Many cities and metropolitan areas in the South are identified including, ‘emerging gateways’ (Atlanta, Georgia) and ‘pre-emerging gateways’ (Charlotte, Greensboro-Winston-Salem, Raleigh-Durham; North Carolina). The unifying characteristic of emerging and pre-emerging gateway cities is that, unlike established gateway cities (i.e. New York, and Chicago, Illinois), they have only recently

experienced significant immigrant population growth and are traditionally not places that have experience with large immigrant settlements and populations. The majority of immigrants into emerging and pre-emerging gateways are of Latino descent.

The next section identifies Latino population growth trends in throughout the entire United States, in the U.S. South, and North Carolina.

2.2 Latino Population Growth

2.2.1 United States

In 2010, Latinos have become the largest minority population in the United States. There are just over 50 million Latinos residing in the U.S., or 16 percent of the total population. This is an increase of 43 percent growth from 2000; in comparison the total U.S. Population had 10 percent growth between 2000-2010. The largest Latino origin countries are Mexican (58.5 percent of Latinos), Puerto Rican (9.6 percent), and Cuban (3.5 percent). All other Latino origins made up the 28 percent of the total Latino population. Even though other Latino origins have smaller populations, they're percent growth rates from 2000-2010 were substantially higher in many cases over the Mexicans and Puerto Ricans. For example, Uruguayans had over 200 percent growth, and Hondurans, Salvadorans, and Guatemalans had over 150 percent growth. Not only is the Latino population as a whole continuing to grow, but it is also becoming increasingly heterogeneous and ethnically de-concentrated (Ennis et. al. 2011).

Geographically, every major U.S. Region[1] (Northeast, West, South, Midwest) experienced Latino population growth between 2000-2010. The highest populated region

1 Northeast Region—CT, ME, MA, NH, RI, VT, NJ, NY, PA; Midwest Region—IL, IN, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD; South Region—DE, DC, FL, GA, MD, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, OK, TX; West Region—AZ, CO, ID, MT, NV, NM, UT, WY, AK, CA, HA, OR, WA (www.census.gov/econ/census07/www/geography/regions_and_divisions.html).

is the West, with the South coming in second. And even though each region experienced growth, the Latino population in the US was relatively concentrated in 2010, with over half of the population living in California, Texas, and Florida. Other significant Latino populated states (greater than 1 million) include New York, Illinois, Arizona, New Jersey, and Colorado). In addition to being the highest populated region (due in large part to Texas and Florida), the South is also the fastest growing region, followed by the Midwest (Ennis et. al. 2011).

2.2.2 U.S. South

The U.S. Census South contained 18 million Latinos in 2010, up from 11.5 million in 2000. Florida and Texas alone comprised approximately 13 million Latinos alone. However, Southern states like North Carolina, Alabama, Tennessee, Kentucky, and Mississippi had faster percent rates of growth (all over 100 percent growth rate between 2000-2010) (Ennis et. al. 2011). The fact that Latino population growth is beginning to de-concentrate away from Florida and Texas into these non-traditional Latino Southern States is a significant demographic shift. Since 1980, the U.S. South has experienced rapid Latino population growth rates. From 1990 to 2000 six of the ten largest states for Latino growth were located in the U.S. South, with North Carolina at the top (Kuchar et. al. 2005).

Within the South, the majority of Latino population growth has occurred in metropolitan areas. These cities include Atlanta, Charlotte, Raleigh-Durham, and Nashville (Singer 2004). However, high rates of Latino population growth have also occurred in rural and non-metropolitan areas across the region as well. Important to understanding Latino population growth rates in the U.S. South is that they are not

occurring in isolation but rather as a part of an increased total population growth. Overall population growth has increased rapidly in conjunction with larger economic growth due in large part to economic restructuring in the 'new South'. Economic growth in the South has created demand for labor across the skill set continuum from low-skill to high-skill. Especially in the 1990s, this demand for labor has attracted the Latino population from other U.S. states and regions as well as foreign countries (Johnson-Webb 2002). Economic growth in the U.S. South occupies a broad set of industrial and occupational sectors from construction work on new city skyscrapers to migrant farm labor in large-scale poultry and pig farms (Haverluck and Troutman 2008). As such, industrial growth sectors have occurred across urban and rural places thus attracting migration across multi-scalar landscapes.

At the beginning of rapid migration into the U.S. South, Latinos where drawn away from their home countries and even other states, where economic recessions and large labor pools created competition. In addition to increasing availability of low-wage jobs due to economic restructuring in the South (Cobb 1990), existing federal government programs like the H-2A temporary visa program that allow migrant laborers legal status contributed to growth (Cravey 1997). In North Carolina, for example, "in 1989, North Carolina had 169 H-2A workers. By 1997, the number was more than 6,000 and in the year 2000, 10,600 H-2A visa were granted to North Carolina farmers" (Torres et. al. 2006). Employers across Southern states would also recruit laborers living in larger Latino populated states like Texas, or Latino countries like Mexico, to work in low-wage jobs like manufacturing, processing, and agriculture. In some cases, these labor

arrangements were made with documented workers, and in some cases they were not (Mohl 2003).

As Latinos arrived and settled in southern communities, they oftentimes came into conflict with the local populations. One major issue experienced in places across the South was the perception by the local, primarily white and African American communities, that Latinos were 'taking' their jobs. B.E. Smith (2006) noted that little empirical support exists for this perception by the local population, but the reaction played out differently in different southern communities. In urban neighborhoods in Atlanta and Memphis, for example, conflict existed between Latinos and majority African American locals but hostility remained low. In contrast, White populations in rural East Tennessee expressed mixed reactions to rapid Latino population growth with some examples of open hostility towards the newcomers.

Community receptivity to increased Latino population growth and presence in the social, economic, and political aspects of these communities has been mixed. A study of ethnic entrepreneurship showed that the presence of ethnically-owned businesses in the Birmingham, Alabama metropolitan area was met with mixed community and official response. Within the same urban area one community vibrantly supported ethnic business and promoted development through an 'international corridor'. Another community however, shut down access to immigrant services following the hostile response by community members who claimed that such service access promoted illegal immigration (McDaniel and Drever 2009). These issues of competition and community have remained for Latinos living in the U.S. South and have represented themselves in the provision of services.

2.2.3 North Carolina

North Carolina currently contains one of the fastest growing Latino populations in the nation. Latinos migrating to North Carolina are foreign- and native-born, documented and undocumented, and originate from U.S. and international destinations. Latinos settle across North Carolina in metropolitan and non-metropolitan destinations. North Carolina experienced hyper-rates of growth between 1990 and 2000 and has sustained steady growth statewide from 2000 to 2010. Only recently, within the past few years, have those growth rates started to decline as immigration restrictions and economic recession has occurred. Overall, Latino population growth between 1990 and 2010 is over 400,000; there are currently just over 800,000 Latinos living in North Carolina according to the U.S. Census Bureau (2010).

Much like the U.S. South, larger economic restructuring and growth has filtered down to Latino population growth. In metropolitan areas such as Mecklenburg County, growth in the financial and banking industry spurred a construction boom that created a demand for workers skilled in that occupational sector (Smith and Furuseth 2008; Smith and Graves 2003). In non-metropolitan counties the growth of agribusiness (especially meat manufacturing plants) created a demand for workers such that employers began recruiting Latinos living in Texas and Central America. Also, the growth of temporary H-2A work visas encouraged increasing growth in agricultural jobs in rural areas of North Carolina. (Cravey 1997). However, economic restructuring has not only operated in isolation from social forces, or in spatially defined places. Rather, "The rapid expansion of *formal* regulated labor markets (through H2A) has encouraged *informal* flows of Latino workers to North Carolina (Cravey 2005).

Case studies conducted in North Carolina have explored causes of Latino population growth in economic, political, and social contexts. In a study conducted across five North Carolina counties making up what's known as the 'Triangle', Johnson-Webb (2002) sought to analyze the role of employer recruitment in the rapidly increasing Latino migration to the area during the 1990s. She found not only that employer recruitment, encouraged through H-2A temporary visa programs, did contribute to Latino population growth, but that employers leveraged Latino employee social networks to promote Latino employment in certain occupational sectors. This confirms Cravey's (1997) statement that formal networks encourage informal flows. Among the Latino population, social networks including transnational networks have shown to be a source of not only population growth, but also social and economic transactions between the new destination and home country. In western North Carolina, Latino employment has grown in galax tree harvesting. Latinos already living in this area have learned about the traditional occupation by watching non-Latino locals, and then spread the word through social networks that there is money to be made (Emery et. al. 2006).

While these social networks contributed to formal and informal bonds and relationships among Latinos both in North Carolina, and from other intra/inter-national places, people within a certain network were often unable or uneducated about utilizing services or resources outside of the network. This would have long-term consequences on the newly-arrived Latino population and accessing healthcare services.

2.2.4 Urban vs. Rural Latino Growth in North Carolina

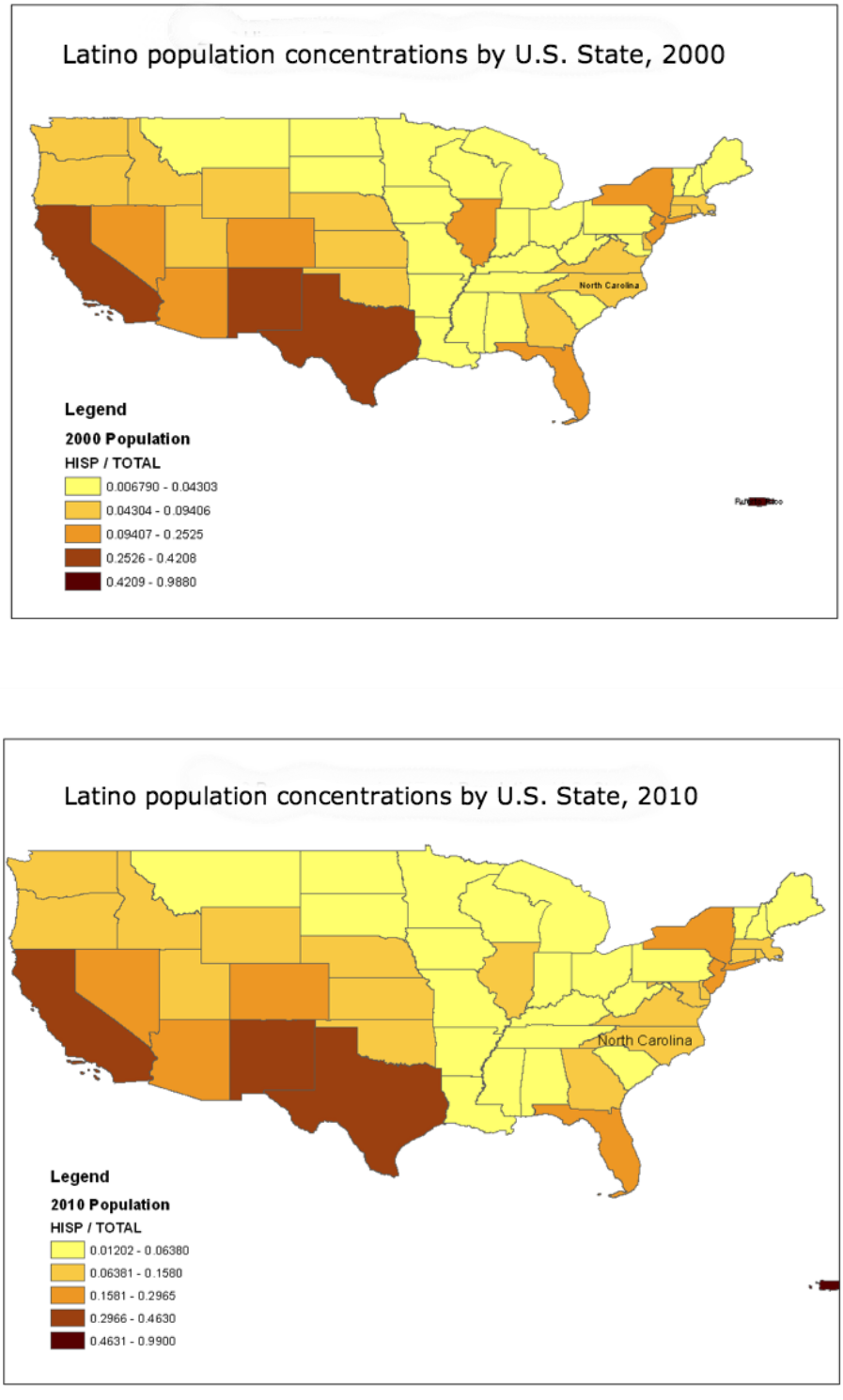


FIGURE 2.1: Lation population growth in the United States, 2000-2010

As mentioned earlier, Latino population growth has occurred in urban and rural areas across the U.S. South. This trend is especially prevalent in North Carolina between 1990 and 2009. Between these time periods, Table 2.2 shows North Carolina's top ten counties for Latino population in 2009. As expected, the counties with the largest Latino populations are all representative of urban counties with overall large total populations. Additionally, in the majority of these counties more than 85 percent of the 2009 population was added between 1990 and 2009. For example, Mecklenburg County, the largest in North Carolina, added 640,936 Latinos between 1990 and 2009, roughly 90 percent of the 717,662 Latinos in 2009. In fact, many of these counties (including Mecklenburg, Wake, Durham, and Guilford) contain or are part of metropolitan areas identified by Singer (2004) as 'pre-emerging' gateways due to their recent and rapid influx of immigrant populations.

TABLE 2.2: Top ten N.C. counties: total Latino population 2009

State/County	Total 2009 population	Total: Hispanic or Latino (2009)	Total Hispanic Change; 1990-2009
North Carolina	9,380,884	717,662	640,936
1. Mecklenburg	913,639	100,625	93,932
2. Wake	897,214	80,870	75,474
3. Forsyth	359,638	39,363	37,261
4. Durham	269,706	32,804	30,750
5. Guilford	480,362	31,430	28,543
6. Union	198,645	20,853	20,178
7. Cumberland	315,207	19,954	6,656
8. Johnston	168,525	19,691	18,429
9. Alamance	150,358	17,284	16,548
10. Cabarrus	172,223	15,865	15,382

Source: U.S Census Bureau 1990 and 2000; American Community Survey 2009

Table 2.3 displays the top ten counties based on the percent of total Latino population change between 1990 and 2009. In this table we begin to see a heterogeneous

mixture of counties emerge; ranging from a miniscule 4,078 total population (Tyrrell) up to a total population of 359, 638 (Forsyth). Among these counties, five have a total population below 50,000 and five have a total population above 100,000. These counties represent a range of rural, urban, and suburban places in which Latinos have recently and rapidly settled. Caution must be noted in the interpretation of percent total change categories from 1990-2009 and 1990-2000. In these cases the percent change is being based on the total Latino population for 1990, which in many of these counties was very small. It is because of the 1990 reference point that we see numbers well into the thousands percent change as much as it is absolute Latino population growth. Perhaps a better indicator is percent total change from 2000-2009 where we can see a leveling of rates mostly in the low three-digit range.

TABLE 2.3: Top ten N.C. counties: Latino percent total population change, 1990-2009

State/County	Total 2009 population	Total: Hispanic or Latino (2009)	*Percent Total Change; 1990-2009*	Percent Total Change; 1990-2000	Percent Total Change; 2000-2009
North Carolina	9,380,884	717,662	***835.36***	393.92	89.38
1. Cabarrus	172,223	15,865	***3,184.68***	1,270.60	139.65
2. Union	198,645	20,853	***2,989.33***	1,031.41	173.05
3. Tyrrell	4,078	320	***2,809.09***	1,263.64	113.33
4. Hoke	45,148	5,318	***2,339.45***	1,007.80	120.21
5. Alamance	150,358	17,284	***2,248.37***	1,100.41	95.63
6. Yancey	18,548	1,091	***2,126.53***	875.51	128.24
7. Davie	41,420	2,817	***2,083.72***	837.21	133.00
8. Randolph	142,151	15,683	***2,036.65***	1,077.93	81.39
9. Forsyth	359,638	39,363	***1,772.65***	831.35	101.07
10. Davidson	158,582	9,967	***1,555.65***	580.96	94.22

Source: U.S Census Bureau 1990 and 2000; American Community Survey 2009

Table 2.4 displays the Latino population as a percent of the total population in 2009. This figure provides a representation of the impact of the Latino population on the

total population for these areas. Also included in this table is Mecklenburg County which is very close in the percent Latino of total population to number ten, Randolph County. Compared to the other indicators of population growth expressed in Tables 1 and 2, the counties that have a larger Latino percent of their total population are generally smaller. Seven of ten counties have a total population of less than 75,000, representing a lean towards dispersed, small-urban counties and rural counties. In fact, many of the counties represent places that employ Latinos in jobs related to agriculture and agriculture-related industries. For example, Chatham County (number six in Table 2.4) was the site of a large influx of Latino migrants from other U.S. states and abroad recruited to work in poultry-processing facilities in the county's largest town, Siler City (Cravey 1997). Chatham County is located in central North Carolina in between the Raleigh-Durham and Winston-Salem metropolitan areas.

TABLE 2.4: Top ten N.C. counties: Latino as percent of total population, 2009

Geography	**Total 2009 population**	***Percent Hispanic or Latino Origin of Total Population, 2009***	**Hispanic Percent of Total Population Percent Change; 1990-2009**
North Carolina	9,380,884	***7.65***	560.93
1. Duplin	53,177	***22.03***	768.08
2. Sampson	63,713	***17.01***	1,006.78
3. Lee	60,477	***16.98***	778.42
4. Montgomery	27,745	***16.49***	592.38
5. Greene	20,658	***13.39***	1,118.84
6. Chatham	64,772	***12.66***	769.90
7. Durham	269,706	***12.16***	976.75
8. Hoke	45,148	***11.78***	1,134.96
9. Alamance	150,358	***11.50***	1,590.13
10. Randolph	142,151	***11.03***	1,501.48
Mecklenburg	913,639	***11.01***	741.59

Source: U.S Census Bureau 1990 and 2000; American Community Survey 2009

Many other counties on this list are similar to Chatham County in that they have represented a destination for rapid Latino growth due to economic demand in agri-business related industries, and are located proximate to the outer reaches of rapidly growing metropolitan areas. These counties include Duplin, Sampson, Greene, Lee, and Montgomery. Torres et. al. (2006) identified the North Carolina Central Coast Plain as a significant region for Latino population growth due to economic opportunities in agriculture and meat processing. Duplin, Sampson, and Greene counties belong to the Central Coast Plain. In their study, the authors utilized qualitatively-based methods to explore Latinos intentions for migrating to this, primarily rural as identified by the authors, region. They found that Latinos particularly liked the 'tranquility' of the region and were, in some cases, willing to forego higher wages to live in the region. Importantly, among the participants in the study, over one half immigrated to the region directly from Mexico or other countries. Additionally, the majority of respondents that came directly to North Carolina from other countries did not first travel to the 'pre-emerging' gateway cities such as Charlotte or Raleigh.

One consideration of this study is when Latino immigrants prefer to settle directly in rural areas as opposed to urban areas in North Carolina (Torres et al. 2006). While economic reasons tend to dominate the factors motivating migration to North Carolina, this evidence suggests that Latinos had other demand side factors, including quality of life considerations that motivated them to choose rural areas. This sets the stage for the importance of comparing experiences in urban and rural places and assessing how elements of gateways may appear in both contexts.

The next section of this chapter provides in more detail the literature regarding Latino settlement and experience in emerging and pre-emerging immigrant gateways. Then, the connection between these experiences and service delivery is made, while also discussing the role of health geography as a conceptual element in Latino service delivery.

2.3 Latino Settlement, Experience, and Reception in Emerging/Pre-emerging Gateways

The concept of a (pre-) emerging gateway is recent, only identified in the last decade (Singer 2004). Since its inception, social scientists across many disciplines have used emerging gateways as a socio-spatial lens through which to examine settlement patterns, experiences, and community receptivity for immigrants. For the Latino population, these studies take place around the United States and across urban-rural environs. Even though there are few studies as evidence, a key finding of immigration scholars is the heterogeneity and diffusion of the intra-urban places where Latino immigrants settle upon first arriving into a new community. As opposed to settling in central city neighborhoods, more settle directly in less concentrated suburbs (Singer 2008). In a study of Charlotte, North Carolina, many factors explained this tendency for suburban settlement by newly-arriving Latinos. Primarily, in Charlotte the stock of affordable housing was located in older suburban apartment complexes (Smith and Furuseth 2008). Additionally, receptivity factored in as landlords of these apartments would offer rent payment in cash and would not enforce limits on how many individuals could stay in an rental unit. Economically, many of the new Latino settlers were men who came to Charlotte to work in construction or landscaping, industries that were booming concurrently with financial sector in the city throughout the 1990s and into the early

2000s. Spatially, these jobs were more likely to be located in the suburbs, and offered close proximity to the apartments (Smith and Furuseth 2008).

Formally, the concept of the emerging/pre-emerging gateway has been identified only in metropolitan areas. Spatial patterns of urban settlement for immigrants have differed from spatial patterns in traditional gateways, with the example given of the increase in suburban settlement. Recently, studies have adopted the emerging gateway method into rural places that still exhibit characteristics of urban areas, most notably large percent growth of immigrants into areas that had little to no foreign-born population throughout the 20th Century. One such study was conducted by a sociologist and examined how community receptivity impacted gender relations for newly immigrated Mexicans in rural Southwestern Montana (Schmalzbauer 2009). In another planning-based study, rural communities in the U.S. Midwest were examined through the lens of Latino place-making, or the social, economic, and cultural representations of those towns that made them spatially appear as 'Latino' (Sandoval and Maldonado 2012). In both of these examples the justification for referring to the rural study area as an emerging or pre-emerging gateway was not expressly stated. In fact, other terminology was used such as a 'new' gateway or new-destination. This study seeks to address this lack of clarity by directly comparing urban and rural locations that exhibit specific, 'pre-emerging' gateway characteristics across the state of North Carolina. A contribution of this study is consideration of how Singer's gateway typologies might be applied to broader scales and contexts than just metropolitan areas. This study seeks to understand the pre-emerging gateway construct as it applies across a continuum of rural to urban environments.

2.3.1 Connecting Gateways to Service Delivery

Critical to Singer's typology of gateway classifications are the disparities between continuous and emerging/pre-emerging in the abilities by those communities to incorporate and provide adequate services to newly-arrived immigrants. Without the presence of set federal policies, as Singer argues, gateway cities build incorporation and service delivery institutions and capacity through local (and sometimes state) political, social, and economic means. In other words, a trend can be established where the longer the gateway city has been present and important to immigrant settlement; the more likely it is to have better institutions and higher capacities to incorporate and provide services to immigrants. Of course, this does not mean that all cities within a particular gateway category share similar experiences, but it does suggest that emerging/pre-emerging gateway cities will struggle to serve immigrant newcomers compared to continuous gateway cities like New York. Among a list of policy suggestions Singer outlines for new gateway destinations to consider is focused on service delivery; "bring cultural and language sensitivity to service delivery" (Singer 2004). And within the realm of service delivery, Singer highlights challenges within health care service delivery. Singer provides conceptualization of the connection between new immigrant gateways and healthcare providers in the following passage:

> "Health care delivery especially can be complicated not just by linguistic problems but by cultural differences between immigrants and American health care systems. Health care providers in emerging gateways may be ill-equipped to deal with the special needs of immigrant and refugee newcomers" (Singer 2004).

Singer goes on to state that local and regional collaborations, as well as the presence of mainstream institutions, generally encourage successful health care delivery to immigrants in new gateways.

Metropolitan areas within North Carolina have been identified as pre-emerging gateways. However, smaller counties in North Carolina (including rural ones) share similar percent Latino growth rates. These similar rates of growth suggest that a continuum of rural and urban places in North Carolina may be experiencing a suite of shared circumstances associated with pre-emerging gateways. Overall, the relative impact of the newly arriving Latino population on these places with little previous immigrant experience implies that these places will likely encounter similar challenges and opportunities in providing healthcare service. Within any community the equitable and efficient provision of services depends upon the institutional capacities and resource capabilities of community providers as well the networks and knowledge of community members to access such services. *So, how is this all playing out across North Carolina gateway communities at varying locations and scales?* This question cannot be answered unless it is framed through the context of the role of place in contributing to or prohibiting Latino health access and service provision. Additionally, this warrants investigation into service provision by interviewing healthcare providers that serve Latinos across North Carolina communities. Next, the investigator outlines trends in Latino health, barriers to healthcare service Latinos experience, and service provider responses to those barriers, utilizing national-level evidence and evidence from North Carolina.

2.3.2 Health Geography and the Importance of Place

The importance of place is inherent to all geographers. At its simplest point, place can be defined as "…one's position in society and spatial location" (Tuan 1996). However, complexity in place dynamics increases as social scientists study and expand upon societal positionality. Ultimately, "place…is more than location and more than the spatial index of socio-economic status. It is a unique ensemble of traits that merits study in its own right" (Tuan 1996). The increase in health geography studies that include the role of place has occurred significantly since the 1990s. At this time, geographers primarily in Great Britain and other parts of Europe were establishing and critically discussing an ideological move from the term 'medical geography' to 'health geography' This debate (see Kearns 1994; Dorn and Laws 1994; Kearns and Moon 2002) stemmed from the inclusion of place effects on what were formerly issues of medical geography and how to analyze and operationalize those place effects. One such case study that illustrates this point was the choice of women in Britain to give birth in their home place; "Their sense of 'healthiness' of the birth experience was enhanced by having a home birth, and their positive feelings about their home place were heightened by this choice (Kearns 1994). This way of examining issues of health from a humanist, social place perspective deviates from traditional medical geography topics primarily focused on disease pathogens and pollution ecologies. In other words there is more of a focus on the importance of people in their places, and how people impact and are impacted by that place.

The effect of place on healthcare or health services provision is difficult to measure and analyze simply because places and the factors that contribute to their creation are so complex. Places can be understood as real or material (buildings, trees,

etc.) or subjective, meaningful (a ‘dangerous’ neighborhood, a ‘good’ school). In fact, there are three primary categories that can be utilized to explain geography and place’s role in health variations; compositional, contextual, and collective.

> “Compositional explanations draw our attention to the characteristics of individuals concentrated in particular places; contextual explanations draw our attention to opportunity structures in the local physical and social environment; collective explanations draw our attention to socio-cultural and historical features of communication” (Macintyre et. al. 2002).

These place categories are not mutually exclusive yet are often studied separately. It is the contention of this study that one cannot understand compositional explanations of characteristics of individuals in a place without input from collective explanations of cultural and social positions and understanding of contextual opportunity structures.

Contextual, or ecologically-based, components of understanding the role of place in health inequalities often are criticized for their connection to the ecological fallacy. The ecological fallacy occurs when an individual in a geographically identified place is assumed to exhibit the same attributes of that place (Dummer 2008). One consequence of the ecological fallacy is that policy interventions may inappropriately address disparities or inequalities for individuals within larger target areas. This consequence can be aggravated when policy-makers, or service providers, do not fully understand the myriad of attributes that represent all community members of a service area (Curtis and Jones 1998). Introducing in-depth, qualitative research methods is one solution to the problem of ecological fallacy. These methods allow the researcher to better understand intra-group level disparities and inequalities (Dummer 2008).

Going back to the concepts of contextual versus compositional and their impact on health geography debates, an additional consideration is the dynamic nature of people

and places. The dynamic in many ways connects people to places and vice-versa. Using the example of migration, it is often situational determinants being experienced in one place (economic decline, loss of jobs, hostile political environments) that will motivate migration to another, more attractive place. Not only have places impacted people, but the effects of migration impact the attributes of the place itself. This 'relational' view of place and space is important to the health inequalities discussion. Cummins et. al. (2007) discuss the importance of relational views of place and space towards understanding health variations:

> "Advancing our understanding of how places relate to health will require moving beyond existing conceptualizations of 'place' in empirical research. This development is necessary in order to fully comprehend the complex relational spatial interdependencies which exist between people and places. Recognizing that individuals can become relationally embedded in multiple health damaging and health promoting environment, across time and space, and at multiple scales is crucial if we are to further understand the importance of 'place' in the generation of health inequalities" (Cummins et al. 2007).

Regardless of the complexities involved in analyzing place-based effects of health, many geographers agree that place does matter (Curtis and Jones 1998). Particularly in a compositional sense, similarly attributed individuals or population groups experience different health outcomes in different places (Curtis and Jones 1998). In the case of newly-arrived Latino immigrants in new North Carolina destinations, a list of the following place-based measures have been well established and offer a starting point for structuring this analysis: place of work, place of residence, healthcare facility, religious, transportation, social relationships, a sense of belonging, length of residence in place. How these measures are analyzed is discussed in the methodology section.

2.3.3. The Importance of the Provider Perspective in Health Geography

Health geography attempts to fold in social and cultural theories with more traditional medical geography theories to increase our understanding of health and the environment. Through utilizing qualitative research, new perspectives on the impact of place and space from embedded individual and community experiences can be formed:

> "Several studies concerned with health service delivery and lay perceptions of health and illness utilize qualitative methods as the sole approach in investigation. Such interpretive research, which relies entirely on accounts gathered from study participants through a variety of qualitative methods, brings subject perspectives to the center of constructing knowledge about health and healthcare phenomena and their links with space and place. Some of this work retains focus on the formal health care system, but other studies explore lay perspectives on the meaning of health and responses to illness. The shift towards the subject's narrative and a concern with how behavior and ideas are deeply embedded in place signal an engagement with the notion of the recursive constitution of place and people, rather than conceptualizing places and spaces as unchanging 'backdrops' against which agency is performed…In conjunction with theorized place becoming more prominent in analysis, concepts from outside medical geography are introduced in the exploration and reconceptualization of different sites within which health, illness, and health service delivery are enacted" (Dyck 1999).

Cutchin (1997) utilized a qualitative design and provider perspective to understand provider retention rates in rural areas. Important to this research is the role that social capital, community ties, and how the provider perceived being embedded into the place was towards the likelihood of physician retention.

The provider perspective is also important in the realm of physician relationships and referrals. A Great Britain study compared referral systems among general practitioners (GPs) and specialists through qualitative methods (Marshall and Phillips 1999). The study researchers found that GPs tended to refer patients to specialists that they had a positive professional relationship with as opposed to the spatially nearest specialist. The study also summed up concisely the intersection and importance of

utilizing qualitative methods from the provider perspective, and their importance towards health/medical geography research agendas:

> "Health care geographers operating at local, regional, or national scales should therefore find the approaches as well as findings in this study very valuable for future research agendas in a range of issues. They might assist in understanding of local and wider variations in, for example, perceived quality of care delivered to patients which might be underpinned, amongst other things, by largely qualitative factors influenced in the least part by the inter-professional relationships amongst the various physicians involved. The approach holds considerable potential for achieving a more fine-tuned understanding in spatially-based studies and certainly for cross cultural studies of care delivery, professional developments, and the evolution of quality of services" (Marshall and Phillips 1999).

2.3.4 Latinos and Health

Generally speaking, the Latino population is underserved by the U.S. healthcare system compared to non-Latinos (*The CDC report from which this statement derives actually refers to Hispanics versus non-Hispanics). In both terms of access and utilization, the Latino population is less likely to receive healthcare service as well as seek out such service compared to non-Latinos. According to a Centers for Disease Control and Prevention (CDC) report that analyzed Behavioral Risk Factor Surveillance System (BRFSS) data for 2001-2002, Latinos are less likely than non-Latinos to; have health-care coverage (insurance) (76.2 and 90.6%), have a regular place of care (93.4 and 96.2%), and have a usual provider (68.5 and 84.1%). Additionally, Latinos are two times as likely as non-Latinos to report their overall health status as fair/poor (28.9 and 14.0%) (CDC 2004). Evidence regarding Latino health access, utilization, and outcomes is often debated due to issues of sample size, data quality and accuracy (Vega, 2009). In reality, reliable data concerning Latino health is in short supply due to the extremely heterogeneous structure of Latino ethnicity and socio-demographic factors. One such example that is debated in the literature regards the inverse relationship between Latino

socioeconomic status and mortality rates. Often called the “Hispanic paradox” or “immigrant health advantage”, Latinos are found to have lower mortality rates than non-Latinos even though their socioeconomic status is also lower. A primary contributor to lower mortality rates for the Latino population is lower average age cohorts compared to non-Latinos. A second factor is that, given that a large percentage of Latinos are foreign-born, there is an inherent migration selection process where physically and mentally healthier Latinos are able to withstand the difficulties of immigration. Third, disparities in mortality exist between Latino generations where first generations have lower mortality that increases stepwise with second, third, and beyond generations. In this case, acculturative and behavioral factors contribute to unhealthy lifestyles for successive generations of Latinos living in the U.S., thus increasing mortality rates in incidences of cancer and heart-related deaths (Vega et. al. 2009).

Table 2.5 gives a portrayal of mortality for Latinos in North Carolina by listing the top ten causes of death in 2005. Notably, deaths due to non-health related reasons were higher for the Latino population than the non-Latino White and African American populations; noted by motor vehicle injuries and homicide. Additionally, this list gives evidence of mortality due to lack of or improper access to care, especially among expecting mothers. Deaths due to conditions originating in the perinatal period or related birth defects were higher among the Latino population when compared to non-Latinos.

TABLE 2.5: Leading causes of death among Hispanics/Latinos in North Carolina, 2005*

Rank	Cause of Death	Number of Deaths
1	Motor vehicle injuries	146
2	Cancer	135
3	Diseases of the heart	85
4	Homicide	71
5	Other unintentional injuries	62
6	Conditions originating in the perinatal period	51
7	Cerebrovascular disease	35
8	Birth defects	32
9	Suicide	23
10	Nephritis, nephritic syndrome, and nephrosis	18
	Total Deaths – All Causes	**641**

*This table is from *State Center for Health Statistics* and only contains deaths reported in the database.

Generally speaking, Latinos fared better than non-Latino whites and African-American in the relative mortality prevalence rates of chronic diseases including heart disease, stroke, diabetes, and lung/breast cancer (Report Card 2006). However, though chronic conditions were not as prevalent for Latinos compared to non-Latinos, the lack of access and likelihood of reporting chronic conditions may be the reason. When compared to non-Latinos in North Carolina, "Hispanics (Latinos) were substantially more likely to report having no health insurance, not being able to see a doctor due to cost, or not having a personal doctor; this means less opportunity to diagnose chronic conditions" (SCHS 2006). In fact, "…Hispanics (Latinos) are less likely than both white and African American non-Hispanics to report diabetes, high blood pressure, or asthma…however, diabetes and other chronic diseases are expected to become much more prevalent in North Carolina's Hispanic population in future years" (SCHS 2006).

2.3.4.1 Barriers to Health Access and Utilization

As mentioned in the previous section, there is evidence at the national and state level of the connection between access to health care and mortality rates for the Latino population. Healthcare accessibility is another major concern among the Latino population. Generally, well-documented barriers to healthcare access for Latinos include financial, cultural, discrimination, transportation, and language (in no particular order). These barriers are found not to exist independently of each other but in fact often compound to even further reduce access to healthcare. Much like documentation status and insurance, these barriers to access are influenced by the economic, political, social, and spatial environments in which Latinos live.

2.3.4.2 Insurance

A primary contributor to barriers and disparities in health access for Latinos nationwide is health insurance coverage. According to the National Health Interview Survey (NHIS), Latinos were the most uninsured race/ethnicity in the United States in 2010. Compared with Whites, Blacks, and Asians (all identifying as non-Latino), "Hispanics were more likely...to be uninsured at the time of interview, to have been uninsured for at least part of the last 12 months, and to have been uninsured for more than a year" (Cohen et. al. 2011). In the United States healthcare system, the presence of insurance is key to access. Even though health insurance coverage has increased for Latino children between 1996 and 2005, significant disparities exist in health insurance coverage between Latinos and non-Latinos (especially non-Latino white) (Wie et. al. 2008). This comparatively low-level of insurance is related to job status where "Nearly one half (45.1%) of working adult Hispanics (Latinos) do not have job-related health

insurance, compared to about a third (34% of working adult blacks and a quarter (22.6% of working adult whites" (NAHH 2001).

2.3.4.3 Political Barriers

Among all ethnic groups, immigration status and documentation status affect healthcare. A study conducted in 2001 found that, for documented and undocumented immigrants (non-citizens) had higher rates of uninsured and fewer rates of having a primary care doctor or having seen a doctor in the past twelve months (Ku and Matani 2001). There is a generational affect as well where children of immigrants have fewer insurance and health care utilization rates than children of citizens, even if the child of the immigrant is a citizen (natural-born) him or herself (Ku and Matani 2001). For Latino immigrants, the compounding role of documentation further inhibits healthcare access. A study of Latina immigrants in North Texas found that those who were undocumented were extremely vulnerable and unlikely to access any form of healthcare (Marshall et al. 2006). Additionally, these women were less likely to be employed and carry insurance over the documented community (Marshall et al. 2006). Another study conducted across California found that undocumented Mexican immigrants were less likely to have seen a doctor or have a usual source of care compared with documented Mexican immigrants. This finding was after the researchers controlled for socio-economic variables (Bustamante et. al. 2010). Both insurance and documentation status are intrinsically linked and form the foundation of other barriers to healthcare access for Latinos.

2.3.4.4 Language and Assimilation/Acculturation

One of the more common and well-studied barriers to healthcare access for the Latino population is language. In a national sampled study that controlled for many

predisposing factors, Latinos that were not fluent in English were less likely to visit a physician, have a usual source of care, and receive immunizations than non-Latino, English fluent populations (Fiscella et. al. 2002). Interestingly, Latinos that were fluent in English showed similar access patterns to English fluent, non-Latino populations (Fiscella et. al. 2002). The association between lack of English fluency and lower rates of healthcare access has been shown in national studies, even though the number of Spanish speakers in the US continues to rise (Dubard and Gizlice 2008). Perhaps the most important finding behind the effect of language is that it creates disparities within the Latino population itself. Those who are fluent in English fare better in healthcare outcomes over those who are not fluent (Dubard and Gizlice 2008). The reality of language (and literacy) disparities within the Latino community is further evidence of its continuing heterogeneity.

For any individual Latino, his or her language status is often influenced and associated to the degree of acculturation or assimilation that person has in the US. In fact, most of the earlier, national-level studies examining access and acculturation use language as the primary acculturation factor (Solis et. al. 1990). However, acculturation is a difficult proxy in which to study causal healthcare outcomes as acculturation plays out across social, economic, political, and spatial realms. Additionally, "flawed assumptions are evident in the theory of acculturation (e.g., individuals born outside the United States must abandon their culture of origin to be acculturated, and individuals are free to choose to become an integral part of American Society" (Zambrana and Carter-Pokras 2010). In other words, and individual is often constrained from acculturating into a community or society because of factors beyond his or her individual control. These

external, or community-level factors are often advised to be added (social determinants, measures of cultural and community identity) but are often not (Zambrana and Carter-Pokras 2010).

Identifying appropriate variables that can measure the cultural and external aspects of acculturation on healthcare access for Latinos is very difficult. In state or national-level quantitative studies the inclusion of 'culture' still primarily revolves around language acquisition and might not accurately depict the true effect of culture for Latinos. In one quantitative study, language and culture was shown to have no significant impact on healthcare access for the Latino study population (Documet and Sharma 2004). However, a subsequent qualitatively-based follow-up showed that the study population did in fact perceive conflict in their potential healthcare visits; "quality of care and distribution of services by cultural variables are key to assessing access equity. Although the results were not statistically significant, qualitative data show realized access was affected more than potential access by cultural aspects. The most obvious of these is language," (Documet and Sharma 2004).

In addressing the role of barriers to healthcare for Latinos, previous studies listed above outline the call for qualitative methodologies that seek to discern and discover the complex and nuanced way in which these barriers work together. And, as mentioned, these barriers exist at individual, community, state, and national levels. Additionally, the outcomes of these barriers and how Latinos respond and react can exist in terms of realized (measures) outcomes or perceived outcomes (quality of care). And it is in these perceptions of quality of care where much of the discussion around barriers lies for patients and providers.

2.3.4.5 Quality of Care

One consequence of Latino health access disparities is that the population reports lower quality of care received when compared with other races/ethnicities (AHRQ 2005). Quality of care received for Latinos is correlated to documented barriers they experience, but relationships between Latino patients and healthcare providers have been documented as a problem. In fact, in a list of suggestions to overcome disparities in Latino quality of care issues, one researcher noted that healthcare providers must respond "…effectively to patient perceptions regarding poor quality of interpersonal communication, satisfaction, and effectiveness of care" (Rodriguez and Vega 2009).

2.3.5 Provider Response to Latino Health Barriers

Ultimately, the state of Latino health understanding and research agendas is dynamic and contextual. It is the expectation of this research that the demographics, length of residence, and socioeconomic status of Latino communities living in particular places/destinations are shaped significantly by the contexts of those places/destinations. In this way, the healthcare delivery system and healthcare providers within the system can influence service provision and increased healthcare access among the local Latino community.

In a national-scale study of health access for Latinos of Mexican descent researchers found evidence of the effects of neighborhood context on health access. Specifically, Mexicans who lived in neighborhoods with higher percentage of Latino population were more likely to have better access to healthcare. These results were tested by linking Medical Expenditure Panel Survey (MEPS) data with geo-referenced U.S. Census data (Gresenz et. al. 2009). Other findings in the study were the importance of

nativity and language in assessing health care access barriers for Mexican-Americans and also the role that minority physicians had in promoting access among the Latino sample, as well as the presence of community-based organizations that supported the minority population. The authors conclude that the social networks among organizations, the community, and between organizations and the community are all critical to increasing health outcomes.

Community-based research has been utilized by healthcare professionals and academic researchers to leverage community opinion and insight in the improvement of Latino health service delivery. Though researchers utilize various definitions and conceptualizations for community-based research the general idea is the inclusion of all stakeholders, including community members, in addressing health disparities and developing interventions. Involving Latino community organization is important as "they remain governed by community boards and have established histories of providing linguistically and culturally credible services within their own communities (NAHH 2001). Arcury et al. (2004) utilized a mixed-methodology consisting of key informant interviews, focus groups, and participant demographic survey analysis to determine beliefs and knowledge of diabetes among rural Latinos in eastern North Carolina. Among the forty participants was a mix of genders and ages. The focus of the project was to leverage participant beliefs in the design of a diabetes prevention program aimed primarily at preventing type-2 diabetes in the Latino community. The researchers found that, among the variation of beliefs concerning diabetes by the participants, they overwhelmingly stated that diabetes was preventable through proper diet and behaviors. However, the study did not utilize place-based considerations in its conclusions. Overall,

little evidence in the research connects provider perceptions and responses to Latino health barriers to the places where those Latinos settle and live. This gap in the literature is partially addressed through this study.

2.3.6 Latino Health in Urban Versus Rural Environments

Consider that having access to a primary-care physician is positively associated with healthcare utilization for all populations. Geographically, locations that have a larger supply of primary-care providers show larger rates of healthcare utilization among that localized population (Continelli et. al. 2010). Because rural areas have a smaller supply of primary-care physicians than non-rural areas, one might believe healthcare utilization is better in urban areas than in rural. Studies have agreed with this ascertain (see Mueller et. al. 1999). Studies examining the total population have found that rural environments are positively associated with less healthcare access and worse healthcare outcomes. Physician retention has been shown to be worse in rural areas than metropolitan areas (Cutchin 1997). Residents of rural areas generally perceive their health to be worse than in urban places (Monnat and Pickett 2008). Conversely, in a nationally based study utilizing Medical Expenditure Panel Survey, the researchers found that non-urban patients reported better communication with their providers over urban patients (Wallace et. al. 2008).

For the Latino population it is very difficult to measure this due to data accuracy and availability across urban and rural environments. For Latinos, self-reported data reports and analysis, as well as qualitatively-based studies have provided the majority of our knowledge base. In these studies, the importance of place has often been a key factor and the role of place has differed between urban and rural environments. As mentioned

earlier, Latino population growth has occurred rapidly in both urban and rural environments across the United States. In one study that compared experiences in health care for rural Latinos in east and west North Carolina, researchers interviewed mothers and found that their perceptions of the availability and quality of interpreters, as well as transportation, were barriers to healthcare delivery (Gentry et. al. 2007).

2.3.7 The Importance of Comparative Studies

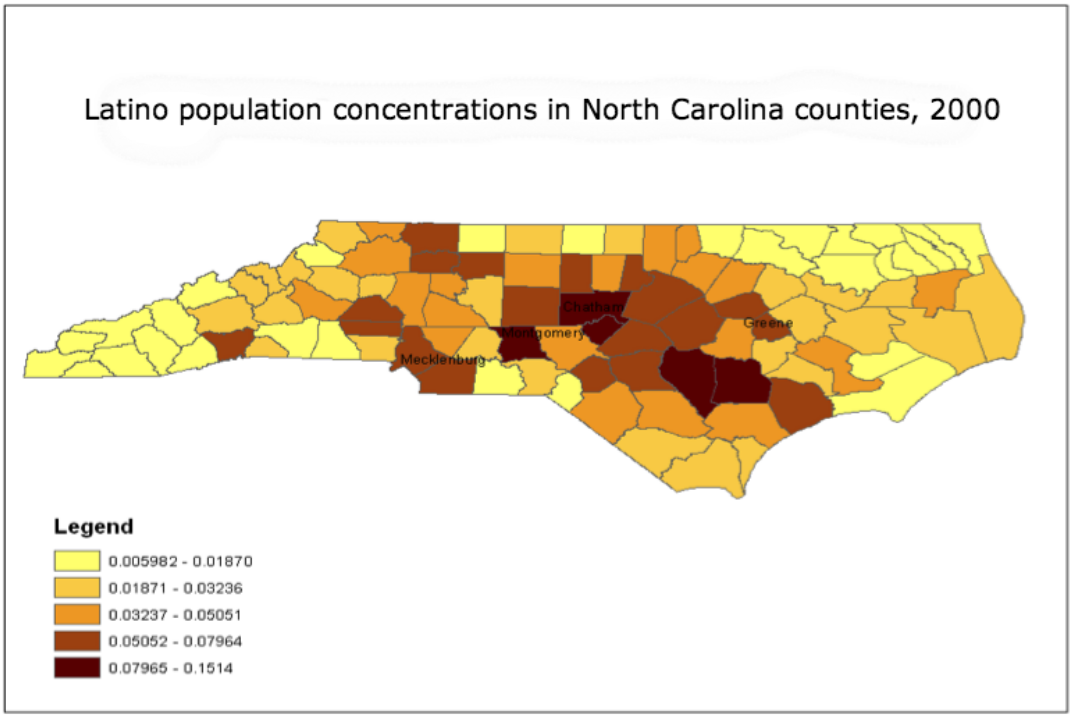
Because many of the issues involving issues in Latino health service provision are exposed in the context of the place in which those issues occur, comparative studies are extremely useful in highlighting similarities and differences across places. In an urban/rural-based comparative study the authors interviewed educators about the health disparities they had seen in their Latino (a) schoolchildren. The authors found that the most common health disparities across rural and urban settings were related to high pregnancy rates and poor vision care. Differences across urban/rural settings were also discovered. In urban settings, behavioral health issues were more common (i.e. obesity). In rural settings, issues related to care were more common (i.e. not receiving vaccinations) (Villalba 2006). In interpreting these rural/urban disparities, the authors concluded that while issues of Latino(a) health disparities might remain similar across place, "these disparities are manifested in different ways, based on location" (Villalba 2006). In other words, it requires knowledge of health trends of the affected population, how the service provider community understands and reacts to those health trends, and how these trends are affected by the place they are located to be able to effectively address access barriers and disparities.

CHAPTER 3: STUDY AREA AND METHODOLOGY

3.1 Introduction

This chapter discusses the operationalization of the study areas and methodology for this research. The methodology applies to; (1) the protocol for selection of counties, (2) the application of a case-study approach across rural and urban areas, and (3) data collection and analysis. The first two points are addressed in 'study area' sub-section. The third point is addressed in the 'methodology' selection. As a reminder, the research questions are listed below:

1) What challenges and opportunities do providers face providing healthcare to the newly arrived Latino population and how are they adapting to/overcoming challenges?
2) How do these challenges vary across different destinations that are different in location, scale and place-based dynamics?
3) What are the impacts of understanding these differences towards improving healthcare service provision for Latinos?



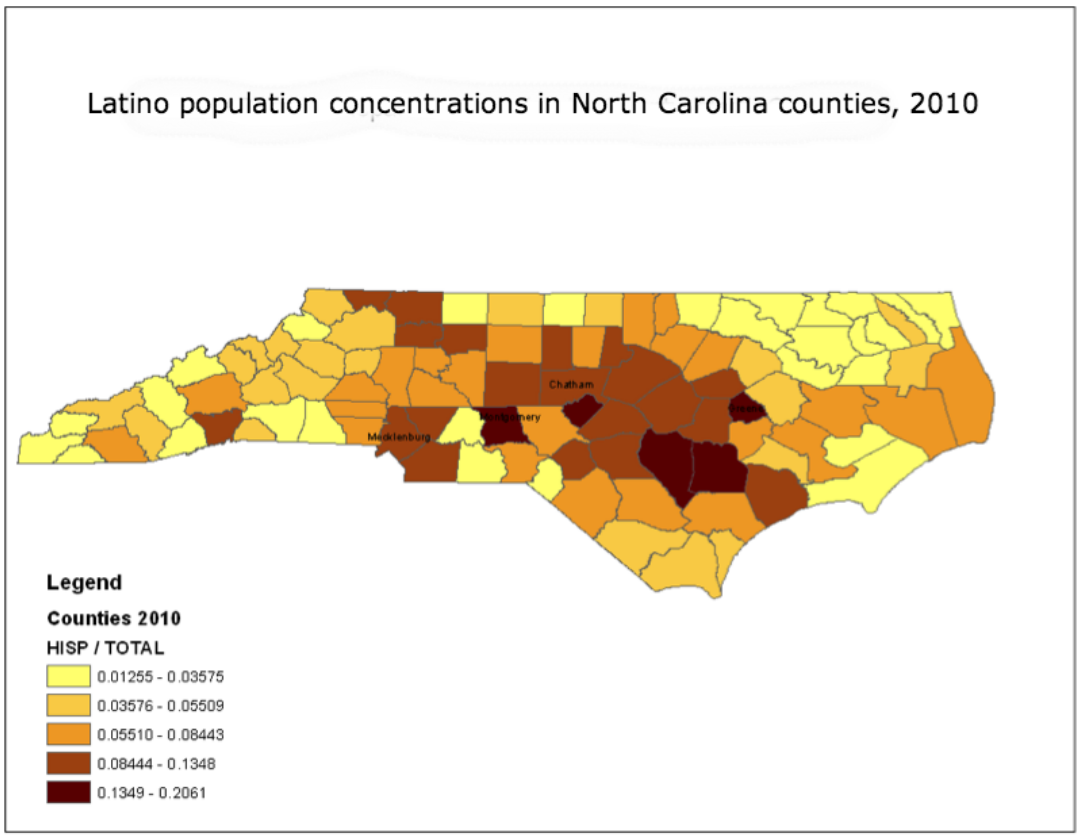


FIGURE 3.1: Latino population growth: 2000-2010 by North Carolina county

3.2 Study Area

This comparative study examines healthcare service provision in three North Carolina counties; Mecklenburg, Chatham, and Greene (see Table 3.1). The methodology for choosing these counties is three-fold: (1) they have relatively similar Latino population growth rates as well as percent Latinos of the total population, (2) they range across urban and rural areas, and (3) they represent a diverse continuum of push/pull factors for Latino settlement as well as community response to that settlement. Mecklenburg and Chatham counties are urban and have been recognized as Latino settlement hotspots since 2000 (See Smith and Furuseth 2004 for Mecklenburg; Johnson-Webb 2002 for Chatham). Most Latinos residing in Greene County, which is rural, are employed in agricultural occupations (Torres et. al. 2003). Choosing counties with similar rate of growth and percent of population characteristics has been utilized in a previous study measuring healthcare for the Latino population in the U.S. Midwest (Casey et. al. 2004). This study expands on this model of similar population growth rates across counties.

In assessing health care service and coverage, health care and geography researchers often address the issue of rural versus urban[2]. However, utilizing the dichotomous concept of 'urban' and 'rural' often oversimplifies the enormous disparities and differences that can occur not only across urban and rural places, but within urban and rural communities. This was the statement of a research study examining healthcare coverage in two 'rural' North Carolina communities. The two small towns were located

[2] For an expanded discussion of the literature regarding healthcare service in urban versus rural counties please refer to earlier sections of this document.

in an urban county that was a part of a metropolitan statistical area in the central part of the state. Rather than calling the study areas rural or the larger county urban, the researchers focused on a 'rural-to-urban continuum' (Gesler et. al. 1997). Importantly, the study found that variables such as 'health-insurance status', 'perceived health status', and a driving/access to vehicles were more significant than traditional demographic variables in determining health coverage. Finally, the authors called for more comparative studies along a rural-to-urban continuum that utilized the previously listed variables, so that differences based on place and locality can be considered (Gesler et. al. 1997). The political, social, and economic situations of each county are now detailed in order to understand their fit into the urban-rural continuum.

TABLE 3.1: Study counties

County	Total 2009 population	Total: Hispanic or Latino (2009)	Percent Hispanic or Latino (2009)	Total Hispanic Change; 1990-2009	Percent Total Change; 1990-2009
Mecklenburg	913,639	100,625	11.0	93,932	1403.4
Chatham	64,772	8,199	12.7	7,635	1353.7
Greene	20,658	2,766	13.4	2,597	1536.6

Source: U.S Census Bureau 1990 and 2000; American Community Survey 2009

Mecklenburg County is the largest in North Carolina and also has the largest Latino population. It contains Charlotte, the largest city in North Carolina. As discussed earlier, Charlotte was recognized as a pre-emerging gateway city by Singer (2004) due to its rapid Latino population growth in the 1980s and 1990s and continual, sustained growth into the twenty-first century. Charlotte has been economically 'reconstructed' due to the growth of its financial and banking industry; Charlotte is now a leading financial center in the United States and internationally (Smith and Graves 2003). This larger

economic growth resulted in demand for construction and related service positions, including landscaping. Additionally, increased labor demands were concurrent with the availability of affordable low-rent housing (Smith and Furuseth 2004). This combination of economic opportunity and low living costs for Latinos spurred impressive rates of migration and settlement. The city and county have struggled in response to provide services to the Latino population, but the county has strong advocacy organizations and a presence of community-based research collaboratives that seek to identify service access barriers and reduce them. One such collaborative is the Mecklenburg Area Partnership for Primary-Care Research (MAPPR). MAPPR has studied issues of healthcare access for the Hispanic population in Charlotte. The studies are built upon a foundational and collaborative research network of healthcare service providers, academic researchers, community advocacy organizations, and other involved stakeholders in the community. And while these healthcare access-related studies have found disparities on a micro-scale within Charlotte, they nonetheless establish that a network of healthcare exists in the area (Dulin et. al.2010).

Chatham County is a small urban county located in central North Carolina. Located within Chatham County is Siler City. Siler City has been a destination for Latinos due to economic restructuring and employment opportunities surrounding agricultural, manufacturing, and service sectors. One of the first North Carolina studies examining conditions of Latino employment, migration, and settlement conditions was conducted in Chatham County in the mid-nineties (Cravey 1997). Latino settlement in Chatham County began to rapidly increase in the early 1980s due to increased jobs in the poultry processing industry. While this earlier migration was primarily men seeking

employment, women and children also began to settle and transform Siler City and surrounding areas through the 1990s. Key to this study was its treatment of local community response to Latino settlement. By the mid-1990s estimates were that the Latino population made up over forty percent of the labor force. But low availability of housing and resulting competition between Latinos and the local population resulted in hostile treatment and negative attitudes (Cravey 1997). Many of the poultry processing facilities that originally attracted Latinos have shut down or changed ownership. One reason is changing economic conditions. Also, pressure from federal immigration enforcement (I.C.E.) has resulted in employers laying off undocumented workers. This has created a situation of economic strain and flux for the Latino community, and as a result they are struggling to access and pay for appropriate health services.

Greene County is the smallest in terms of population of all the study areas. It lies within the Central Coastal Plain of North Carolina and in 2009, had the largest Latino percent of total population of the four study areas. Greene County has a large agricultural presence and has been the source of Latino labor and settlement since the 1980s. In a qualitative study of 139 Latino families in Greene County conducted in 2006 over 40 percent of the families were employed as ‘farm workers’; building and construction was the second highest category at just over 25 percent (Torres et. al. 2006). In the same study, respondents were asked what they liked about living in the rural environment of Greene County. “Clinics/Health Services” was a choice but only received ten percent of the votes. The number one like was the peace/tranquility of the rural environments (Torres et. al. 2006). This suggests that, while Latinos might choose rural areas for their

non-economic, quality of life attributes, they sacrifice in the quality and perceptions of the clinics and health services available to them.

3.3 Healthcare Infrastructure in Study Counties

As the largest county in North Carolina in terms of total population and Latino population, it logically follows that it has the largest healthcare infrastructure network of any of the study counties. The largest healthcare network is Carolinas Healthcare System (CHS), a not-for-profit system which is actually the third largest integrated healthcare network in the United States. In fact, the hospitals and clinics represented by CHS provide over 85 percent of the care to underrepresented populations in Mecklenburg County (Dulin et. al. 2010). Piedmont Healthcare is another health network serving North Carolina. Among the many specialty care services that these networks provide are prenatal and pediatric care, family medicine departments, and primary care. Alongside these health networks are a wide range of general health clinics and pay-for-service physician's offices that serve the county's Latino population.

According to U.S. Census 2010, the total number of Latinos living in the smaller two study counties is roughly 10,000 (Chatham 8,199; and Greene, 2,766). This represents approximately ten percent of the total Latino population in Mecklenburg County alone. Because of this, the health infrastructure networks in these study counties are understandably much smaller. That being said, each county has a fully functioning county health department with general clinic services. Additionally, located within each county is a general hospital that is part of a larger, regional healthcare system. The

exception to this is Greene County, which did not have a general hospital with emergency room services.[3]

The largest healthcare organization in Chatham County is UNC Healthcare. This network is owned by the state of North Carolina and primarily conducts its operations on campus of the University of North Carolina in Chapel Hill. Chatham Hospital is a part of UNC Healthcare and is located in Siler City, the largest city in Chatham County. Chatham Hospital contains a 24 hour emergency department as a well as a wide range of specialty services including cardiac, radiology, and surgical. The hospital is expanding and recently opened a new administrative building called Chatham Medical Park in close proximity to the main hospital. Another healthcare organization is also located in Chatham County; Piedmont Health. Piedmont Health provides medical services, dental care, pharmaceutical services, and other services across counties in central North Carolina. Siler City Community Health Center is a branch location of Piedmont health in Siler City, North Carolina. This health center provides primary care to residents of Chatham County. The Chatham County Health Department is located in the city of Pittsboro, the county seat. The health department has a fully functioning clinic that provides general care to the community as well as immunization services, primary care services, and maternity care. It also provides a postpartum home visiting program where a nurse travels to the home of the new mother and baby and conducts health checks and assessments. A satellite health department clinic also operates in Siler City.

The largest healthcare organization presence in Greene County is Community Partners HealthNet, Incorporated. Through community health centers, clinics, and

3 Healthcare networks by county and their websites: Greene County (Community Partners HealthNet—Greene County Health Care www.cphealthnet.org/greene.htn), Chatham County (Piedmont Health www.piedmonthealth.org/siler-city-community-health-center and Chatham Hospital part of UNC Health Care www.chathamhospital.org).

services (including dental) this organization serves over 130,000 a year; with focus on the underserved population. Underneath this umbrella health network is Greene County Health Care network, which contains six health facilities in Greene County. The majority of these facilities are located the city of Snow Hill, which is the county seat and largest city of Greene County. The Greene County Health Department offers an array of services focused on women's and children's health. These services include "Women in Crisis" or WIC, and mammogram screening programs. As mentioned earlier, there is no hospital in Greene County. The closest hospital is located in Greenville, about 25 miles to the east of the county.

Across all counties, consistent service provision patterns emerge that ultimately decide the types of health providers that will be recruited to participate in the study; prenatal and pediatric care, and family medicine/primary care. This is due to the availability of these types of providers for each county (especially in Greene County that does not contain a hospital or many specialty care options). Due to the role of health departments in health care and service provision across the study areas, they will also be included as target sites for provider recruitment in the study.

Among the two smaller study area counties, a spatial trend emerges where the majority of health care locations and services are isolated to one or towns in those counties. Cities/towns such as Snow Hill in Greene County, and Siler City in Chatham County are central points that the community in those counties most often must travel to in order to receive services. Additionally, hospitals and clinics in the study areas are often a part of a larger healthcare network or infrastructure that extends over many counties, or even across state lines. These emerging spatial and scale-based trends reinforce the need

to discuss issues of healthcare service provision to the Latino population in the context of geography. Specifically, how do places of healthcare provision affect healthcare service outcomes for the community, and what role do larger-scaled healthcare networks play in healthcare service provision?

3.4 Methodology

3.4.1 Qualitative Methodology—Thematic Analysis

This research utilized qualitative methods. Qualitative methods are frequently used in studies of immigration geography (Johnson-Webb 2003), health services and experiences (Errico and Rowden 2006), and health geography (Curtis et. al. 2000). In terms of the specific qualitative methods used in this study, thematic analysis was the primary method and key informant interviews were the form of data collection. Thematic analysis is "…a process that involves coding and then segregating the data by codes into data clumps for further analysis and description" (Glesne 2006). Thematic analysis allows the investigator to categorize and prioritize the method of data collection, in this case key informant interviews, into such a way where potential themes will emerge that evolve out of the initial research questions. In this way, even though the larger research questions guide the data collection process for the investigator, eventual themes that emerge are organic and ultimately shaped by study participant responses. A logical organization of the data analysis process is presented in Figure 3.2. Specifically, the identification of emerging themes was determined by the consistency of their presence across interview transcripts. Each transcript was examined and analyzed for similar ideas and words in the first reading. Upon subsequent readings a list of investigator identified quotes were organized and categorized into themes. Finally, an examination and analysis

of each transcript occurred where pertinent quotes and content were placed into the thematic categories.

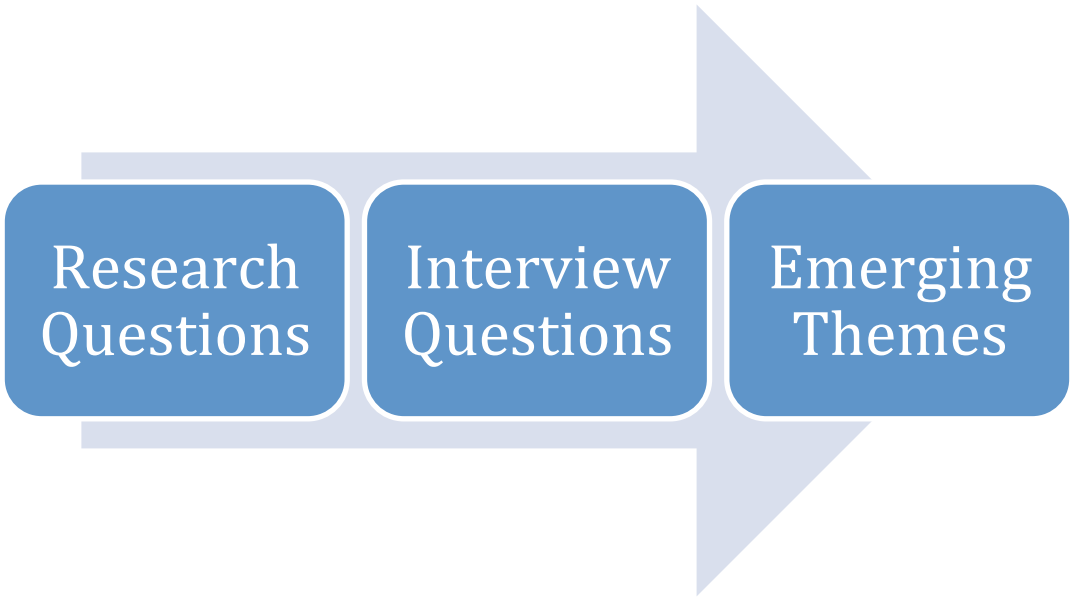


FIGURE 3.2: Thematic analysis of key informant interviews

3.4.2 Data Management and Validity

Broad 'a priori' categories formed the beginning of the thematic analysis. A priori themes are those that can be identified from existing research (Curtis et. al. 2000). These categories included the interview questions, place themes, and barriers to access themes (these categories are discussed in more detail later in the methodology section). First, the investigator applied the 'long table' method. In this method, interview transcripts were compared and where similar quotes existed they were actually extracted from the word document and placed into an entirely new document (Curtis et. al. 2000). An example of a priori thematic analysis utilized in this study is employment/labor's impact on Latino healthcare service provision in the study counties (Cravey 1997). The investigator identified sub-codes i.e.; plants, construction, poultry plants, agricultural, tobacco,

documentation, documents, farmworker, etc. The presence of these codes across provider transcripts confirmed that employment was, indeed, a major a priori theme in the analysis. In another example of a priori themes, it is widely accepted that health insurance status impacts healthcare service provision for immigrant and undocumented populations. In provider responses across study areas, insurance became a major a priori theme because of its absence. Virtually no one from the providers' patient populations had access to insurance, which significantly and negatively impacted healthcare status.

Whereas a priori themes were identified in the literature, emergent themes identified in the analysis were not necessarily established in the literature. From these similar groups of statements emerged codes that where then broadened into larger sub-themes and over-arching themes. An example of how an emergent theme (provider leadership) was coded by the investigator is presented at the end of this study in Appendix B.

Because of the magnitude of the data, confirmation of themes was achieved using the computer software analysis program NVivo10 by QSR International©. NVivo has been used by many social scientists and health researchers in assisting with thematic coding and analysis (see Cabassa et. al. 2007). Validity or 'trustworthiness' of qualitative analysis is always an important issue due to the subjectivity of the data and the positionality of the researcher (Glesne 2006). To ensure validity, the investigator triangulated a priori and emerging themes utilizing NVivo software and the long table method. This was carried out by importing documents created from the long table method directly into NVivo, and comparing analysis results with word queries and coding from the computer program itself.

3.4.3 Data Collection--Interviews

In this study, the qualitative method that the investigator employed to collect data is in the form of key informant interviews. In a Robert Wood Johnson Foundation initiative title "The Access Project," key informant interviews were defined in a community and healthcare system context:

> "The key informant interview has a very specific purpose. It involves identifying different members of your community who are especially knowledgeable about a topic…and asking them questions about their experiences working or living within a community or health care system…The interviews provide structure and consistency to information-gathering and are especially suited to getting a picture of a particular environment and how it works – a local health system, political relationships, community organizations, etc" (Sherry 1999).

Additionally, the Dictionary of Human Geography specifies appropriately what qualitative interviews in geography do and don't do in the following passage:

> "The aim is not to collate typical responses to pre-defined questions from a random sample, or to generalize about the views of a population, but rather to record in complex detail the opinions and ideas of a relatively small number of individuals or groups who may have been selected systematically for the light they can cast on a particular area of sociological concern" (Johnston et. al. 2000).

Participants that were eligible to be included in the study were providers of healthcare and health-related services in each study area. Front-line providers were the first to be contacted for participation in the study. These providers included physicians, nurse practitioners, nurses, hospital staff/interpreters, and community service providers. Subsequently, hospital administrators and managers, as well as community organization service administrators were also included in recrutiment. In the first stage of identifying key informants, these groups of physicians existed in each study area thus allowing for consistency in the recruiting process.

TABLE 3.2-Hierarchical structure of key informants

Stage/Type of Provider	Scale of Analysis	Sampling Method	Sample Size
Front-line providers 1. Clinic/Primary-care Physicians 2. Pre-natal/Pediatric Physicians 3. Community Service Providers Second Stage 4. Nurses/Physician Assistants 5. Hospital staff/Interpreters 6. Hospital Administrators	Individual/ Community	Purposive and Snowball	30 total; 10 in each county

In the first stage of recruiting study participants, front line providers were contacted through telephone and email under purposive sampling methods. Purposive sampling involves investigator-initiated contact with study participants that have direct experience with issues related to the study's research questions and aims. This method of sampling is often used in key-informant interviews where the participants' expertise and experience is required (Johnson et. al. 2000). Studies and general reports have shown that the Latino population accesses healthcare at local clinics versus specialty-care practices (Cordasco et. al. 2010). In addition to clinic and primary-care physicians, pre-natal and pediatric physicians and community service providers are also contacted by telephone or email. Among the Latino population the fasting growing age cohort are children and adolescents, due in part to high birth rates among Latino women. Another reason for looking at prenatal and pediatric care is that, in North Carolina communities, recently

arriving Latino populations are more represented by women and children whereas before they were primarily migrant, single men (Johnson et al. 2000). Additionally, through public insurance plans and citizenship status Latino children are more likely to be insured and have access to care than older cohorts (Wie et. al. 2008). In many cases, Latinos do not have any insurance and little-to-no English proficiency upon arrival into new emerging gateway destinations. Because of this, they will often seek referrals and counsel from community service providers.

Participants in the administration and managerial sectors were contacted through the same methods. Through snowball sampling initial physicians and community service providers were asked to identify potential participants within their clinic or practice. Snowball sampling involves a form of exponential participant increase as initial participants lead the investigator to potentially multiple future participants (Johnson et. al. 2000). These second stage potential participants were then contacted by telephone or email.

Table 2 includes a column called ‘scale of analyses’. Important to the research methodology is that it intersects across multiple scales; particularly individual, neighborhood, and more broadly (county, state, national). For example, many interview questions with healthcare providers address perceptions and experiences that they have with individual patients. In other questions, study participants are asked to comment upon neighborhood or community impacts and issues with health service provision (for question examples refer to Table 3.3).

Upon contact with providers, they were screened to determine if they provided healthcare or health-related services to the Latino population living in their study area

(county). If this is the case, they were invited to participate and arrangements for an interview were made between the investigator and provider. Through this method, thirty providers were recruited to participate in the study, ten in each county. The investigator was initially concerned about only having ten participants in each county, however, a degree of saturation was reached in provider comments with this study population as evidenced by repetition amongst respondents across question guide and study areas

All interviews were conducted in places that were comfortable with the participant. These places included offices, conference rooms, and coffee shops. The interviews were conducted in a timeframe between 45 to 60 minutes. The interviews were conducted by the primary study investigator and were audio recorded. Additional notes and comments were made by the study investigator as needed. The interviews were conducted in English. Each participant was directed through the interview question guide (see Appendix A). The audio-recorded interviews were transcribed into word documents where they were analyzed by the investigator. The information provided by participants was kept confidential. Any identifying information mentioned during the interview was removed from electronic and subsequent paper documents. All documents, whether in electronic or paper form, were kept in secure locations. Electronic documents were password protected on the investigator's personal computer, and paper documents and electronic storage devices were kept in a locked office.

3.4.4 Provider Sampling Issues

As part of the research design and inclusion criteria for the study, only health care providers that had Latino patients as part or all of their patient population were allowed to participate. Understandably, the investigator wanted to gain perspective from providers

directly serving the Latino population. This requirement brought with it sample size and validity issues that arose during the processes of participant recruitment and analysis. Studies have shown the importance of bilingual, culturally-competent, and minority physicians when researching healthcare barriers and access for Latino population (Gresenz, et al, 2009). Ultimately this research tapped into a sample for whom these characteristics were common. However, previous research has demonstrated that this is not the norm for many communities experiencing unexpected and rapidly growing Latino population growth. Additionally, in the smaller and more rural study areas, finding a suitable amount of providers that were willing to participate in the study from cold-contact methods was extremely challenging for the investigator. Particularly in the rural county, in-person recruitment and snowball sampling was needed to gain the interest and trust of provider participants. Though this in-person recruitment resulted in the eventual sample size needed for each county, the recruitment process itself required extensive relationship building efforts with the investigator involved in discussions with providers of the importance and passion of health provision issues for Latino patients in pre-emerging immigrant gateway places. Some providers chose to be a part of the study following these discussions thus introducing another likely element of bias into the sample.

3.4.5 Study Questionnaire

As discussed earlier (see *place in geography and health—Literature Review)* effects of place on health service provision can only be identified and determined through the contextual understanding the overall state of health service and community attributes (real and meaningful) that construct those places. Therefore, research questions 1 and 2

are more concerned about understanding, through provider perceptions and experiences, these contextual factors. Question 3 becomes focused on placing health services challenges and issues in the vein of place dynamics.

TABLE 3.3: Question list

1) Please describe your patients. Where do they come from? What do they do?
2) What barriers do you encounter providing healthcare to your Latino patients?
3) Have the barriers remained consistent over time? Have new barriers emerged (or dissipated) recently? Why do you think this is?
4) How do you think that place (the town, the city, community) where you do your work impacts how you do your work or how the Latino community navigates their health care?
5) What challenges do you perceive Latinos face in accessing healthcare in your city/county that they might not experience in other cities/counties in North Carolina?
6) Do you consult/work with other providers in (x) county/city to discuss issues of Latino healthcare service/access issues?
7) Do you consult with providers in other cities/counties in North Carolina or even other U.S. states?
8) What are the top three positives about providing care to Latinos in your community?
    a. What are the top three negatives?
9) Have you been able to change (either personally or through other resources) your service delivery methods to reduce barriers to Latino service that you have encountered?
10) Have you had to go outside resources available in your county to seek solutions to healthcare service issues for the Latino community?

3.4.6 Descriptive/Supporting Analysis

A second source of data in the form of descriptive provider surveys was utilized. Each provider is asked to supplement information received in key informant interviews. Key to this survey is finding out characteristics regarding the participants themselves as well as the type of services they provide along with their experience as providers. Items on the survey include;

-Ethnicity, Gender, Age, Bilingual status

-Type of provider (specialist, primary care)

-Employer (private practice, hospital system, county, etc.)

-Years as a service provider

-How long serving (in some capacity) Latinos

This information allowed cross-referencing of interview responses based upon the above survey responses. For example, do bilingual providers provide similar challenge responses as only English speaking respondents? The survey instrument can be accessed in Appendix A. This descriptive analysis was important not only for identifying characteristics of the providers, but allowed the investigator to categorize a priori and emergent themes based on provider type.

3.4.7 Field Notes

Throughout the data collection process, the investigator kept field notes about characteristics of the study areas to support other forms of data. Examples of these characteristics included notes on; where community members lived, the types of households they lived in, the location of provider facilities, the distance between residential and service provider locations, and major employer locations. These field notes were used as needed to provide context to provider interview responses, descriptive statistics, and provider survey analysis.

CHAPTER 4: A PRIORI THEMES

4.1 Introduction

This chapter begins the process of analyzing, reporting, and critically discussing the results of data collected through the research process. The goal of this chapter is to confirm a priori themes of the challenges providers experience or perceive in healthcare service provision. This goal is carried out through the context of the first research question. The key data source utilized in this chapter is interview transcripts analyzed both by investigator thematic analysis and with the aid of NVIVO qualitative software. Additionally, field notes and secondary data sources describing the health and socioeconomic characteristics of the study areas and population are incorporated into the interview comments to provide depth and context where needed. Characteristics of the study participants are described in the first part of the chapter. In the second part, analysis results and primary themes are presented based upon provider comments.

4.2 Study Participants

Figure Group 1 shows the types of characteristics that were identified for each participant of how those characteristics are classified. This data was collected through surveys administered and completed by providers during the interview[4]. Each characteristic was self-identified. The 'Language' characteristic refers to if the provider

[4] 20 of the 30 providers completed surveys. This completion rate was due to the fact that many providers only had limited available time, which did not allow for the survey. In these cases, data was confirmed through provider transcripts and subsequent contact with the provider. It is stipulated in the IRB for this study that completion of the survey was not mandatory; in fact, general participation in the study is voluntary.

speaks Spanish with patients/clients. It was important to the investigator to go further than the classification of bilingual or Spanish-speaking to being able to use Spanish in service-delivery, as that requirement is needed to be able to attempt to overcome the language barrier between provider and patient (Jacobs et. al. 2001). The 'In-County' characteristic refers to if the provider works full-time in the study county (designated as 'full-time'), or if the provider works in multiple counties; only part of the time in the study county ('part-time'). This characteristic proves to be important where providers are employed through multi-county healthcare networks or university collaborations.

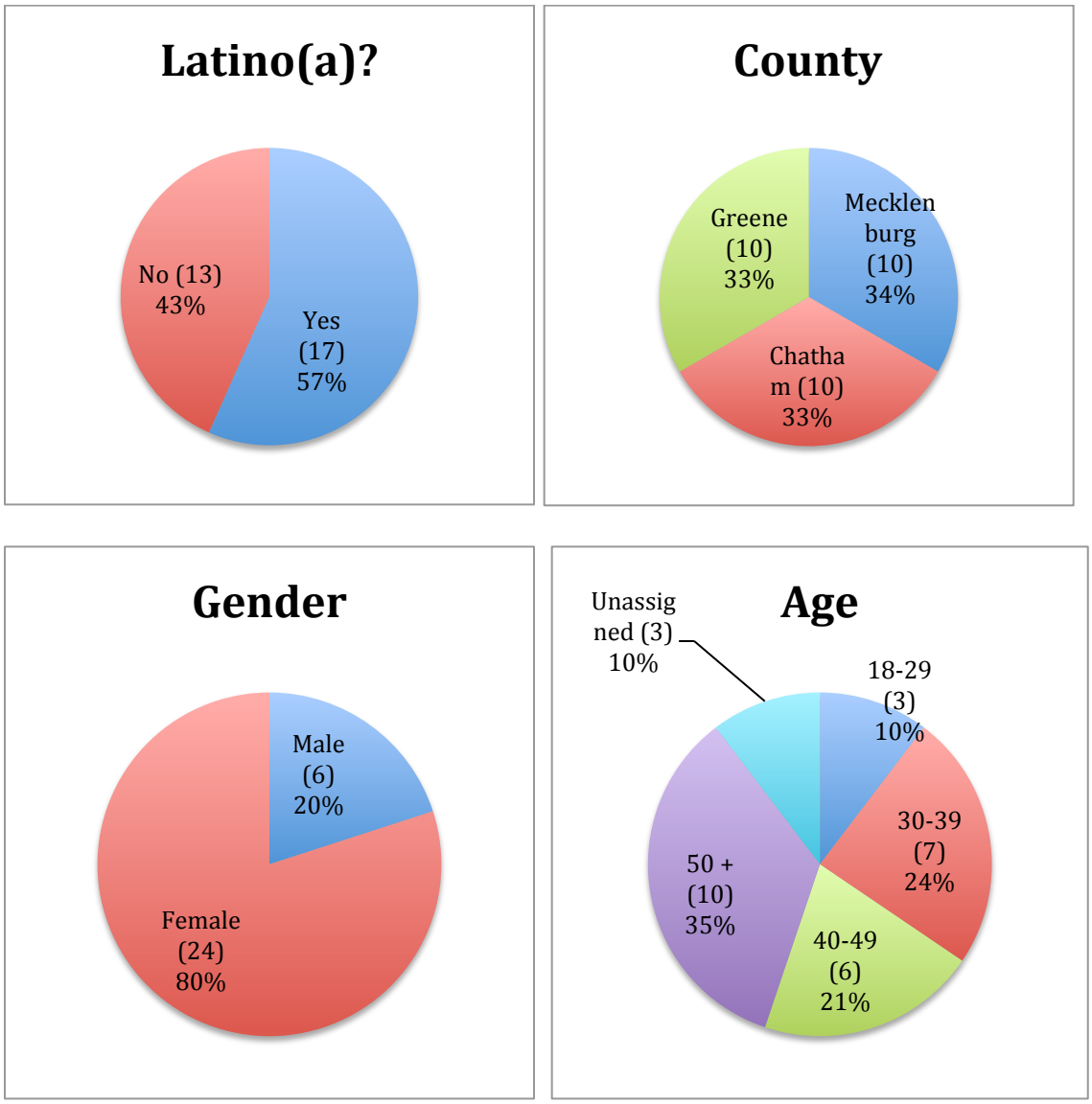
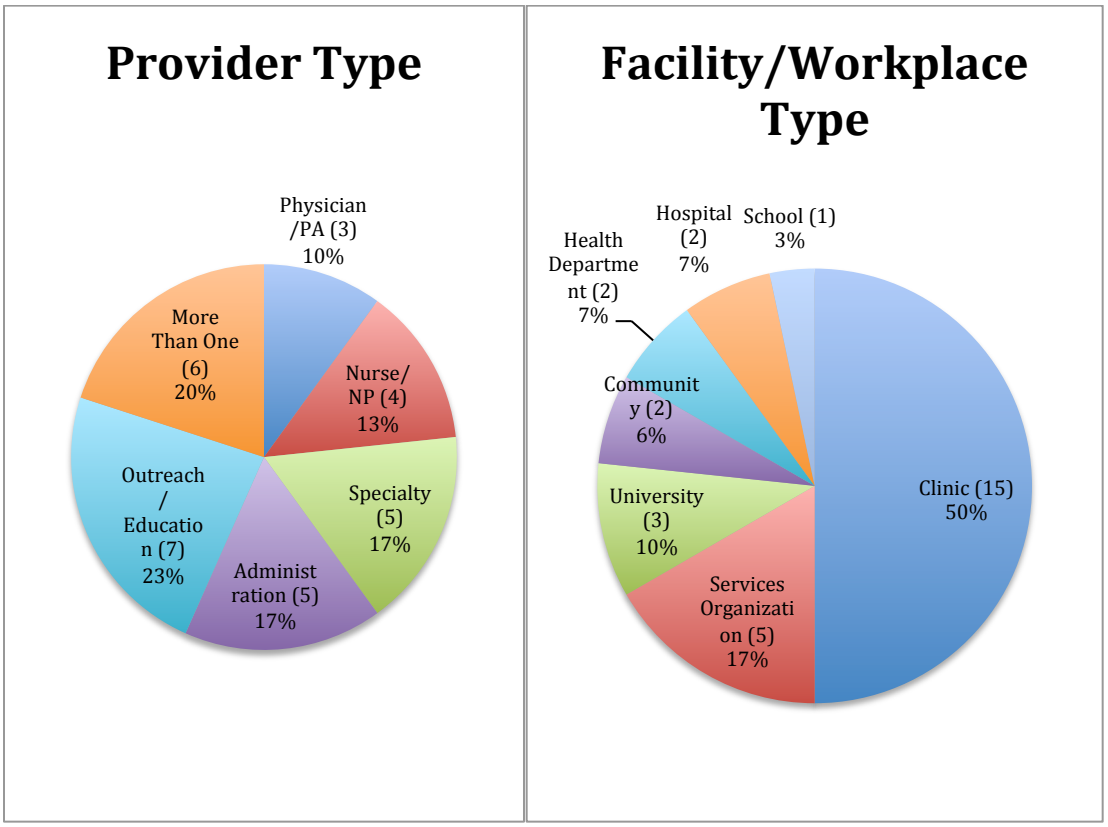


FIGURE 4.1: Classifications of study population characteristics (N=30)



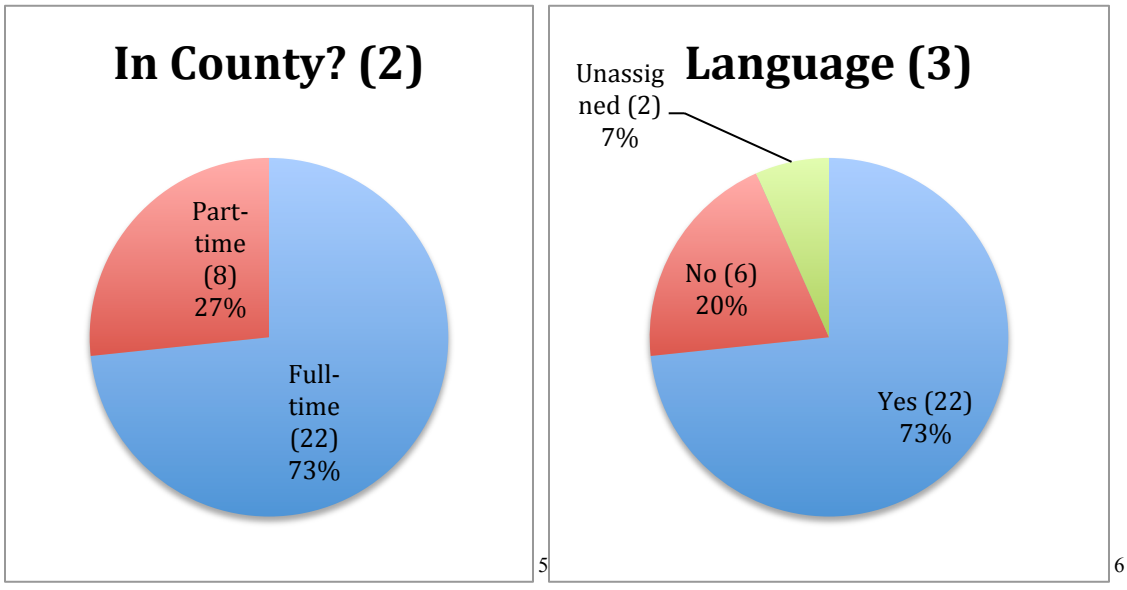


FIGURE 4.1: (continued)

[5] Refers to if the provider only works in the study county (full-time), or in many counties (part-time).
[6] Refers to if the provider speaks Spanish to his/her patients.

The total study population was thirty, divided equally between the three study areas. Fifty-seven percent of the providers identified themselves as Latino(a). And regardless of ethnicity, 73 percent of providers speak Spanish while providing service to their Spanish-speaking patients/clients. The National Alliance for Hispanic Health (NAHH 2001) has identified having language and culturally-similar attributes as important factors in improved provider-patient communication and perceived quality of service to Latino community[7]. Eighty percent of the providers are women. Even though this percentage seems high, actually The Centers for Disease Control and Prevention state that, across the field of 'Healthcare Workers', 80 percent are women (CDC 2013). Also, among the age cohorts, the largest representation is '50 or greater', at 30 percent. Overall, a majority of providers in the study are over the age of 40. Across the study counties, and North Carolina, the fastest growing age cohort of the Latino population is under 18. And while providers ages are older than this, these providers fit into larger trends that the healthcare industry is aging. By 2030, an additional 13,500,000 plus healthcare providers will be need to be added to the workforce each year to maintain current provider-to-patient ratios (Harrington and Heidkamp 2013). All of this is to say that, issues of increasing and sustaining both Spanish-speaking and Latino(a) providers are very real, but are also in the context of larger-scaled challenges of replacing the aging healthcare workforce.

The majority of providers work in clinic settings. And these tend to be safety-net clinics that are either funded through their own sources, or are a part of a larger

[7] It is important to note that these percentages are a reflection of the study requirement related to the service-provision to Latinos as outlined in Chapter 3. McGee and Fraher (2012) have recently found that North Carolina's healthcare provider diversity, while growing, is still less than the state's population diversity.

healthcare network. Other primary workplace types include; service agencies, hospitals, schools, and directly in the community. Twenty-seven percent of providers do not work exclusively in their study county. In fact, a few of these providers are based in other counties, and spend a day or two a week in the study county (Figure 4.1).

Among the types of provider categories, the divide between direct-care providers, and outreach/education or health services providers is roughly split in the middle. Of the direct-care providers, three are physicians or PAs, four are nurses or nurse practitioners, and five are in specialty care fields including dentists, mental health providers, and substance abuse providers. Also, there are three cases where a direct-care provider is also significantly involved in administration or outreach/education; in these cases they have been assigned to the 'More Than One' category. In the non-direct care provider stream, five are in the administration field. This includes agency directors and operations managers. Seven are in outreach and education. This includes research investigators, outreach program managers, and the community health workers (promotores). Finally, 'do-it-all' providers fit in to the 'More Than One' category. These providers interpret, triage, do screenings, and participate in outreach/education.

Upon further comparison of these study characteristics, a few trends emerge. The first trend, and most obvious, is that the 'Language' and 'Latino' characteristics are highly correlated. No provider that identifies as Latino(a), do not speak Spanish during service provision with the patient/client. However, five non-Latino identified providers do speak Spanish (two providers did not make any language identification because they did not fill out the survey. This was due to time available.). The second trend is that every provider that did not identify as Latino or speak Spanish was over the age of 50 (and one

provider did not have an assigned age). This includes two providers that did not have an assigned language identification, and in total makes up 27 percent of the study population. To put it another way, 70 percent of providers over the age of 50 did not speak Spanish to patients and did not identify as Latino. This trend fits in with larger demographic restructuring in new, Southern destination places that had high median-aged populations demographically restructured due to high immigrant growth rates (and younger) (Lichter and Johnson 2009; 2006; Barcus 2006). The last trend is that 70 percent of non-Latino providers are in Chatham County. However, some of these providers do speak Spanish to their Latino patients. The implications of stating this are not to project that Chatham County has fewer Latino, Spanish-speaking providers than the other two counties. That is impossible given the sample size of the study. However, it is important to delineate these study characteristics with the potential of different answers among the study counties (cultural competency, provider-patient communication) due to cultural/ethnic differences among the providers recruited for the study (NAHH 2001).

Despite these emerging trends that focus on the characteristics of the non-Latino/non-Spanish speaking providers, a few overall conclusions about the study participants can be made. The providers are overwhelmingly women. This is interesting based on the presence of similar research studies focusing on women's health (Horwitz et. al. 2008; Wilson and McQuiston 2006). The majority of the participants do speak Spanish to their patients/clients. This is in and of itself is very important to overcoming cultural competency and provider communication barriers and issues to Latinos (NAHH 2001). Just over half of the providers work in clinic settings, and most provide care full-time in the study county. For those that do not work full-time in the county, their

employment is usually associated with a partnership between a clinic and university healthcare/hospital collaboration (Zambrana 1996), which is an emerging theme further discussed and analyzed in Chapter 5. Also, just over half of the providers identify as Latino, and are over the age 40.

4.3 A Priori Themes

As this study is interested in defining challenges to healthcare service and access in place-based contexts, the descriptions and analysis of a priori thematic confirmation is divided into three sections; one for each study county. However, these sections of the chapter are more descriptive than analytical, in part because of the sobering fact that they confirm that identified and established challenges and barriers to healthcare remain in place. These well documented, a priori themes, include; insurance (or lack-thereof) (NAHH 2001; Wie et. al. 2008), documentation status (Ku and Matani 2001; Marshall et. al. 2006; Bustamante et. al. 2010), language (Fiscella et. al. 2002; Dubard and Gizlice 2008), and transportation (Carillo et. al. 2011; Gentry et. al. 2007). These themes also are identified and discussed in the study county sections, and other themes are included where they were identified in provider responses.

As mentioned in the methodology, the importance in data collection and analysis was from the perspective of the healthcare provider towards their Latino patients across the study areas. This is because the provider perspective is often not mentioned as often as the patient or environmental perspective in these studies. Another important consideration as these counties are analyzed and discussed in their place in the perspective across urban to rural areas. These core thematic considerations are discussed alongside analysis where necessary.

4.4 Mecklenburg County

As a place, Mecklenburg County is far larger in population than the other, more rural-based counties. This county reflects the 'urban perspective' in relation to the comparison across urban to rural places. Based on field notes, the healthcare service network for Latinos in this county is larger and more complex. Providers were more spread out, not only over different types of provider agencies, but also geographically. However, providers interviewed for this study practiced in locations that were relatively near concentrations of the Latino population. Similar to the other counties these areas had physical access barriers to the points of service. Many of the agencies/facilities were close to main highways that would make it difficult for a pedestrian. Overall, Mecklenburg County is distinct as a large urban county with virtually none of its Latino residents living in rural-like conditions.

The major themes of challenges Mecklenburg County providers experienced or perceived were; patient's lack of insurance, un or under-employment, documentation, fear/mistrust, lack of education and health literacy, and cultural misperceptions. Of course, these challenges did not emerge independently of each other, but were rather interwoven through provider responses.

Latinos in Mecklenburg County access and receive healthcare through a variety of formal and informal networks and institutions. (Tapp et. al. 2013(a); 2013(b); Dulin et. al. 2012; 2011) The Mecklenburg County Health Department conducted an assessment of healthcare needs for the entire county population and determined areas in which to focus attention. One of these focus areas was 'access to care' (MCHD, 2012). Within the 'access to care' objective, five primary issues were addressed in provider surveys; (1)

insurance rates, (2) employment and it's association with healthcare, (3) federal and state programs (including Medicare), (4) local level, safety-net sources, and (5) the impact of the 2010 healthcare reform on access. In many ways, these issues are similar to the themes of challenges in participant responses. Particularly important are; insurance, employment, and local-level, safety-net sources. However, the unfortunate reality is that virtually every a priori challenge and barrier to healthcare access discussed in Chapter two was reinforced by Mecklenburg providers. And in many ways, these challenges and barriers become the context through which socio-economic, political, and place-based conditions at local, state, and national scales inhibit Latino healthcare access.

4.4.1 Employment

Latino population growth in Charlotte has been significantly occurring since the 1980s. Throughout the late 1990s into the early 2000s, native and immigrant communities moved to Mecklenburg County for jobs associated with the growing financial sector linked to the location of headquarters of major international banking institutions (Smith and Furuseth 2008). Reflecting the two-tiered nature of the service-economy, many of these associated jobs included construction and landscaping, which were occupied in large numbers by Latinos. This trend was confirmed in provider responses, where sixty percent explicitly mentioned construction as a primary source of employment for their patients and clients. One provider stated:

> "And they're mostly working in labor-type-force…construction…mainly construction. Some agricultural but mainly construction." *Mecklenburg, #2*

Most provider responses listed construction in a list of other jobs in which their patients and clients are employed:

> "We have a lot of construction workers, waitresses, day care workers, convenience store workers, gas station, landscapers, generally low wage jobs with no benefits." *Mecklenburg, #5*
> ---
> *"*Construction. Housekeeping. Factory jobs. What else can we see, yeah that's the main thing. I don't think I have somebody that work's in business. I do but, I can say probably two percent*." Mecklenburg, #3*
> ---
> *"*They do a lot of painting work, construction, lawn work, factory work, those are the kind of jobs I would say they do the most...work in restaurants, bussing tables, kitchen work, cleaning, a lot of cleaning services..." *Mecklenburg, #6*

These other jobs listed range across landscaping, cleaning and home services, and retail/restaurant sectors. These are jobs that tend to be low paying, part-time, and without benefits. This was confirmed by a provider discussing the job status of her patients:

> "Predominantly our patients are laborers, seventy percent are employed, a majority of those that are employed are underemployed meaning they can't get fulltime hours where they would get benefits," *Mecklenburg, #5*

The Mecklenburg County Health Assessment discussed the negative influence that low-paying and part-time jobs had on insurance coverage and associated access to care. The report had this to say regarding insurance:

> "Part-time workers are much less likely to have health insurance than full-time workers. In North Carolina, 42.9 percent of part-time employees are eligible for coverage at companies that offer it, and many work for small businesses that do not offer insurance. Even fewer part-time workers actually enroll in employer sponsored insurance, with only 22.1 percent of part-time North Carolina workers that are eligible for insurance through their employer actually enrolled…Low wage workers earn wages that at full-time work would leave a family of four below the poverty line. In employment establishments where over 50 percent of the workforce is considered low-wage, 34.6 percent of employees are eligible for and enrolled in insurance plans. In employment establishments where less that 50 percent are low-wage workers, 69 percent of employees are eligible for and enrolled in insurance plans" (MCHD 2012).

These statistics refer to the entire workforce in Mecklenburg County, not just the Latino population.

Latinos living in Mecklenburg County tend to be employed part-time or in low-income jobs, uninsured, and/or undocumented. In the cases where they are eligible for employer-based or state benefits, they are often not accessing said benefits (MCHD 2012). While specific data for the county is difficult to obtain, the county's health assessment specifically did not include the undocumented as; 1) they are non-eligible for most local, state, and national programs, and 2) they are not mentioned in the provisions of the 2010 Healthcare Reform Act. In Mecklenburg County, providers are resigned to solving service provision challenges without the aid of a larger-scale benefit infrastructure.

Employer-based health coverage comprises the largest source in the Charlotte MSA, according to the report. Approximately 65 percent of employers provide some form of health coverage, and 81 percent of employees are eligible for insurance. Of those who are eligible, 64 percent are enrolled in coverage (MCHD 2012). This particular data does not break down by ethnic group nor by those who identify as Hispanic/Latino.

4.4.2 Insurance

The ability to access health care is affected by the presence of insurance (NAHH, 2001). For the overall population at the national level, over 50 percent of the uninsured have no usual source of care, compared to less than 20 percent for those who are covered either through public or private insurance (MCHD, 2012). Other access barriers include "cultural differences regarding care, limited English proficiency, lack of knowledge of resources available, and/or how to navigate the system and incompatible locations of hours or service" (MCHD, 2012).

The consensus among Mecklenburg providers was that their patients and clients were overwhelmingly uninsured. As a result, many Latinos seeking access to care are waiting until their health problem is so severe that they must utilize the emergency department, or they go to no-to-low cost safety-net clinics. This consensus has also been shown in locally based studies where these effects impact greater cost and stress for patients, healthcare systems, and taxpayers (Tapp, et al., 2013; Dulin, et al., 2012). Personal and system-wide stress negatively impacts likelihood for the patient to access a healthcare facility and the ability of the facility to provide service.

4.4.3 Documentation

Recently arrived immigrant populations are especially susceptible to these barriers. The situation is even worse for the undocumented, where not only are they not covered by federal, state, or local safety nets, but are also not included in the 2010 health care reform. Regarding the undocumented, the report concludes, "the problem of access to health care facing the undocumented in our community will not go away with health care reform and will continue to be a challenge facing our community," (MCHD 2012).

Access to care as it involves the compounding barriers of employment, insurance, and ineligibility of government benefits, permeates from the demand to supply side for healthcare providers. One provider discusses these challenges as they pertain to clinic funding:

> "It impacts the ability for me to do my job in that it's hard to find funding for people who are misperceived as something else, or doing wrong, or not contributing. So, yes in a clinic that serves a large amount of Latinos all are not undocumented. It is still difficult they want to know percentages and the automatic assumption is that person is undocumented which is not the case." *Mecklenburg, #1*

Documentation affects health care access for a variety of reasons. However, the issue of documentation is a very sensitive one. On a national scale, issues of healthcare access for undocumented people are a well-known debate that has yet to be resolved (Marshall et. al. 2006). And national views on the undocumented and their rights to services, including healthcare, are mixed. Because of the small sample size and protection of patient privacy rights, providers were not directly asked about the documentation status of their patients or how documentation impacts their views on service provision. However, in some cases providers brought the issue up on their own volition:

> "Well, there's an immigration, of course another one that's huge. You know, a lot of our clients are usually coming here with some kind of charge…legal charge. And then, if they're already in the system, if they're not here legally or if they don't have…or if they're a resident they might have issues with immigration which then could cause them to...how do I say...it would just be a barrier." *Mecklenburg, #2*

In terms of documentation and health care access, one provider discussed experiences in families where one child qualifies for Medicaid because of being born in the U.S., and a sibling who was born outside the U.S. and may be undocumented does not qualify:

> Provider: "And sometimes they have one child who has Medicaid, but the other one doesn't qualify for Medicaid.
>
> Interviewer: Right. So you're saying one child will and one won't?
>
> Provider: Yes, because one was born here and the other was brought here." *Mecklenburg, #3*
>
> ---
>
> "So they then they go to Social Services and they can have a doctor. But with the other kids they are afraid because they don't have a Social, they don't have any legal documentation, and they don't, I mean, sometimes with the immigration people think that these people are taking advantage of the government. But, they don't qualify for social services, so that's why some of these kids have not seen the doctor in seven years, they are teenagers. Sometimes, the last time they saw the doctor was when they left their country. When they came here, maybe they just went to get the vaccinations. Because, the parents cannot afford to pay for the care, you know?" *Mecklenburg, #3*

The second passage discusses documentation as a barrier to healthcare access for kids that don't have a social security number. And because of the lack of documentation, these kids can go years without seeing a doctor. One final example of documentation prohibiting healthcare access involves medication:

> "Being undocumented is really hard. That's another issue we have because term medications that are not provided to undocumented people like insulin for example. There are certain brands of insulin that are not provided. That can be difficult when someone needs treatment with insulin and you can't give it to them or they can't afford it because it's too expensive. So I think undocumentation, not being legally here in the country is a big issue." *Mecklenburg, #4*

To provide clarification, insulin medication is offered on a subsidized scale to patients who qualify for Medicare and Medicaid. Undocumented people do not qualify, and because insulin medication can otherwise be very expensive, they are oftentimes not able to afford or access it.

The lack of insurance is a huge access barrier for Latinos to healthcare, and Latinos are less likely than non-Latinos in the U.S. to have insurance (CDC, 2004). Saddled with the issue of documentation status, many Latinos living across study areas did not have access to insurance even if they were employed. This trend is similar to other studies of documentation and insurance (Ku and Matani, et al., 2001; Marshall, et al., 2006). As a barrier, among the Mecklenburg providers, insurance was primarily only mentioned in the context that their patients did not have it.

4.4.4 Health Education and Literacy Among the Latino Community

The education and health literacy level of the participant's patients and clients repeatedly surfaced as challenges for Mecklenburg providers. And these barriers were

oftentimes combined in provider responses. One example is provided by a response from a Mecklenburg provider:

> "First and foremost would be not only literacy but health literacy. So number one, being able to understand typical, we're talking about the Latino community right, so just understanding general everyday Spanish. Then there's another level, being able to understand Medical Spanish and medical terminology, and how to take medicines. What's the proper way to function in a medical clinic? How to make an appointment, not just walk in, and those sorts of things..." *Mecklenburg, #1*

This passage discusses how low education levels and literacy among the Spanish-speaking population result in the lack of medical understandings and ability to navigate through the healthcare system. And it also speaks to access issues about being able to make an appointment, take medications properly, and have a basic understanding of medical terminology in English and Spanish. These health issues have been identified in other Latino health studies (Garcia et. al. 2005; Rhodes et. al. 2007).

4.4.5 Health Education and Literacy—Service Provision

As opposed to barriers that specifically inhibit a Latino patient's ability to access healthcare, provider responses in this study were more likely to revolve around education and literacy as a service-provision barrier to being able to provide quality care:

> "Sometimes they don't understand certain things in, like they didn't go to school in their country. So it's kind of difficult to make them understand what's going on with the kids. So you have to, even though I'm a native speaker, I have to kind of find the words to explain to them, in specific cases, what's going on with the kids." *Mecklenburg, #3*

In this case, the provider is a native speaker, bilingual and bicultural, who still struggles to disseminate health information to patients because of their limited formal education in their home countries. And this was a very important and problematic barrier as this provider was trying to provide quality care to parents' children.

> "Maybe literacy, their education level is, you find people who cannot write, who cannot read. It's still difficult to educate them in the health. Sometimes they cannot read your handouts or materials. The poverty level because you teach them how to eat healthier and you tell them to buy this and not that but that is the most expensive thing. And I try to teach them that its quality not quantity but they still have to feed a family of five or six. So the budget is limited. Sometimes I see not understanding the health system or how it works. So, even if you educate them on how to make the whole family be healthy they still go to the emergency room if they find that the child has fever." *Mecklenburg, #7*

What this provider is saying is even if education is provided and the patient might understand the importance of healthcare, there are still no guarantees they will carry it out when economic pressures are still present. This is the very nature of compounding barriers.

4.4.6 Cultural-related Challenges

Culture is such a broad factor that some providers immediately jumped to other barriers and issues when question of culture came up. A Mecklenburg provider expresses one example of this in the following quote:

> Interviewer: "What are some of the cultural barriers that are common between providers and patients in a clinical setting?
>
> Provider: Sometimes the patient will not disclose all the information. They have to feel trust, and that's when they start telling you everything. There's another thing and sometimes it can be annoying, especially if you're in a hurry. The patient will tell you what's going on a roundabout way. Or they'll go, well six years ago when...and the whole time you're going, hurry up, get to the point, I can see the doctor losing it." *Mecklenburg, #7*

The provider in this example was acting as an interpreter. And the response directly connects culture to patient issues of trust and the importance of communication between patient and provider. There are other issues and barriers that surround this response to a question of culture. One is the demand of the healthcare system for physicians to quickly and efficiently diagnose patients. A more holistic form of patient and provider

communication that the patient in the quote might have been used to in his or her home country or background is not the case. What we find here is a fundamental problem directed by culture; the physician and interpreter are driven by time demands and quotas, and the patient is driven by establishing trust, something that cannot happen within a quick timeframe.

4.4.7 Discrimination

The final challenge discussed here is discrimination. And, like fear, discrimination was often not expressly stated and isolated in providers' responses. Rather, it was an underlying factor in a broad range of healthcare barriers and issues. However, here is one example of a direct discrimination response by a Mecklenburg provider:

> "Or maybe discrimination. Sometimes in my programs if I offer the programs at a certain place they feel like they are being discriminated against by those staff." *Mecklenburg, #7*

Providers responding to misconceptions in service have come from not only their service experience, but also their personal experience:

> "A lot of times, yes. I see that or people judging you. From my own personal experience I've gone to places where they ask me if I speak English. They haven't even talked to me, they haven't even said hi. The first word out of their mouth is do you speak English? I was raised in this country. I was born in the Dominican Republic but I've been here since I was three years old. So yeah, I do speak English. It's just like, a lot of people start to judge you before they even know you. I think it's a learning process. It's gotten better through the years because we have more people kind of coming to North Carolina from different states and but, yeah, I've gotten that question asked many times." *Mecklenburg, #4*

In this case, misconception was related to the provider's ethnicity and ability to speak English. Interestingly though, the provider did mention how personally experienced misconceptions have improved as migration into North Carolina from other states has

become increasingly diverse. A Mecklenburg provider gives another misconception quote:

> Interviewer: "If you feel comfortable could you describe some of these misconceptions that providers have?
>
> Provider: We always joke. The one thing we always say is number one, because they're Latino they think they're Mexican. They're illegal, most likely if they're male they tend to drink a lot. And if they cough a lot they have TB…This patient had several health issues. And one of them was renal. And the provider was actually thinking, well this guy is going to have to go back to his country because he's illegal and we won't be able to provide him with dialysis. Turns out the guy was from Puerto Rico. So, I try to use that as a teaching moment decision and say, what you need to do is don't assume where they're from. Ask them where are they from." *Mecklenburg, #6*

Provider responses in this study represent experiences and perceptions that not only express patient barriers, but barriers among colleagues or in working conditions. And providers often mentioned misconceptions about the Latino community about other healthcare providers in the same clinical setting. In the above passage, the provider was giving a perception of experience through a colleague that resulted in the patient not getting the care he or she was entitled too. In so many ways, misconceptions of providers were connected to cultural competency.

Cultural competency was a primary source of barriers for providers in the study. The following provider responses relate cultural competency to quality of care and need:

> "Another thing I see, and this might be completely off. Whenever the Latino patient is in the hospital there might be a lot of family members in the room because everyone comes and sees the patient. The provider many times comes and starts talking without finding out if it's okay to discuss in front of all these other people. Because it could also be the neighbor or people that have no business knowing what's going on." *Mecklenburg, #6*
>
> ---
>
> "And cultural competency is an issue because when someone translates a document into Spanish or interprets. If they're not interpreting in culturally appropriate way then they might as well not be interpreting. So, it's not, and that's another issue for a volunteer coordinator who's trying to find providers and

> interpreters. It's just time consuming. We know we need it, but to find that specialized individual who can speak Spanish, do it culturally appropriately, knows all medical terminology, that's three things right there. And also can speak English. Sometimes they can speak Spanish as a first language but they don't have an English capability in medical terminology. So, it is just time consuming." *Mecklenburg, #1*

Beyond the provider barriers of need and trust, cultural competency really gets to the quality of service barriers that providers experience. In the first passage, the provider was discussing experience with colleague providers where cultural competency was not practiced. In the second passage, the provider was discussing all the elements necessary to find a culturally competent service provider, and how difficult it is. These passages work well together to illustrate time and resource demands that providers have to meet the need, but how cultural competency can suffer in the equation.

4.5 Urban Context

Previous studies analyzing health care challenges for Latinos across study areas have been primarily quantitative and focused on metrics such as healthcare utilization (Continelli et. al. 2010; Cutchin 1997). However, from a qualitative provider perspective, more complicated challenges and barriers related to being in an urban service environment emerge as a priori themes were discussed. Well identified barriers and challenges include patient lack of insurance, un and under-employment, and fear/mistrust/documentation. Compared to provider perspectives in other study areas, providers in Mecklenburg County were able to comment on their experiences with more clarity because they occurred primarily once the patient had accessed the healthcare facility. More of the providers in this urban context had education and advocacy roles than in the other study areas, and thus were able to give more context regarding how patients were able to navigate the healthcare system and understand their medications.

But, other studies have identified that urban areas have more complicated healthcare systems, so this makes sense (Cutchin 1997).

In conclusion, the major themes of challenges Mecklenburg County providers experienced or perceived were; patient's lack of insurance, un or under-employment, documentation, fear/mistrust, lack of education and health literacy, and cultural misperceptions. These themes were in the context of a large, urban county and given from the perspective of the healthcare provider as opposed to studies that give the patient or environmental perspective. The next county discussed is part of a metropolitan statistical area (MSA), but has many rural and agricultural place-based characteristics that make it an intriguing county to analyze health care service issues and barriers.

4.6 Chatham County

Chatham County is a small, urban county located in the larger Raleigh-Durham MSA. It is one of the largest areal counties in North Carolina with distinctive place-based intra-county differences. The eastern half of the county, which contains the county seat of Pittsboro, is where much of the population density exists. Many residents in this section of the county commute eastward into Raleigh-Durham-Chapel Hill for work. The western half of the county is more agricultural and agricultural-based industrial. This section of the county includes the remnants of what was a very large network of hog and poultry farms alongside animal processing factories (Cravey 1997). This network has been largely disassembled due to down-sizing and relocation of these plants, but the former epicenter of this network was Siler City. Siler City is the focal place of analysis for Chatham County, as it contains the largest concentration of the county's Latino population, as well as the concentration of the population's healthcare service

infrastructure. The importance of this introduction to Chatham County is that, across the urban-rural continuum, there is geographic spatial distinction. As is discussed later in this chapter and next chapter, through university partnerships and collaborative networks, providers receive resources in an urban setting. But this plays out in rural-based environment that is Siler City. This is a distinction over Mecklenburg County, which is decidedly urban, and Greene County, which is more rural.

The main challenges that brought out similarities and differences in Chatham County providers were; lack of employment for Latinos (due to poultry-processing plant closings), concomitant access to care challenges because of no insurance and the financial barrier, and provider isolation.

The population growth of Latinos in Chatham County over the past thirty to forty years has been due to agro-industrial growth, and employer-based recruitment. Large poultry processing plants located in Siler City provided the majority source of employment for Latinos either migrating from other countries or states in the U.S. Through the 1990s into the early 2000s (Cravey 1997). One provider spoke to the employment situation in Chatham County and the recruitment of employees:

> "We started seeing a big change in Chatham County probably fifteen years ago, is what I remember. And that was basically the immigration of Latino Hispanic residents primarily to work in the chicken plants and some of the other factories. There was actually a direct recruitment in Mexico bringing people to Siler City. So, it went from pretty much being black and white to being especially in Siler City, large Hispanic population." *Chatham, #1*

Many Latinos employed in the poultry-processing plants were documented through temporary work visas permanent green cards. In other words, with documentation status and full-time wages, relative barriers to healthcare accessibility were not as high. Issues of healthcare access barriers for Latinos in Chatham County have

significantly increased over the past five years. The reasons for these increased barriers are tied to the closing of the two main poultry processing plants.

Chatham County providers discussed the impact of these plant-closings at length. In the following example, the provider was simply asked about the types of jobs patients/clients occupied:

> Provider: "Let's see, in Chatham County, the adults that I work with are either unemployed, or they used to work in the factories, furniture factories or the chicken plants."
>
> Interviewer: "Would you say there's a higher employment rate?
>
> Provider: Now there is, Yeah. Six months ago it would've been equal but now due to the chicken plants and the factories closing, unemployment has just soared." *Chatham, #2*

Another provider spoke to the unemployment situation in the county:

> "And it's usually one person per household working if that, because of the layoffs over the last few months. So that's been the trend. Low employment, unemployment, one person working in the household." *Chatham, #3*

In Chatham County, the promise of employment was the central reason for the influx of Latino migration throughout the 1980s, 1990s, and early 2000s. Latinos migrated from other U.S. States including Texas and Florida, as well as their native countries like Mexico. Employers used recruitment strategies and well as transnational and social migration network to fill the need for meat processing plant positions (Cravey 1997.) Until the early 2000s, Siler City was the location of two large poultry-processing plants, which employed the majority of Latinos living in and around Chatham County. This is reflected in Chatham provider responses. One provider generally summed up the state of employment for poultry-processing workers:

> Provider: “Yeah, the reason there are so many Hispanics in this town are because of the factories opened over the past twenty years, poultry processing plants. One company had two plants close, one in February 2011 and the other in September, which employed around seven hundred people. And a lot of those people are still out of work and are still waiting for them to reopen or waiting for something else to come into town. Or commuting, I have a lot of clients who commute three hours to work in other places...
>
> Interviewer: Other processing plants?
>
> Provider: Mhmm. So that's been the big economic impact on the community in Siler City in particular.” *Chatham, #4*

An interesting development in the provider responses to their patients and clients' employment situation was how, even though the question posited to them was to describe jobs, how they focused more on employment versus unemployment. In Chatham County more than the other study areas, the place-based economic ramifications of the closing of processing plants seemed to drive the overall discussion.

Related to the bleak economic and employment conditions in Chatham County is the financial barrier. With no income, and in many cases, no government unemployment benefits, Latino families had little to no income to spare for healthcare access and programs. One provider spoke about this issue:

> “A second barrier is financial. Not as much at the school, cause there are grants that cover my work at the school, for families, so students receive services for free. But at the clinic, the county was helping us and they asked for a small copay of ten dollars a session. Now families don't even have that, that has become a barrier for some families to regular treatment. And now the county is requiring that all persons prove a social security number effective April one.” *Chatham, #2*

Unless the services can be provided for free, many in the Latino community were simply not able to access care. This becomes an issue not just for Chatham but also across study areas. Even when clinics or agencies receive subsidized cost from grant funding,

providers and administrators still have great difficulty paying bills when their patients and clients cannot afford ten dollar co-pay.

Providers in Chatham County also experienced personal feelings of struggle and isolation as a result of bleak economic conditions and funding. The first struggle that providers responded to was difficulties in meeting patient-care demands with limited funding and resources. This actually translated to the investigator's difficulty in scheduling interviews with providers agreeing to be a part of the study. They simply did not have enough time in their schedules to spare an hour. Another challenge for Chatham County providers related to isolation was being the only person in their role at their organization or clinic. Specialty and social services for Latinos were only provided by one or two organizations, and providers in those positions commented about feeling alone or that they were unable to connect with the health infrastructure in the county. A few providers even spoke to perceived discrimination they personally felt from other individuals or organizations within the county.

4.7 Urban-rural Context

Unlike the urban context (Mecklenburg County), in the context of Chatham County and, more specifically, Siler City providers, the biggest challenge was Latinos not having access to healthcare in any capacity. Providers were well aware of the economic, social, and cultural contexts of the place where they practiced, and those contexts were reflected in their comments regarding a priori themes. Additionally, providers in this context were more likely to report feelings of isolation both from their colleagues and from the community, and in some cases, felt discrimination from other providers in the study area. National level studies have shown that physician retention is worse in rural

areas than metropolitan areas (Cutchin 1997). Qualitative provider perspectives give insight into because of these challenges they perceive both from a provision and a personal standpoint.

As previously mentioned, the main challenges that brought out similarities and differences in Chatham County providers were; lack of employment for Latinos (due to poultry-processing plant closings), access to care challenges because of no insurance and the financial barrier, and provider isolation. As with Mecklenburg County, these challenges and barriers have been highlighted in-macro analyses by other studies and through perspectives of patients, but are confirmed here by provider perspectives. The next county provides a rural-based provider perspective.

4.8 Greene County

Greene County is a rural, agriculturally based county in the lowlands of eastern North Carolina, an area known historically for its tobacco production. For Latinos living in Greene County, a primary distinction is that tend to be migrants rather than permanent residents, and live in farmworker camps in close proximity to the fields where they work. This creates a distinct spatial divide between Latino residential areas and service agencies that does not exist to the same degree in the other counties. From a service-based perspective, in many cases getting patients to the clinic or agency just is not an option. The provider must go to the camps to provide care to these people. Because this spatial barrier looms so large for providers, from their perspective just getting to the patient is half the battle.

As is the case in Mecklenburg and Chatham Counties, employment was a primary push factor in attracting Latinos. The roots of Latino migration to Greene County went

back to the initiation of temporary H-2A migrant work permits where the primary source of employment was agriculturally based (Johnson-Webb, 2002). The types of agricultural, or farm work that the migrants are employed in is discussed by a provider:

> "In this county, we have tobacco...cucumbers, sweet potatoes, watermelon, cantaloupes are going to be the main, manual labor crops that they have in this county...probably the big thing in this county is sweet potatoes. We have the sweet potato factory and we also have a place called Yamco, which turns them into yams. So that's probably one of the bigger crops. I think we're one of the biggest growers in the world, in the top five, right here in this county. That produces sweet potatoes. As you know that is a manual crop, you have to go out and pick it. So we have a large number that work-all the crops, the tobacco, are pretty common in this county." *Greene, #1*

Based on the Greene provider responses towards employment status, the overwhelming amount of their patients and clients were farm workers or had a family member in the fields. One characteristic of these farmworkers is that they most likely lived nearby the fields in employment housing (Torres et. al. 2003). This housing, or 'camps' as many Greene providers referred to it, became a focal point of service provision. Here is a description of the camps given by a provider:

> "That can include a trailer, it can be an old farmhouse. Here in Greene County we actually have a barrack style camp that houses around 100 to one hundred twenty five people or so, at any given time." *Greene, #1*

Because farm work is so prevalent among the Latino population in Greene County, provider responses often focused on the difference between the H-2A workers versus undocumented workers.

> "In the summer time it's the migrants, H2A workers that are here legally and then the illegal ones. Those are almost always male. I don't see, I rarely see females during that time. They're usually young males, twenties, thirties, that sort of thing. Then the H2A workers who are really older, mid fifties to sixties who are still wearing themselves out with all the work they do." *Greene, #2*

Finally, trust issues were discussed among providers even in the same clinical setting. In the following passage, the provider discussed difficulty in building trust with other clinic physicians as a medical family therapist:

> Interviewer: "It's like, from your perspective, you have to build these trust issues with the provider as much as the patient?
>
> Provider: Very much so. If they don't really trust what you do, they're like, I don't want you in my room. It's hard. But once they see how the patients respond, the patients are like, I want to see the therapist. Then they're like, oh, okay. The patient might bring something up and they're like, oh I know someone that can help you, hold on a minute. So then they begin to see the value of working with a medical family therapist. It's really neat." *Greene, #3*

In this case, however, the provider details how trust was eventually built with other clinic physicians to the betterment of care for the patient. Later in this chapter is a section where providers discuss how they overcame barriers. Many solutions involved improved communication and building trust.

4.9 Rural Context

From the qualitative perspective of providers in this study, the primary challenge with Latinos and healthcare service provision is patients being able to access and receive care. This is due to transportation and economic/financial issues that have also been addressed in Chatham County. Mueller, et al., 1999 found overall healthcare utilization to be better in urban areas over rural areas (Mueller, et al., 1999). Logically, areas with a larger supply of primary-care physicians see larger utilization rates (Continelli et al., 2010). However, providers in Greene County have found ways to make up for smaller provider supply by travelling to where their patients live and streamlining the healthcare provision resources in an attempt to make navigating the system easier for Latinos.

The main challenges that brought out similarities and differences in Chatham County providers were; lack of employment for Latinos (due to poultry-processing plant closings), concomitant access to care challenges because of no insurance and the financial barrier, and provider isolation.

As previously mentioned, from a provider perspective, just accessing the patient in Greene County is the primary challenge due to employment and transportation barriers. In this rural area where the sole purpose for many Latinos is migrant jobs, they often sacrifice health care for fear of losing their job. And this weighs heavily in provider responses, as is discussed in the next section of the analysis, transportation.

4.10 Transportation

The primary similarity across provider responses is the challenge of transportation. Due to this, the discussion of transportation as a barrier has been saved for this section of the chapter. When providers were asked what access barriers they or their patients' experienced, transportation was listed as primary often and in all study counties. The primary categories of transportation barriers mentioned by providers are broken down into three categories. The first in general access issues in that patients did not have vehicles or the ability to make it to appointments. The second issue relates to laws and restriction changes that make it more difficult for immigrants to get driver's licenses. The third issue is public transportation, or lack thereof.

The following quotes represent just the sheer frustration and complexity of transportation as a barrier by providers across all counties.

> "The other issue we have is, transportation issues. Patients who can't always get here. They're coming by mass transit, or they're relying on someone to bring them, so they don't always have the ability to get here when they need to. They also don't always understand that they need to call to let us know. So, we do have

> some that will do that but not everybody knows that they can't just not show up." *Mecklenburg, #1*
> ---
> "I think the other big barrier in this particular case in the community is transportation. And a lot of folks don't have access, or the right drive, aren't legally privileged to have licenses, so they don't drive. So, if you can't drive to a clinic or can't drive to Chapel Hill you're not establishing that care. So what I've seen is people going for emergency situations rather than going for yearly biannually to maintain health." *Chatham, #3*
> ---
> "Yeah. A lot of times if they don't have transportation, one of our outreach workers will provide services and pick them up, either to take them to the clinic to get checked up, or to the pharmacy to get medicine." *Greene, #6*

In the first passage, the provider spoke to how lack of transportation not only takes away access for the patient, but it also disrupts their system and ability to provide service because they cannot fill that missed appointment with another patient. And that can be very frustrating when you're limited by space and resources trying to meet an extensive demand. The provider in the second passage connects lack of transportation to continuity of care. Rather than preventative clinic check-up visits, people that have no access to vehicles or cannot legally drive will wait until their health situation is an emergency. The third passage from a Greene County provider plainly states that if they need to get a patient into the clinic, there solution is to go and pick that patient up. It's not just transportation barriers on the patient's end. One Chatham County provider talked about transportation difficulties on the service end:

> "Transportation is a huge issue in terms of, even for the services we provide because we typically, as an agency, get money for certain things and for us it covers salaries. For any kind of other access like bringing kids to activities, if that's what you were talking about..." *Chatham, #1*

Another issue for transportation barriers involves driver's licenses.

As mentioned earlier, in recent years North Carolina legislation increased requirements needed to obtain a driver's license. These are restrictions that as recently as

five years ago were not present. One of the restrictions is a social security number, or documentation showing legal status in the U.S. Particularly in Mecklenburg and Chatham counties providers mentioned this issue with their patients and getting drivers licenses:

> "In my program it would be transportation, they don't have drivers license. It's expired and they can't renew it. They have to take public transportation, which is a different system than in their country of origin. Or they get rides, but that's kind of hard. It's a big barrier." *Mecklenburg, #7*
>
> ---
>
> "Yes. There's a lot of fear and especially now with a lot of changes and laws you know people can't get their driver's licenses. So I have a lot of patients who are driving without a license or expired licenses and now their fearful to drive around or come to the clinic for help or treatment because they might be stopped somewhere down the line." *Mecklenburg, #4*
>
> ---
>
> "I haven't been here long enough to see the change. I'm only been here since last summer. But, just from talking to people I know it's more difficult. You can't get a license unless you show papers, you're immigration status. It's a lot harder than it used to be." *Chatham, #3*
>
> ---
>
> "Also it depends on where they live, because now that they cannot get a driver's license unless they're a resident. They're driving without a license, so they're afraid to drive very far. The one's that are illegal are worried about driving a long distance for any reason." *Chatham, #7*

One of the primary consequences of the changing driver's license requirements is fear on the part of community members. This is expressed in the second and fourth passages. People living in these counties that are prohibited from having licenses see driving as a gamble. They don't want to chance deportation from driving to a clinic. Essentially they will only drive if necessary, places like work or to the grocery store. And regardless of a rural or urban county dynamic, driving to the clinic might be ten to twenty miles. It's a risk a lot of people are not willing to take. Public transportation becomes another option.

Across the three counties, Mecklenburg is the largest in population and the only county with an established public transportation network. Chatham and Greene offer limited shuttle service but do not have regular bus routes. But even with the established

network, providers in all counties commented about the impact public transportation had on their clients gaining access to their clinic or facility:

> "Yes. And I always try to give them the right line if they're coming from the other side of town. Because I know all of them have to come to downtown and then take the bus to take them here. So, I have already have the line. I think it is (number). So, I've been giving this information, like, you go to downtown, and then you take the bus (number). I think it starts at (street name). So you have to walk one block through the neighborhoods." *Mecklenburg, #3*
>
> ---
>
> Interviewer: "Is there any sort of established public transportation in Chatham County?
>
> Provider: There is, but it's very inaccessible and flawed from what I get from my clients. It doesn't run on a schedule that' very predictable, you have to call them twenty-four hours in advance to set up a pickup. It's not as accessible as it could be." *Chatham, #3*
>
> ---
>
> "…Patients who need good public transportation, in Charlotte it is inadequate in my assessment." *Mecklenburg, #5*

In these passages from Mecklenburg and Chatham providers, the general consensus is that accessibility is not good. For example, in Mecklenburg County, to take a bus from one part of the county to the other usually requires connecting buses in the central business district of Charlotte. This transfer can make for a long and difficult to maneuver ride that might last two hours. Chatham public transportation requires a call to reserve a pick-up. This call usually requires the person to be able to speak English. And even if people get around these initial problems, public transportation can be inefficient and not accurate.

Public transportation was also brought up in Greene County:

> "Transportation is a great big one here in this county. Even though we provide the outreach program, we serve 19,000 in ten counties, it can't be our priority just because there are so many other things we need to be doing. But if it's a last resort and we know we're not going to get them here unless we bring them. We do a lot with H2A workers because they're more at mercy of the grower than the other groups are, the migrant. A lot of them usually do have access to a vehicle or

> another. But with no public transportation in this county it's definitely a big barrier, even though we're providing some transportation." *Greene, #1*

In this instance, the Greene County provider recognized no public transportation was available and the only real solution was to pick up clients. This provider works for a healthcare network in Greene County that provides the majority of healthcare to Latinos living in the county. And this solution to the problem was unique to Greene County. However, the amount of people living in Greene County is far less than in Chatham or Mecklenburg, where personal transportation is not a feasible option. Nonetheless, it is interesting that, in this analysis, the best solution to the barrier of transportation impeding healthcare access seems to come from a rural county with no public transportation. In fact, it is the place-based contexts of Greene County, spatial, physical, social, that define its unique adaptation to overcoming transportation.

4.11 Discussion

Identified a-priori themes in the literature included; language, financial, insurance, cultural, documentation status, and transportation. Through analysis of participant interviews, these barriers still exist in the service-provision environment for Latinos and, in many ways, have become even more prevalent towards reducing healthcare access. One of the ways in which these barriers have become worse was in how they have compounded together to make their sum greater than its parts. Providers discussed how it wasn't just the patient not being able to speak the language during a visit, but efforts for interpreting were made more difficult by cultural differences between the provider and patient. In another example, safety-net clinics would reduce rates to try and accommodate the financial barrier for patients, but their absolute financial standing would not allow them to even afford ten dollars for a general check-up.

Transportation was the most impactful a priori theme mentioned by participants across counties. Providers across study areas continuously pointed to the difficulty of their clients and patients ability to physically travel to the point of service as a chronic challenge to service provision. The primary focus on the barrier of transportation, as providers stated, is the automobile dependent nature of their clients and patients. This was the case even in Mecklenburg County, which had the largest network of available public transportation. Providers mentioned that their patients had difficulty finding the clinic or agency location once they stepped of the bus. Also, in many cases bus routes would require a transfer point out of the way that would make the trip time over an hour. Because of this, patients would be late for appointments or not make the appointment at all. Providers across study areas also mentioned changing statewide regulations and enforcement on obtaining drivers licenses as a challenge to service provision. Without a drivers license, individuals are only driving when they absolutely have to; for example, to work or to drive children to school. And by choosing to not drive to doctor's appointments, patients waited until a medical condition became severe and then they would access the emergency department.

Transportation was the pervasive barrier in provider's responses that directly impacted ability to provide effective healthcare. And only in Greene County was the healthcare infrastructure somewhat able to react and respond. Compared to the other study areas, the patient population of the largest health network, Greene County Healthcare, is relatively concentrated in the camps where farmworkers live. Providers, including outreach workers, nurses, and physician's assistants, travel to these camps to provide health screenings and basic care to the farmworkers - including treating minor

injuries and conditions sustained while working. Additionally, in many cases outreach workers will travel to a patient's home and physically bring that person to their doctor's appointment at one of the health network's clinics. Of course, this personal service and home visit system is something of a relic of days past where the small town family doctor would visit the family home when a member of that family was sick. It would be difficult for clinics in larger cities with larger patient populations to be able to provide this individual service.

The role of geography and the provider's construction and experience of place became very important with the theme of transportation. Though transportation was a challenge experienced across study areas, the assumption would be that the urban area, with a larger public transportation infrastructure and resources, would be better equipped in overcoming it. However, it is the rural county and it's unique relationship between the patients and providers that actually allow for the seemingly best ability to overcome transportation as a healthcare challenge.

4.12 Conclusion

This chapter described a-priori themes as they exist in the place-based contexts of the study counties. The themes were reflected in the form of challenges and barriers providers experienced and perceived, based on a priori themes. Unfortunately, many of the previously identified challenges and barriers including; financial, insurance, language, cultural, and documentation status, are still prevalent for Latinos accessing health care services. And, as provider comments reflected, they in many ways compound and have become worse.

The urban study area has been identified as a pre-emerging immigrant gateway, and an appropriate assumption can be made that provider experiences and challenges as well as the ability to overcome those challenges would be in the urban place. The a priori thematic findings presented in this chapter show that, while there are nuanced differences in service challenges across study areas, there is a shared provider experience that exists based on barriers to access, and the provider's response to those barriers. And this common experience is especially present in the issue of transportation as a barrier/challenge to healthcare access and service. Where providers have overcome these challenges to create opportunities in service provision, themes begin to move beyond a priori and into the emerging category. The next chapter addresses these emergent themes and their role, from a provider perspective, in improving service provision to Latinos living in North Carolina.

CHAPTER 5: EMERGENT THEMES IN A PLACE-BASED CONTEXT

5.1. Introduction

Whereas chapter four has described and analyzed a priori themes largely focused on challenges the providers experienced, chapter five contains a discussion and analysis of emergent themes – those that were not explicitly embedded in the interview guide but rather arose from provider responses and subsequent analysis of the interview transcripts. Under the emergent themes and issues discussed in this section, similarities and differences can be explored among the study counties. The interesting aspect of discussing similarities and differences across study areas in this manner is that general similarities give way to nuanced differences in how the issue impacts healthcare service for Latinos either positively or negatively. Likewise, generalized differences in experience and approach can also emerge as more similar when finer grain details are explored. It is in these nuances that the contextual, collective and compositional elements of place become clarified as important players in how providers most effectively adapt for the benefit of improved health outcomes – and how they do so in a manner across all three locations and scales that binds them as pre-emerging immigrant gateways.

The emergent themes that are discussed in this chapter are: (1) the role of geographic scale; (2) place-based factors; (3) comparison of pre-emerging immigrant gateways to traditional gateways; (4) policy impacts; (5) institutional roles; (6) provider

isolation; (7) the importance of provider leadership. These emergent themes reflect conceptual findings that are intertwined with the study's three methodological considerations of: (1) the role of geography; (2) the perspective of the healthcare provider; and (3) the context of pre-emerging immigrant gateway places. A framework for organizing and analyzing these emergent themes derives from work by Mactinyre et. al. (2002). The effect of place on healthcare or health services provision is difficult to measure and analyze simply because places and the factors that contribute to their creation are so complex. Places can be understood as real or material (buildings, trees, etc.) or subjective, meaningful (a 'dangerous' neighborhood, a 'good' school). Bearing this in mind, three primary categories are used to explain place's role in health variations; compositional, contextual, and collective:

> "Compositional explanations draw our attention to the characteristics of individuals concentrated in particular places; contextual explanations draw our attention to opportunity structures in the local physical and social environment; collective explanations draw our attention to socio-cultural and historical features of communication" (Macintyre et. al. 2002).

Using these categories helps to break down the complexities of describing and analyzing the emergent themes. Additionally, they add substance to instances where the dynamic relationship between individuals and the places where they live and work add to understanding regarding the service-provision environment. Importantly, emergent themes could contain one, two, or all of the three factors. Also, compositional, contextual, and collective factors did not necessarily exist isolated from each other.

5.2 The Role of Geographic Scale

As discussed earlier, the study areas in this research range across urban to rural areas. And from a geographic perspective, most research shows that urban areas have

better healthcare service provision and experiences/attitudes. For example, locations that have a larger supply of primary-care providers show larger rates of healthcare utilization among that localized population (Continelli et. al. 2010). Because rural areas have a smaller supply of primary-care physicians than non-rural areas, one might believe healthcare utilization is better in urban areas than in rural (see Mueller et. al. 1999). Studies examining Latino and non-Latino populations have found that rural environments are positively associated with less healthcare access and worse healthcare outcomes. Physician retention has been shown to be worse in rural areas than metropolitan areas (Cutchin 1997). Finally, residents of rural areas generally perceive their health to be worse than in urban places (Monnat and Pickett 2008).

Contrary to above, provider responses across the three study areas did not form any consensus that geography in the form of being in an urban or rural environment showed better or worse outcomes or experiences. Providers in Mecklenburg County for example *perceived* varying differences between what situations might be like in urban areas versus rural areas. The quotes below reveal reflection on a combination of disadvantages and advantages that might flow from urban versus rural scales:

> "I don't have experience but I would imagine that if it's a really small town or place one of the things would be the language barrier. And you've gotta be able to communicate, otherwise you're not going to get the care you really need. I would hope in the rural areas people would be as open to people that are documented or not." *Mecklenburg, #6*

> "So, I don't know if that makes a difference, or if just, I don't know. I think our population is larger here in Mecklenburg than other places where the Latino population is not so prevalent. It might be easier to access care than here where we are turning away three hundred patients every month that are seeking care." *Mecklenburg, #4*

Going back to the analysis of barriers in an earlier chapter, two extremely important issues providers had difficulty overcoming, regardless of their location along the urban-rural continuum, were communication and meeting the overwhelming need of their community. The first passage above addressed communication and the language barrier, and the provider was perceiving that perhaps these barriers are more prevalent in rural areas than in urban areas. And the first passage also touched on the shared documentation barrier. Due to the compounding of barriers the provider discusses, the perception was that the need might not be met due to the higher prevalence in rural areas. The provider in the second passage perceived the opposite situation based on need. This is simply due to the higher population in the urban county and the absolute higher need.

Other Mecklenburg provider comments referred to network capacity advantages and options for specialty care one would have in an urban area versus rural area:

> "Hmm. I think that being in a bigger city, you always have more options. However, sometimes in a smaller community, you know more people, and it makes accessing those options a lot easier. So what happens I think in a larger community like Charlotte people bond together, in their subset, in their own community...I think they'll do that in a smaller town as well, but in a smaller town there's going to be one or two or three options, and those options are going to be relatively clear. Whereas in Mecklenburg you're going to have twenty organizations doing twenty different things and nobody knows where to go. That's a bit of a barrier as well. Also, Mecklenburg is so spread out and the transportation is not good. So, accessing those options, if you have a car or a bus, you can get there, if you don't have three young children and it's 20 degrees out. In a smaller place you can get to those places faster. So, I think that makes it easier." *Mecklenburg, #6*
>
> ---
>
> "Well, medically, the scope, Charlotte has huge medical facilities, research centers, specialists. Big emergency departments. Accessible to pregnancy centers, it's the law they have to take in people. There may be a difference in the level of care, this is just a guess because I haven't been out in the rural areas, but some of the logistics for the families getting to the doctor's appointments, transportation, the language. Some of the clinics provide translators, some don't…my first thought would be the scope of services available. Quality and level of care, the number of doctors, number of clinics, access points is greater in a bigger city. In a

> rural environment you have limited hours, limited doctors, a forty-five minute car ride to get to a dentist. So I think it would be the environmental." *Mecklenburg, #10*

The commonality of these first two passages by Mecklenburg providers was the point that their large urban county had a larger service infrastructure and more available options than smaller urban and rural counties in North Carolina. And based on the perceptions, they diverged at the advantages of having a large infrastructure. In the first quote, the provider believed that by having so many options spread across the county it could be difficult for a person to gain access to the right place for the right issue. This difficulty might not exist in more rural, tight-knit places where only two or three options are available, but at least they're known and easier for families to get to. The second passage takes the opposite view that it is because of larger availability of specialized centers and clinics, as well as safety-net emergency departments, that people are better off than trying to navigate into rural clinics.

Provider comments about scale in Chatham and Greene were similarly "conflicted" about the pros and cons of being in a smaller county:

> "It also depends on the service. So, if I need HIV services in Siler City, they're probably not that much harder to get than if I were in Charlotte. But if I need legal aid for my documentation status, I would assume you would have more resources in Charlotte." *Chatham, #9*
>
> ---
>
> "You know, I think it was probably harder in general being a small town because all of a sudden these new people are here...Or, if you don't speak Spanish you can't get a job at (clinic) anymore. So there were a lot of challenges where in the bigger counties maybe there's more diverse population that they didn't have to address. But on the other hand, being a small knit, once the word did get out it goes pretty fast. And everybody knows everybody, so as far as the people we're trying to help, you know, it wasn't as big a challenge because they weren't so spread out, as in some of the bigger counties like Mecklenburg." *Greene, #1*
>
> ---
>
> "In places in Durham you have transportation, in Chapel Hill you have an incredible transportation system, I think that's part of it. Siler city is a rural town

> removed from everything, and the lack of public transportation connecting it is the biggest challenge. As far as opportunities go I think there's a lot of room for development. I think because of the increasing need I think we can, that may be something that the county or city prioritizes in the future, not just for Hispanics but for everyone." *Chatham, #3*

The first quote reflects how place comparison disparities are based on the type of service the patient is trying to access. Charlotte, as a larger city, will probably have a larger network of legal representative services, but not so much for very specialized treatment services which are in this provider's view limited across all scales. The second quote also conveys a balancing out of pros and cons of living and working in a smaller community. Larger communities might have more diversity and opportunity for services, but smaller communities tend to be more tight-knit and exhibit better, faster communication, which could actually increase information and overall access. And the third comment places healthcare issues in the context of increasing demand over time. Even though services are lacking in smaller counties compared to more urban places, the provider explains that as demand increases, there are opportunities for local level officials to prioritize meeting that demand – the assumption is that there are potentially fewer demands to be met so those that are apparent and pressing have greater likelihood of being prioritized and met.

5.2 Place-based Factors

5.2.1 Contextual Factors

Place-based factors identified by providers comprised largely contextual explanations of their impact on healthcare service provision. In issues of spatial scale, economy, and culture, the study areas are more different than similar. As identified, they were chosen for two primary reasons; they had similar percent rate Latino population, and they have experienced similar percent-growth of the Latino population over the past

thirty years. In how these attributes of difference relate to the landscape of each study area, a few central conclusions are worth noting. One, Latino residential clusters are located in three areas across Mecklenburg County-City of Charlotte; Northeast of the central business district (CBD) along a busy corridor called Tryon, East-Southeast of the CBD, and South of the CBD (Smith and Furuseth 2004). Two, the majority of Latinos in Chatham County live in or immediately surrounding Siler City, which was the location of the two poultry processing plants that had employed many prior to closing (Cravey 1997). Three, Latino residents in Greene County mostly reside in rural areas outside of town limits, often in farmworker camps of their employer (Torres et. al. 2003).

One clear place-based dynamic that emerged from the interviews significant to healthcare service provision comes in the form of the difference each county has faced in economic transformation. Due to larger level economic and political shifts, each county has had to transform its local industrial and economic landscape to adapt to these shifts. And these transformations have impacted the Latino community. Providers in all study areas had identified unemployment as a consequence of these impacts, but the severity of unemployment has been most noticeable in Chatham County. When the poultry plants were fully operational, workers had relatively good pay, better insurance rates, and more disposable income (Cravey, 1997). With plant closings; people moved away, businesses closed, healthcare visits dropped, and subsidized-based clinics have struggled to meet costs.

All of these consequences have impacted healthcare service provision for Latinos in Chatham County. As in other counties, many of the subsidized health programs, including Medicaid, require documentation to qualify. Both patients and providers are

struggling to adapt to the lack of employment and employer-based insurance as the plants have closed within the past five years. Perhaps it is premature to say the impact in Chatham County is worse as it has experienced impactful transition so recently. Unfortunately, many providers noted how their clinics or agencies operate fully or temporarily on grant funding. Concern over the continuation of the funding is a constant.

Comparatively, Greene County has adapted to the decline of the tobacco industry over the past twenty years, responding by growing sweet potatoes and other labor-intensive crops in former tobacco fields. More importantly, farmworkers in Greene County are still majority migrant laborers who do not permanently live in and are incorporated into the social milieu. Furthermore, the majority of migrant laborers in the United States are documented under temporary work visas, thus able to access many of the federally based assistance programs

5.2.2 Compositional Factors

Not every aspect of placed-based factors was contextual or related to opportunity structures. In some instances, primarily related to culture, compositional factors, or those that reflect dynamic individual experiences related to place, explained provider experience. Providers in Mecklenburg mentioned cultural competency as both a challenge and an opportunity. The challenging perceptions and experiences the providers spoke about referred to seeing or hearing about other providers 'not' implementing cultural competency. However, Mecklenburg providers utilized cultural competency both directly and indirectly in their responses. Even outside of the interview responses, the fact that the majority of providers in this study area are bilingual and have

Spanish as a first language are indicative of their cultural sensitivity. For one bilingual provider, cultural competency arose when she was defining terms about the population:

> "I use that a lot, I use immigrant population so people understand but I try not to tag people as being undocumented or aliens or things like that, you open up a can of worms when you talk like that." *Mecklenburg, #10*

This quote reflects the majority of providers' opinions about labels for this population. Across all study areas there was a genuine and common respect and understanding of how harmful labels could be and providers were extremely sensitive to how they used terminology in their responses.

5.3 Comparing Pre-emerging Immigrant Gateways to Traditional Gateways

5.3.1 Compositional Factors

Important to this discussion and analysis is the concept of emerging gateways and new destinations. The literature has established the importance of emerging gateways to service provision for Latinos (Sandoval and Maldonado 2012, Lichter and Johnson 2009, Stamps and Bohon 2006). While providers did not specifically discuss their location as an emerging gateway or new destination, their descriptions and explanations highlighted those characteristics. This was particularly the case for providers who had lived and worked in their environment for many years and were able to speak about increasing Latino population growth, changing economic and industrial opportunities, and the evolution of service-based challenges. This emerged in the analysis of transcripts across study areas, and it influenced and shaped important elements of the study participants' service provision.

5.3.2 Contextual Factors

Another emerging theme regarding place and scale contexts relates to comparisons between North Carolina and other, more traditional gateway destinations. One of questions asked to the providers was as follows; "what challenges do you perceive Latinos face in accessing healthcare in your city/county that they might not experience in other cities/counties in North Carolina or across the country?" Mecklenburg County providers were more likely to respond with perceptions of how the capacity for servicing the patient base was better in other states like New York or Texas. This fits in exactly with Singer's (2004) conclusions about how established immigrant gateways have larger service-network capacities than emerging gateways. In these responses, the traditional gateway of New York was most often mentioned. This is illustrated in a lengthy but significant discussion by a provider about experiences having lived in New York and then coming to Mecklenburg County:

> Provider: "I think half of the community look for help, but half they don't know or they are too busy to work to even think about their healthcare. Charlotte doesn't have many places to go and get help. I think we are one of the biggest ones they have. I think the other one is, there is another free clinic in Matthews but it is smaller than this one. And then, because I used to live in New York so I moved here three years ago. So the difference between the big city...New York has the, I think it's, what's the name of this program, it's a health program where everybody, even people who have only a permit in the state can apply for services and they will give you the care. You pay taxes, like what you're supposed to do when you're here in America, in the U.S., they help you.
>
> Interviewer: Why do you think New York has those kinds of programs, but in Charlotte they don't?
>
> Provider: I think New York has learned from the past. They have to spend more in emergencies. And that's why they changed the policy and started to help people in that way. Even though you have a sliding scale, if you make more money then you pay some kind of money like with insurance. And they have it here also but they give you a lot of, it's kind of difficult because for North Carolina you have to be a resident and in the U.S., otherwise you will not get benefits." *Mecklenburg, 3*

New York is arguably the most established center of immigration in the U.S. (Singer 2004). And as the provider stated, it has been dealing with and learning from serving immigrant communities far longer than Charlotte and Mecklenburg County have. Because of this, it has adapted to a system that is more inclusive to serving as many as possible rather than creating barriers around documentation and system barriers that make it more difficult to provide care for everyone.

New York was more commonly referred to by providers in an anecdotal way. Three examples of this are listed below:

> Interviewer: "So when you say, here it is harder...?
>
> Provider: Than other places, like New York, where healthcare is more easily accessible. It's not as difficult as here in Charlotte. Here they have lots of rules, I think more than other states." *Mecklenburg, 4*
>
> ---
>
> "I think that Mecklenburg is a pretty big area. It's not a huge city like New York, but I think we have more services here and more Spanish speaking people here than most other areas in North Carolina." *Mecklenburg, 2*
>
> ---
>
> "Maybe we're blessed because we have more folks here that can interpret for us than if they were in rural North Carolina or the mountains of North Carolina. And typically, it's easy, it's not like living in New York, but getting around. We do have a bus route, whereas maybe if they were in rural North Carolina there wouldn't even be a bus to get them across town to get to a doctor's office." *Mecklenburg, 8*

The first quote is a straightforward perception that New York is more of an accessible place to access healthcare than Charlotte in Mecklenburg County. And this provider had experience working in New York. The second and third quotes are interesting in how they almost place Mecklenburg County in between a continuum of New York being the best place for healthcare, Charlotte-Mecklenburg being relatively in the middle, and other areas of North Carolina (notable rural areas) being on the low end. The context for the second quote was the general availability of services and bilingual providers. Language

and communication was also mentioned in the third quote in the form of there being more interpreters in Mecklenburg than other areas in North Carolina. The interesting element of New York appearing in provider comments was that only Mecklenburg providers raised the comparison. Mecklenburg providers were far more likely to compare service in their county to other urban as opposed to non-urban places within their own state. Non-urban providers were less likely to make comparisons overall.

5.4 Policy Impacts

5.4.1 Contextual Factors

Place and scale impacts on Latino health do not only come from the individual and contextual place-making attributes of the community, but also the institutional and structural components that allow or hinder one's access to healthcare service (Sandoval and Maldonado, 2012). This falls in line with broader statements about how institutions can impact social relations among a specific group (Granovetter, 1985). Consider the two following statements from Mecklenburg providers:

> "Charlotte has been growing and with that growth came immigration. I think some areas, I see that they're open to that growth, in others they're not. When I see our hospitals and clinics I see, yeah we want you but I'm not going to make it so easy. Sliding scale, you have to be a legal resident to qualify for it. It used to be where it didn't have to be that way. It's like, yes I want you but I'm going to have a barrier here. And that makes a lot of people not be able to afford to go there. Population, per se, you see some people that say...that are not welcoming. But others are." *Mecklenburg, 6*
>
> ---
>
> "In terms of the barriers I know that here in Mecklenburg we have an I.C.E. office that, I guess if you're undocumented and you fall into some kind of legal charge then of course you're at risk for deportation. So, being that it's here in Mecklenburg, anyone living here in Mecklenburg is more at risk. And that has changed things a lot for our clients. You know, a lot of them are falling into that and are being held in the county jail. And my thought is, I understand they don't have documents, but a lot of these people need help too. So, if they were to come back into the county in the future, whichever way they come back they're still potentially at risk if they don't get treatment or get deported prior to getting any

> kind of service. So, then they come back and can have other issues. Then they have another DWI and…you know…" *Mecklenburg, 2*

The first passage discusses the duality of some acceptance but still a lot of barriers that are put in place by hospitals and clinics requiring documentation for access. And this comment is interesting in how the provider discusses separates streams of change. Whereas it might be getting better for patients, restrictions and enforcement is at the same time making it more difficult to get access. The second passage is also referring to change for patients because of stronger immigration laws and regulations.

Immigration regulations and restrictions have become stronger across North Carolina. And it has even impacted employment opportunities for community members in Chatham County:

> "I think there are opportunities for people who are Hispanic and bilingual but they have to be documented. It's just hard to find, for instance, we've been advertising for a position and we started out just doing it for ten hours a week, but we haven't gotten anybody interested. And I think part of that is that people that are bilingual, better documented, they would have access to more hours, better jobs. The people that are undocumented that could do the job, which would be perfect for the job, we can't hire." *Chatham, 1*

These adverse changes for local community members are certainly representative of larger law enforcement restrictions and policies. And even though these providers relate these comments to their local environment and place-based conditions and changes, these provider comments could just as easily come from any county in North Carolina, or even across the United States.

Contextual and larger-scale forces do not work to only inhibit access, but also work to improve it. A Chatham provider expressed how larger changes in the community are working to reduce barriers and make life better for Latinos:

> "I think in a lot of ways we're getting used to having Latinos here. People still, also it's the company that I keep, the company I keep is very open to immigrants, so I don't spend a lot of time around people that aren't. You know, this community while there might be racism, I know there is, they also, people are beginning to inter-marry. And so, their kids are going to school. They've gone through the schools with Latino kids. I'm hoping that helps. And I think that Latinos are getting more empowered. So, they're getting more sort of empowered, is the word." *Chatham, 1*

Empowerment is an important community-based factor in overcoming barriers to healthcare access (Rhodes, et al., 2007). And this provider response is interesting in how it related empowerment to change over time and acculturation and assimilation through marriage across ethnic backgrounds.

5.4.2 Collective Factors

The issues of fear, trust, and discrimination are intricately tied to the narrative of Latinos, immigration, and health care in North Carolina (Bowden et. al. 2006). Fear is a barrier that many Latinos in North Carolina face when trying to access a healthcare facility to receive service (Bowden et .al. 2006). And this was reflected in provider responses across study areas. Even though these are health care or health-service related providers, their responses related to fear often had little to do with specific health issues. Rather, fear responses focused on patients' troubles with immigration policy, documentation status, employment, and transportation. Indeed, providers' perceptions about their patient and clients' fear was passionate. This is a cross-section of provider responses across the study areas related to fear:

> "A lot of times they have fear or worry because of that…because they're involved with the immigration court. And of course, here in the U.S., having the social security number is necessary. So, that is another issue that I see." *Mecklenburg, #2*
>
> ---
>
> "And I've heard stories of them saying there was a lady with kids in her house that wouldn't come out of her house, she would hire somebody else to do the shopping

> for her because she was afraid of getting deported. And these stories are real because they know somebody that was deported just by standing outside their apartment or house. It's a lot of intimidation that's affecting how they live, how they mobilize, how they access to care. And it affects everything. Immigration affects your life in every way possible. And it empowers through these laws that don't consider the human rights per se of having access to care. It empowers people to get away with mistreatment and abuse." *Chatham, #5*
> ---
> "Lately the licenses have been expiring. And then they become afraid because of all the immigration situations where parents have been taken away, or one gets taken away while another stays here, and some of them are scared. That's very understandable. They're from here, they want to stay here. That's also a challenge because they don't come. They have appointments but they don't come because of transportation." *Greene, #5*

It is very difficult to separate the issue of fear with broader issues of immigration and documentation. And that becomes apparent in these responses. These providers perceive and experience their patients' fear due to arrest, possible deportation, and discrimination by those that take advantage of immigration status. Policy also affects fear for Latinos. One example of this, which is addressed in the third passage above, is the issue of transportation. Transportation was discussed in the previous chapter, but with the passage of 187 legislation in North Carolina the requirements to obtain a driver's license changed. Whereas before, a social security number was not necessarily required, now it was (Denning 2009). And as that third passage shows, the inability for patients to now get a driver's license is directly related to not getting care.

5.5 Institutional Roles

5.5.1 Collective Factors

One challenge that was mentioned in responses more prevalently in Mecklenburg County than the other two was communication, interaction, and partnerships among providers. One reason for this is that the health safety network in the large, urban county is larger, more intricate, and in many ways more complicated than in the smaller

counties. Clinics and agencies in Mecklenburg county come from a myriad sources including large hospital networks, religious-based, health departments, local offices of state and nationally-based organization, as well as one-off publically and privately funded facilities (Dulin 2012; 2011). The patchwork of un-connected clinics and agencies created an environment where providers many times were not aware of or did not have access to resources that they could then pass to their patients and clients. Also, providers in Mecklenburg noted difficulty in collaboration due to larger-scale regulations or restrictions, lack of time, or political/social stigma towards the Latino community. The ultimate consequence of lack of communication among providers in Mecklenburg County was the trickle-down effect to the community (patients) who were not able to access information and resources to find the most effective care. Of course, this is not to say that communication and collaboration did not exist among providers and agencies. In fact, providers concurrently noted tremendous effort either they or their clinic/agency put forth to create inter-agency partnerships.

Communication among providers in Chatham and Greene Counties was not as oft mentioned in provider responses. However, safety-net care in these areas depended on networks and partnerships with hospitals, universities, and organizations from outside the county. University partnerships in particular are important to the low-income and immigrant care in the two smaller counties. Both are located proximate to large, research universities. Chatham County is adjacent to Wake County, which houses the University of North Carolina-Chapel Hill, and Greene County is adjacent to Pitt County, which houses East Carolina University. Providers, interns, and recent graduates affiliated with these universities work or donate their time in clinics and agencies in the two counties.

Additionally, collaborations with universities, as well as public or private institutions, were responsible for grant funding that allowed research projects or clinics themselves to exist and serve the community.

5.5.2 University Collaborations

Another similarity across study areas was the presence of university-healthcare collaborations and their overwhelming positive impact on health outcomes for the Latino community. Indeed, these collaborations were mentioned as opportunities in provider responses. The importance of collaborations between the community and healthcare researchers has been established (Zambrana 1996). The difference between counties was the nature of these collaborations and just how direct their impact was on health outcomes for Latinos, as well as their influence on provider perceptions.

The University of North Carolina at Charlotte (UNCC) is located in Mecklenburg County and represents the major university collaboration by providers. The nature of UNCC's influence was two-fold, in creating job opportunities for providers and as a source of community-based interventions aimed at reducing health disparities for Latinos. In the case of a nurse educator, her position was created through a partnership between her agency, the university, and grant funding. A community health nurse also began her role at the clinic where she was employed as an internship, and eventually moved into a full-time position. Two providers, one a public health educator and the other an interpreter in a hospital system, discussed the role that collaborations played in implementing interventions to aid improved Latino health outcomes. Academics supported research design and analysis as well as grant funding to these projects, while student interns and researchers aided in the implementation and conduct of the

intervention. In full disclosure, the investigator has worked as a graduate research assistant in a collaborative research environment called MAPPR, which stands for Mecklenburg Area Partnership for Primary-care Research. UNCC, Carolinas Medical Center, and a multitude of service-based organizations comprise MAPPR, and it is in part working in this environment that informs the understanding of university collaborations in Mecklenburg County.

For both Chatham and Greene Counties, providers discussed in-depth the role of university collaborations in assisting with research, supplying clinics with providers and creating new positions, and with more critical funding support. Unlike Mecklenburg County, whose healthcare service provision environment is driven through two large healthcare networks, the role of universities in Chatham and Greene are crucial to providing services Latinos can access.

Chatham County is located inside the Raleigh-Durham-Chapel Hill metropolitan statistical area (MSA) (U.S. Census 2010). Three major research universities are also inside of this MSA; University of North Carolina (UNC), Duke University, and North Carolina State University (NC State). Chatham County is also proximate to the Greensboro-Winston-Salem MSA, in which Wake Forest University is located. In Chatham provider interviews, UNC and Wake Forest played direct roles in service provision, through direct care and research interventions. Duke was also mentioned in an indirect way. A provider was working full-time at Duke and was recruited to a healthcare facility in Chatham County.

In terms of spatial distance, UNC is the closest to Chatham County and Siler City. UNC also has the largest presence in Siler City. Chatham Hospital, which contains the

county's only emergency department, is a part of the UNC Healthcare System. Ironically, Chatham providers did not mention Chatham Hospital as a primary referral source, and the investigator was not able to interview any providers at the hospital. A major source of UNC involvement in Siler City service provision is in the area of social work in the schools. A provider who splits time between Chatham County and another office out-of-county commented on UNC's involvement:

> "I think it's been a slow building effort but we've been working a lot with UNC School of Social Work and doing a lot of teacher trainings around race and difference and how to work better with Latino kids and understand where they're coming from in the mental health issues that kids face. And it's been a long road. For about three years my predecessor was involved with that but I think that we're finally getting payoff from that work." *Chatham, #2*

It is through grant-funded partnership with UNC, the school district, and another agency that this education is possible. Also, university students have gained experienced in educational efforts through internships. A community-service provider in Chatham became employed through a relationship with a UNC professor.

While UNC has a physical, service-provision and research presence in Chatham, Wake Forest's collaborations with service agencies are primarily research-based. Four of the Chatham providers interviewed had a connection with this research partnership, with is aimed at reducing disparities and improving access and education for Latinos across Central North Carolina. Even though this is a multi-county effort, it began in Chatham County.

Through the mention of collaborations in Greene County provider responses, it is the study area most dependent upon universities for direct care provision. The university in question is Eastern Carolina University (ECU), located thirty miles east of Greene County in adjacent Pitt County. Unlike the other two study counties, an emergency

department is not located in Greene County. The closest ED is in fact, an ECU system hospital in Greenville. Providers in the county health department and largest healthcare network repeated that Greenville was a primary referral source for specialist and emergency care in the Latino population.

The first way that ECU is collaborating with health service provision for Latinos in Greene County was already mentioned with ECU hospital being a safety-net referral source. The second way ECU maintains collaboration is through establishing specialty based clinics and care in Greene County healthcare facilities. One example is given by a mental health professional explaining how mental health services became incorporated into the clinic where the provider worked:

> "It was basically ECU that got it started here. They were the ones that introduced the idea to the CEO. It was through the program that it was even possible. Now that it's established, now that I'm here full-time I'm not linked with ECU anymore." *Greene, #3*

In this case, the provider began her role in the clinic on a part-time basis. It garnered success to the degree that her position was made permanent. She explained that the healthcare network still utilizes ECU students to supplement services and care and in many cases, fill the gap between demand and supply for mental health services in the county. Another example is given by a nurse who described how ECU pediatricians would run clinics a few times a week to see children that could not make the trip to Greenville:

> "We have an arrangement with ECU pediatrics and they actually send a pediatrician here for two half days a week. And I function as a practitioner to assist in that clinic. We very likely could have twenty-five patients show up and that's more than our provider can take care of. So I kind of shift into the clinician role with that provider. But during those two child care clinics, the ECU provider is the primary person to be seeing patients." *Greene, #7*

This is another example in Greene County of a university-healthcare collaboration bridging the gap between demand and supply for healthcare services. Also, this provider exhibits adaptation by filling the role of a clinician nurse and practitioner based on the needs of the ECU provider and the demands of the clinic.

The third way universities are collaborating with or are connected to local healthcare facilities is when the providers were students at the university. Three of the providers mentioned that their degree came from ECU, and initially learned about their current position through university connections. In some cases providers were from Greene County or places nearby, attended ECU, and then returned to the county and obtained employment. In other cases, providers came from other parts of the state or across the country, attended ECU, and then learned about the opportunities in Greene County.

ECU is not the only university collaboration with Greene County. A provider in dental service explains how UNC is supporting efforts to provide dental care to the Latino population:

> "We have UNC Dental School, we've had them come through since we were open. So they come through on rotations for five weeks. And then we'll have some coming in for spring. So we're in constant communication with them. Two of us are on the faculty there. So we collaborate with them. I'm trying to think. Wherever we can, wherever, we just don't turn anybody down, if they want to work with us." *Greene, #8*

This comment sums up the role of university collaborations in Greene County. They are essential not only to fostering research and understanding about better care for Latinos, but also critical in the direct healthcare service provision for this population in Greene County. This same provider also spoke about how ECU is getting a new Dental School

and how it is hoped that a similar collaboration will bring dental providers to Greene County and improve supply to a place that sorely needs it.

University collaborations are an important element that many providers mentioned in their experiences towards providing and improving services to the Latino population. Collaborations included; academic-healthcare research partnerships, student internships at clinics, providers being on faculty at universities, and the provider's finding themselves at their positions due to connections they had at their university. Additionally, through university collaborations healthcare organizations were better positioned to apply for and obtain grant funding for either research interventions or direct care to Latinos.

The healthcare infrastructure in Mecklenburg County has more breadth and depth than the other two counties combined. With two large healthcare systems with many emergency departments and primary care clinics, there are many options for patients seeking care as long as they have access to such options. This was a theme in provider responses, especially when asked to compare how Mecklenburg County might compare in its healthcare service provision over other North Carolina counties. Being the largest county in North Carolina, Mecklenburg providers were in consensus regarding their perceptions that a stronger infrastructure resulted in better care outcomes for their patients. They were also in consensus, however, that many of their patients could not access the system, and were therefore in low quality of care environments.

5.6 Provider Isolation

5.6.1 Collective Factors

Provider isolation is a theme that was directly and indirectly addressed in responses across study areas. In some cases, providers mentioned how their clinic or

health facility was isolated from the surrounding healthcare infrastructure or opportunities for needed funding. More commonly, providers brought up how they were personally isolated in their job and how they were basically alone in meeting the service needs of their patients/clients. These personal isolation narratives were found in Chatham and Greene County providers, but not Mecklenburg providers. However, communication challenges in the urban study area did exist and they too could be interpreted as continuing to a form of isolation as well.

Isolation statements were not limited to a type of provider (i.e. nurse or physician) in the two smaller, rural-based study areas. Most comments relating to isolation derived from a demand for services perspective. A Chatham community services provider and a Greene mental health therapist spoke about being by themselves within their clinic/agency. Because of this, they were overwhelmed with demand and were isolated from similar-experienced professionals. Both of these providers were relatively new at their job and still assessing the needs of their patients as well as becoming embedded in the community.

Being new to a job or a community was one source of isolation comments for providers. Another source of isolation was being located in a geographically remote service environment. One example came from a physician's assistant in Greene County:

> "I'm very isolated out here. The only time I discuss anything is when I have provider meetings with other providers with Greene County. So, it's kind of a relief to say I have that problem too but I would love to be able to talk to people that are in similar situations. But I don't know how to connect with them." *Greene, #2*

This provider is located in a small, geographically remote clinic and divides time between clinic hours and location-based care in farmworker camps. With so much time devoted to

providing care in a spatially-isolated environment, the provider addressed overcoming personal challenges:

> "It's a stressful job. You have to take care of yourself. You can get burned out. You care a lot. And you, I have to take care of myself and deal with my stress because I'll start taking it out on others and that's not healthy. Because you do feel frustrated a lot. You do all you can and you feel like you're talking to a wall and they don't get it a lot of times." *Greene, #2*

Also in Greene County a healthcare network program director, who hires providers in the same area as the PA, spoke to the impacts that isolation and stress have on retention:

> "And it's hard to keep people. They work a lot of hours. They don't get paid great. And, they're having to work, to go out to these camps where it's 95 to 100 degrees sitting inside of a trailer or sitting in the field out in the sun all day." *Greene, #1*

The program director was speaking about retention in a range of providers including outreach workers, community nurses, physician assistants, and doctors. Understandably, the place-based context of a rural and isolated environment that challenges the physical and mental capabilities of community members also challenges providers.

In Chatham County, a mental health provider discussed isolation in the context of overwhelming community need and difficulty establishing relationships with the service-provision infrastructure of the community:

> "In my work here in Siler City I definitely exist in a bubble. There's a certain level of isolation. So, and if anything, if there's an overwhelming need and because of the lack of professionals available I am sort of considered the expert, so then I don't have anyone else I can go to…" *Chatham, #2*

The providers went into more detail concerning increasing community need for mental health:

> "I think most families have come here for work and then work shuts down and there's no options and they return to living in extreme poverty situations, I think it can re-stimulate and exacerbate their mental symptoms. We had the fourth chicken plant close recently in October. And I think, we thought that would see a

> drop in need for services and what we saw was an increase, almost a doubling of new people calling, and new folks initiating services. So it actually had an opposite effect of what we thought...we are two therapists serving the whole county and we have people come from two hours away…so I just that that the need is incredible and there are only two of us at the center. And so, folks might not get an appointment for one, two, or three months out." *Chatham, #2*

When asked about why the provider thought need would go down, the answer revolved around a belief that people would leave to either a place with a better job market or from where they had migrated. Regarding networking or consulting with other, the provider commented:

> "Just can't do it. It's a clinic day for me now…on a personal level, I often feel the exclusion. So I tend not to reach out to circles where feel that (there is) some closed-ness. I'd rather use that time and energy in the families." *Chatham, #2*

Despite the isolation perceptions and experiences, this provider spoke positively about how things are beginning to become better in terms of other providers reaching out, but only after significant time and embedded-ness has occurred. One particular example the provider gave was a local school administrator who has given support and inclusion. Additionally, the provider acknowledged that, even though tensions with other service providers existed, relationships with the Latino community were strong and motivated her work. In many ways, the provider identified as part of the community rather than the service provision network.

The importance of discussing provider isolation is that, among study participants experiencing or perceiving it, isolation significantly and negatively impacts Latino service provision. The more likely a provider spoke about isolation, the more likely to follow were negative perceptions about healthcare service provision and infrastructure, larger-scale access barriers and restrictions, and the state of Latino health. These providers were heavily concentrated in the smaller two study areas and tended to work in

clinics or agencies with just a few employees and unsustainable service demands. More importantly, these providers felt as though they were 'all alone' in many aspects of their service provision; meeting demands, obtaining funding, and networking with other providers. So, while similarities exist across study areas, differences in the degree to which isolation impacts positive provider experiences and perceptions is highly concentrated in two smaller populated study areas. As much as professional and social isolation are barriers to a provider, spatial isolation has also shown to be a barrier for providers in rural, more remote places. In urban areas, providers' comments with communication challenges whether with professional colleagues or with patients also contributed to overall positive or negative experiences associated with isolation. Even though isolation was not specifically mentioned among urban providers, there were similarities between urban and rural areas to the extent that communication challenges distanced providers from one another and from patients.

5.7 The Importance of Provider Leadership

5.7.1 Collective Factors

Provider leadership, as one might expect, is an attribute that is associated with positive perceptions and experiences related to Latino healthcare service provision for the participants of the study. Leadership emerged as a theme in the analysis in two forms. One, providers discussed leadership generally in terms of executives and administrators when giving answers related to other healthcare networks or specific clinics/agencies in the study area. Two, unlike isolation, providers did not self-identify as leaders. Rather, leaders and leadership emerged as a provider quality through subsequent analysis of transcripts. Leadership emerged as a collective factor because it was primarily tied to

social networks and ties with the provider to his/her patient population and communication broadly defined. However, this does not exclude compositional factors related to providers' dynamic relationship with their place. In the first instance of providers identifying leadership in other people/agencies, all study areas were similar and had examples. Within the providers themselves, qualities of leadership followed two general levels; individual and system-level. Individual attributes included time spent providing care in the area, how tied to the Latino community the provider was, and creative thinking solutions in overcoming challenges and barriers. System-level attributes that encouraged leadership included resources, community support, and collaborations with other providers, clinics, and universities. Individual level contributions to leadership were similar across study areas. System-level attributes, however, were more common in Mecklenburg and Greene County, and these attributes were tied to place-based contexts.

Leadership in others (or lack thereof) was a common theme discussed by providers across study areas. One example of a general leadership comment as it relates to past trends and the local healthcare infrastructure dynamics is provided by a Mecklenburg nurse practitioner:

> "There have been changes in leadership in some of the community agencies. We had a good ole boy mentality and we've had some people in charge in agencies for many years that hadn't changed with the times. I can think of two or three of those agencies who have new leadership and the new leadership has been open to saying what can we do to work better, and how can we make this better. And that's really all it takes is the leadership to get together. We also have in this community two major health systems that feel like they can't work together. The mile between those hospitals is like the great divide and I've never understood that." *Mecklenburg, #5*

Those who were described as leaders exhibited unique traits and skills in obtaining funding and/or offering culturally-competent care within larger-scaled system

restrictions. Providers at all levels who were new to their position oftentimes spoke of mentors that shaped their motivation and skillset in overcoming service barriers to Latino healthcare. Most importantly, the presence of leadership in provider experiences and perceptions were associated with positive experiences and perceptions about healthcare service provision to the Latino community.

Evidence of individual leadership was abundant in provider comments across study areas. At its core, the most common leadership trait in provider comments was that their primary career motivation was caring for this population and seeing them get better:

> "Yes. I try to bond with my patients. I get to know them personally. A lot of them, just by seeing them, I know how they're doing. So I bond a lot with them and I try to let them know, I am here for you, I'm not here against you. I'm here to offer my help. If I can help someone achieve something, no money can buy that." *Mecklenburg, #10*
>
> ---
>
> "When you see that they are not getting better you don't feel so good, but if they do good you feel so happy to see that they are doing good. Those are the rewards I get. The smiles of the kids. The happiness of the kids. There was a girl today that was not very happy. So, I examined her and then I gave her three stickers, and her face just changed! And she brightened up and was happy. I myself was so surprised." *Greene, #5*
>
> ---
>
> "I love the warmth and humility and humbleness and, they're just wonderful people. I've never worked with a better community of people. Even thought their resources are so small they're still so giving. That's been the most rewarding thing about this job, the people. And the cute kids, I love them."
> *Chatham, #3*

These quotes are indicative of the feelings that study participants have towards their patients and clients. They came from a pediatrician, a community nurse educator, and an outreach programs provider.

Another trait associated with leadership was unique adaptations to individual service barriers and challenges. A Mecklenburg interpreter provided one example:

> "I had one physician that was explaining cardiac problem to a parent. And this issue is taken for granted and they start talking about the heart and figure everyone knows cardiac anatomy. And it doesn't matter what language you speak, you might not know it. I told this physician, draw her a picture. He made faces…he drew here a picture and showed her what was wrong with the kid and the kid (later) presented to the ED and the kid was blue, had all these problems. Everyone was going, what's wrong? The mother whipped out the piece of paper, and then they knew." *Mecklenburg, #6*

As an interpreter, this provider exhibited leadership characteristics through cultural understanding and the importance of all communication methods. In this case, the mother and child were not only not able to speak English, but did not have medical literacy to understand cardiac problems. Even though it is not the role of the interpreter to bridge between these literacy gaps, this provider reached out in a culturally competent way that resulted in the child later receiving appropriate care.

Another example involved a certified medical assistant in Greene County. But this provider's medical setting is a very small clinic with few employees. The provider also plays the role of interpreter, educator, outreach worker, and triage. And, this provider is oftentimes asked to serve in other clinics due to her embeddedness in the community and culturally-based care. In this example, the provider was describing an interpreting role with a doctor:

> "Sometimes, they go for the x-ray and they (physician) still have to wait for someone to translate for them. I used to go over and help them for eight months. I was everywhere, different areas in the lab and x-rays. Or, answer the phone. I went two weeks ago to drop off blood. And there was only one Hispanic worker, and she was with a patient in a lab. As soon as she saw me she said, "I'm glad you're here." And I said, "why?" (She said), "because you going to use your magic words." (I said), "what are you talking about?" She asked me to take a phone call with a lady to explain…a procedure that she has to do. It was that this girl knew some Spanish but not a lot of Spanish words. I pick up the phone, and the woman was so pleased. And the girl (provider) said, "Thank god! You used you're magic words!" *Greene, #4*

Being embedded in the community was another important trait in leadership. Most providers in the study had been in their community for over five years. And for some the number of years was 10, 15, even 20 years. For providers that had longevity and many years of service in their community, the increase of the Latino population and changes in demographics, economics, and places impacted their experiences and perceptions. A Greene outreach worker provides one such example of longevity impacting leadership:

> "I moved here years ago, being a farmworker. When I moved here, there was nobody, only a few Hispanics. There was nobody to trust there for you. I'm glad I'm here to help my people. There's a lot of help now to help you out, and it's getting better every year." *Greene, #4*

Longevity and embedded-ness was important as it instilled values of place and community, and that was reflected in provider comments. Additionally, it increased the likelihood in a professional setting that the provider had access to networking resources and understood the myriad referral agencies to send clients and patients if it was needed.

Tied into the issues of isolation discussed earlier, providers new to their field or area tended to have a more difficult time accessing resources and gaining the acceptance of the community at large. In this way, system-level traits of leadership were not present in their experiences and perceptions. A community clinic director in a Greene County facility, for whom attracting providers to the region is a job duty, described the difficulty of the system in creating newer leadership values for the county:

> "My biggest challenge is really finding providers. That's really hard, that's what just tears me apart. It takes so much time and effort and so many times I've found the wrong providers. And I understand if they're a young person and want to come here and work for a couple of years and then ease into private practice. And that's fine, that makes perfect sense. This isn't for everybody, here. I've had many people coming here and were just looking to get whatever they could out of it, and not really get in the spirit of giving a whole lot back. And I don't blame them so much as I blame the system a little bit. We have a state that is very insular...They have their own state board. It's very hard to pass. I've talked to people all the time

> on the phone and they say, they would love to come to North Carolina and work, but they say, "I'm not going through that board. I'm not going to pay the money. I'm not going to go through an FBI background check." And the board has made it a little bit easier recently, but not much." *Greene, #8*

As important as leadership is to improving Latino healthcare services in environments where resources are limited, it is difficult for directors and administrators to find the right provider for the right place. Among the study participants the following traits were associated with themes of leadership: (1) being of Latino ethnicity, (2) having cultural competency, and (3) regardless of race/ethnicity, having longstanding ties to the community.

Provider leadership came in many ways. In Greene County, one way is how health agency directors and administrators were able to secure funding through myriad public and private funders to keep service provision viable at low costs to the community. And in the largest healthcare network, general care visits are 25 dollars to the patient. However, if the patient cannot pay, they will still be seen. Within the same network, dental visits are also 25 dollars. Costs are also based on a sliding-fee scale, and for many patients, visits are free or virtually free. Most importantly, a social security number is not necessary for a patient to access these low costs and sliding-fees.

Another form of leadership was the extra efforts provider's took to overcome barriers to service. In the case of transportation barriers, outreach workers travel to patients and pick them up for appointments. Also, physician's assistants and nurses would hold clinics at farmworker camps or even residences in the case of a particular patient need. In provider responses, stories about going above and beyond were common, but were in the context of modesty. Rather than providers believing they were going above and beyond, they thought these services and actions were just necessary to get the

job done. An example of this given by a nurse at a community clinic regarding overcoming the barrier of scheduling appointments:

> "We have several patients who call and we can see them that day. Or they can make an appointment. We always give them the option. You want to come back today or when do you want to come in? So for physicals, all appointments in a week or two or less. In the other clinics it's months…we're very flexible. We always say, yeah you can come in. Or if I know the patient I'll say, you be here in ten or thirty minutes or you be here at 2pm…things like that. But we always treat all the patients the same." *Greene, #4*

Among providers was a strong sense of taking responsibility for their patients and clients. If they had to bring services to patients, transport them, or stay open late to accommodate the demand, there was a consensus that they would do that.

The third aspect of leadership that emerged among Greene County respondents is longevity of service among providers. With the exception of one outreach worker, every provider has been in his or her position at least five years. Many providers have been servicing patients/clients in Greene County for over 20 years. For providers, this longevity translates into an understanding of their patient population and how it has changed over time. As the demographics of Latinos have changed from single men to more families, providers and clinics have adapted to offer more pediatric and family-based services. Also, providers commented that more of their patients are living in Greene County full-time as opposed to migrating for the growing season. As a result, more specialty-based services including dental and mental health have been provided at clinics. Perhaps, most importantly, providers are embedded into the Latino community and their lives;

> "I've been living in this area for 25 years…and everyone knows me and is looking for me at the clinic. And sometimes you carry the patient's concerns with you. You take it home with you to the house. And sometimes it's not good, but we are human and it's hard to not have feelings." *Greene, #4*

Because the total population of providers and Latinos in Greene County is so small, there was a consensus among providers along the 'everyone knows everyone' mentality.

5.9 Results and Discussion

The emergent themes that are discussed in this chapter included: (1) the role of geographic scale; (2) place-based factors; (3) comparison of pre-emerging immigrant gateways to traditional gateways; (4) policy impacts; (5) institutional roles; (6) provider isolation; (7) the importance of provider leadership. Emergent themes were organized by compositional, contextual, and collective factors (Macintyre 2002). Importantly, emergent themes could contain one, two, or all of the three factors. Also, compositional, contextual, and collective factors did not necessarily exist isolated from each other. The utilization of these factors represented a clarifying form of categorization by the investigator to better discuss the analysis of the emergent themes and how they intersected or diverged across the three study areas.

The first result of this chapter is the role of geographic scale on effective healthcare service provision. Providers have been successful in overcoming challenges of scale through creative grant writing and funds soliciting, as well as catering to individual transportation needs of their patients and clients. This is most evident in Greene County, where the healthcare network that serves Latinos has improved access and service by not requiring specific documentation and working to eliminate the transportation barrier. However, part of Greene County's ability to overcome the issue of documentation and healthcare access is the presence of migrant farm laborers, who were covered under state and federal assistance programs. Overcoming the drawbacks of their larger scale has been extremely difficult for the urban counties due to the absolute size of the patient base and

need for a breadth and depth of service that providers of safety-net clinics and agencies simply cannot provide. In this way, the rural setting of Greene County and the ratio of providers to patients have seemed to result in a better healthcare service provision environment. This is not necessarily because rural practitioners are providing better service, but they have adapted well to the prism of place-based and scale dynamics that best fits their patient-base. In this way, the role of geographic scale combined all three factors; compositional (individual), contextual (related to place), and collective (communication).

The second result of this chapter is that place does matter as a variable providers considered when meeting and overcoming challenges in providing quality healthcare service provision to patients and clients. In terms of compositional factors, factors that represent characteristics of individuals concentrated in places, providers became socio-demographers in the way they understood trends in their patients' residential locations, employment (and unemployment), transportation issues, and culture. In every study area, providers had a good idea of where their patients lived in relation to the healthcare facility, work, church, and service opportunities. Providers also displayed cultural competency and sensitivity to how the Latino community was settling, adjusting, and incorporating into the larger community. This cultural understanding was particularly important in cases where providers travelled to homes or neighborhoods to provide care or health services. And while these specific place-based dynamics were unique in each study area, providers utilized similar practices to understand and leverage these dynamics to increase service provision.

The third result of this chapter regarded policy impacts and institutional roles. These two emergent themes were ranged across contextual and collective factors. Policy impacts were mentioned by providers across all study areas. For example, increasing state and local laws and regulations made it more difficult for patients to obtain drivers' licenses or access insurance. Also, policies often contributed to fear and mistrust among patients, making them less likely to access healthcare. Institutional roles regarded healthcare partnerships and university collaborations with agencies in the study counties. Providers mentioned these collaborations and partnerships as important tools that provided resources, funding, and even labor towards helping their clinic or agency provide better care to Latinos. Regardless of scale or compositional factors, policy and institutional structures were perceived and experienced in similar ways by the providers.

The fourth result of this chapter was the importance of provider leadership and isolation. The importance of provider leadership was in the form of going above and beyond to serve patients' unique needs, and for the purposes of this study, understanding how those unique needs are driven through circumstances of place and scale. Leadership emerged as a collective factor because it was primarily tied to social networks and ties with the provider to his/her patient population and communication broadly defined. However, this does not exclude compositional factors related to providers' dynamic relationship with their place. Providers in Chatham County understood that their Latino patients were, for the most part, going through extremely difficult financial times due to large economic restructuring and the closing of poultry-processing plants. These patients were not going to be able to even afford a 25 dollar subsidized visit. However, in Greene County, with a history of migrant workers who have access to subsidized care, financial

considerations weren't as problematic as being spatially-removed from clinics. Therefore, because of rural, smaller-scaled patient populations, providers could offer personal transportation and/or health services at residences. And in Mecklenburg County, providers had realized that they must better communicate and collaborate with each other to connect the various safety-net clinics and agencies that serve a much larger and spatially-distributed Latino population. Provider isolation, was also a shared experience and emerged in service environments - both urban and rural - where barriers to service-provision were negatively impacting perceptions of care. In these instances, providers spoke of difficulty accessing resources, communicating with other providers or officials in their town or county, or just physically being isolated in a rural environment.

Ultimately, while these emergent findings cannot be generalized any further than the study areas, the researcher suggests that larger-scaled analysis at the scale of the state of North Carolina is warranted. To this point, the similarities of provider experience, perception, and challenge across urban to rural environments suggest the possibility that the context of the pre-emerging immigrant gateway can appropriately be applied at a regional or state level. At the very least consideration should be given to its moving beyond the metropolitan scale alone. The results of this study direct towards this line of research inquiry. This rescaling of the pre-emerging gateway concept may lead to practical impacts and potentially collaborative efforts towards better Latino service-provision once researched and tested.

5.10 Conclusion

This chapter introduced emergent themes from analysis of provider interviews and focused (1) the role of geographic scale; (2) place-based factors; (3) comparison of

pre-emerging immigrant gateways to traditional gateways; (4) policy impacts; (5) institutional roles; (6) provider isolation; (7) the importance of provider leadership. All of the themes were tied to the place where they occurred. These emergent themes reflect conceptual findings that are intertwined with the study's three methodological considerations of: (1) the role of geography; (2) the perspective of the healthcare provider; and (3) the context of pre-emerging immigrant gateway places. Also emerging in this chapter were similar themes of provider experiences as they relate to the characteristics of pre-emerging immigrant gateways. While nuanced differences occur between study areas, larger similarities existed in terms of the role of geographic scale, place, and provider perspective. The similarities that emerged in this chapter suggest that the study areas, though representing urban to rural places, share experiences in healthcare service provision. To this effect, future studies that downplay scale but emphasize similar characteristics towards re-imagining the pre-emerging immigrant gateway are warranted.

CHAPTER 6: CONCLUSION

This study examined healthcare service provision by healthcare providers to the Latino population through the three-dimensional lens of: (1) the role of health geography and place, (2) the pre-emerging immigrant gateway, and (3) the perspectives and experiences of healthcare providers.

Explorations of geography in health and healthcare research have been present since the nineteenth century. However, an increase in studies that include explicit investigation of the role of place in health and healthcare has occurred significantly since the 1990s. At this time, geographers primarily in Great Britain and other parts of Europe were establishing and critically discussing an ideological move from 'medical geography' to 'health geography'. Health geography is a way of examining issues of health from a humanist, social place perspective and deviates from traditional medical geography topics primarily focused on disease pathogens and pollution ecologies. In other words, there is more of a focus on the importance of people in their places, and how people impact and are impacted by that place (see Kearns 1994; Dorn and Laws 1994; Kearns and Moon 2002).

The effect of place on healthcare or health services provision is difficult to measure and analyze simply because places and the factors that contribute to their creation are so complex. Places can be understood as real or material (buildings, trees, etc.) or subjective, meaningful (a 'dangerous' neighborhood, a 'good' school). Drawing

from the work of Macintyre et. al. 2002, three primary categories were utilized in this dissertation to help explain place's role in health related variations across a range of urban and non-urban places: compositional; contextual; and collective.

> "Compositional explanations draw our attention to the characteristics of individuals concentrated in particular places; contextual explanations draw our attention to opportunity structures in the local physical and social environment; collective explanations draw our attention to socio-cultural and historical features of communication" (Macintyre et. al. 2002).

These place categories are not mutually exclusive yet are often studied separately. It is the contention of this study that one cannot understand compositional explanations of characteristics of individuals in a place without input from collective explanations of cultural and social positions and understanding of contextual opportunity structures.

It is also the contention of this study that research on place effects on health and healthcare often overlook the perspective of providers whose work is directly shaped and impacted by the compositional, collective and contextual characteristics of the places in which they practice. Whereas many previous studies have focused on healthcare issues based on the population being served (Arcury et. al. 2004), this study addressed a suite of place based research questions by exploring the experiences and perceptions of service providers. Health disparities can differ across places that seem similar in place-based characteristics (Villalba et. al. 2006). One element of difference flows from the providers and their distinctive approaches. With that said, "…Current directions in health professionals' practice, which increasingly take account of the links between society and the health of individuals and groups, and a greater reliance by health care systems on community care suggest that there are many potential points of convergence in the quest for developing knowledge and managing health in rapidly changing societies," (Dyck

1999). Therefore, to more fully understand points of convergence and divergence in health care provision and outcome, and to determine place's role in those, it is important to study service provider experiences based on the intersecting compositional, collective and contextual characteristics of the places in which they provide care.

Such a task is particularly important in the "rapidly changing societies" of newly formed immigrant gateways. Immigrant gateways are most commonly discussed and researched in the context of cities. And while established Latino gateways have existed in places like Miami, New York, and Los Angeles for quite some time, new immigrant gateways have been identified in the South; including three metropolitan areas in North Carolina alone (Charlotte, Greensboro-Winston-Salem, and Raleigh-Durham). These 'pre-emerging' gateway cities, as defined by Singer (2004), had high rates of foreign-born population growth between 1990 and 2000 and are places with little experience incorporating and providing services to foreign-born populations. Effective service delivery is very important to Latino populations in these new gateways in terms of incorporation and the long-term health of this population. However, new gateways likely experience extensive service-delivery challenges to their newly arriving foreign-born populations due to culturally inappropriate or insufficient service infrastructure and network capacities (Singer 2004). It is important to examine the state and conditions of service delivery in new gateways as they are the primary receiving areas (and likely long term settlement locations) for foreign-born populations whose expectations and needs may differ significantly from those of the more established communities.

Due to larger economic restructuring, changing federal and state level immigration policies, and many other factors, the U.S. South has experienced large and

sustained rates of immigrant population growth over the past twenty to thirty years. Latinos from the collective countries of Mexico, Central and South American comprise the clear majority of these foreign-born newcomers. As the Latino population in southern communities grow, access to services including; housing, education, and health care, have been strained due to a lack of initial resources and the growing population itself which places increasing pressure on established resources (Drever, 2006). Healthcare service provision is particularly important to Latinos as research shows the Latino population across many places faces significant barriers to healthcare access and suffers from negative health outcomes as a result of such access disparities (Kuchar et. al. 2005).

Between 1990 and 2000, North Carolina had the largest rates for Latino population growth in the U.S. South, and has continued sustained growth through 2010. North Carolina is the location of an increasing and diversifying set of new Latino communities within both metropolitan and non-metropolitan places. And while North Carolina metropolitan areas have been identified as new gateways, in what ways are experiences and challenges in all new Latino destinations in North Carolina similar or different? Do new gateway destinations have similar or unifying issues in healthcare service, or might a continuum of experiences that might be similar or different based on scale and place exist in new gateway places? Through a qualitative analysis of 30 key informant interviews with healthcare providers, this study addressed such a research inquiry by examining healthcare service provision across North Carolina communities that differ in scale and location but share some compositional, contextual and collective place-based characteristics with specific respect to their Latino populations.

6.1 Summary of Findings and Significance of Research

The results of this study followed both a priori and emergent themes, which are overviewed in Table 6.1.

TABLE 6.1 Overview of thematic findings

A-priori Thematic Findings
1. Major barriers to access confirmed: insurance, documentation, language, financial 2. Transportation is pervasive: attaches itself to other major barriers 3. Similarities and differences across urban and rural places
Emergent Thematic Findings
1. The role of geography and the impact of scale 2. Place-based factors 3. Provider perspective: isolation and leadership 4. Pre-emerging immigrant gateway compared to traditional gateways 5. University collaborations/institutional factors 6. Policy factors

Across the U.S. South, including North Carolina, metropolitan areas have been identified as either "emerging" or "pre-emerging" immigrant gateways, generally characterized as areas with substantial immigrant growth without having a significant tradition or history of immigrant settlement. As mentioned, these areas were predicted by Singer et al., (2004), to have challenges incorporating and acculturating newly arrived immigrants and providing them with the services they needed to advance economically and adjust socially and culturally. Mecklenburg County (Charlotte urban area) was identified as one of these pre-emerging immigrant gateways. Charlotte has seen triple digit percent growth rates of the Latino population since 1980, many in that population are foreign-born immigrants who arrived in the city/county directly from their country of origin or by way of an earlier stop in another US area. While gateway status has been conferred upon the Charlotte metro area, other counties in the state of North Carolina have seen similar growth rates and experienced the impacts of unexpected and rapid

Latino population growth. Two of these counties are Chatham and Greene Counties in the central piedmont and eastern part of the state respectively. In each of these places the challenges and opportunities that flow from the intersection of immigration and healthcare are being addressed. Given this common experience, it behooves us to understand how similarities and differences in health care provision for Latinos in all areas and at all scales of settlement are playing out. Policymakers and healthcare providers across these urban and non-urban places have an opportunity to learn from one another as they seek ways to adapt to provide effective and quality service provision to all members of their communities

Across study areas, providers became socio-demographers in the way they understood trends in their patients' residential locations, employment (and unemployment), transportation issues, and culture. In every study area, providers had a good idea of where their patients lived in relation to the healthcare facility, work, church, and service opportunities. Providers also displayed cultural competency and sensitivity to how the Latino community was settling, adjusting, and incorporating into the larger community. While these specific place-based dynamics were unique in each study area, providers utilized similar practices to understand and leverage these dynamics to increase service provision. Indeed, the role of geography and place emerged as an important factor in providers' understanding of their patient's healthcare challenges and how those challenges were met. Consider this description from a Greene County provider addressing the physical challenges of farmworker patients and associated overall negative health outcomes:

> "If they're, especially when it's high season times, they're working sixty plus hours a week. You begin to notice the burnout, the stress. They're not sleeping,

> they're not getting the rest they need. So clearly, you're going to see a cycle start happening because they're not sleeping, they're not resting, they're not eating well. And mentally, they're getting burned out, physically, emotionally. They don't have time for their family. Everything, one thing begins to affect another. So, it depends on the hours, if they have a position with a lot of responsibility" *Greene, #3.*

Similarly, a Chatham County provider speaks to the impact that the decline of poultry-processing plants had on the health of the Latino population and community:

> "Well, people have left. Businesses have closed. At one point there was more activity downtown. People had more money…so, there's just not as many people staying here. And I'm sure a lot of people have left. There's not the vitality that was here a few years ago. I think you'd have to talk to a private business person, but Hispanic persons were able to get loans five years ago, and they were buying things because they had money. So, there's that depression sort of sense of things" *Chatham, #1.*

While the details differ, the health care reality is that both providers must deal with the depression of their Latino immigrant patients. And so it went with several of the other a-priori and emergent themes and issues identified in this study. While in no way should this diminish the distinct compositional, contextual, and collective characteristics of each of these distinct communities, this study encourages to look beyond expected axes of place based difference and identify that ways in which places of different scale are united in the common cause of addressing similar processes, dynamics and impacts of untraditional immigrant settlement in untraditional gateway locations.

6.2 Research Limitations

The first limitation of the research is difficulty in generalizing results. While working towards a methodology that can be reproduced in other new immigrant gateways, the sample size of healthcare providers is too small to make justified claims about the larger state of Latino healthcare service provision in North Carolina or the U.S. South. The second limitation of the research is the number of study areas utilized. Due to

time and financial considerations, the investigator conducted interviews in three counties. A larger number of interviews across more study areas would contribute to sampling issues as well as provide depth to the narrative. The third limitation of the research is using counties as study areas. While county-level analysis provided standardization and access to broader demographic data, in many cases interviews were conducted in concentrated segments of the county, not evenly spatially distributed. The final limitation of the study was the wide-scope of healthcare providers interviewed for the study. This was initially done to allow all possible perspectives and experiences to be included in the analysis. However, a more focused and narrow subset of potential provider participants would work towards allowing a better comparison between study areas.

6.3 Future Studies

From the results and limitations of this study there are many future research considerations. First, a comparative analysis across study areas with similar site and situation would allow a standard baseline where different service-based scenarios can be analyzed. Second, a smaller scale of study area (city limit, neighborhood, hospital network) could bring a better understanding of micro-level processes with healthcare service provision. Third, with more time and resources, a larger sample size of providers in a more narrowly defined healthcare profession or setting (i.e. nurses, physicians, outreach, family medicine, community clinics) would certainly allow for results that could better be generalized to that profession or setting in new gateway destinations.

6.4 Conclusion

In summary conclusion, this study suggests that provider experiences across the study areas, despite their different place-based contextual, compositional and collective

characteristics, tend to be similar, and highly characteristic of the pre-emerging immigrant gateway. Similar to Mecklenburg providers, Chatham and Greene providers were, for example, keenly aware of the socioeconomic, demographic, and cultural characteristics of their patients and the Latino population living in their counties in general. And, in all cases, they sought ways to address the common challenges of transportation; cultural competency; financial limitation, insurance and documentation. While nuanced differences occurred between study areas, larger similarities existed in terms of the role of geographic scale, place, and provider perspective. The similarities that emerged in this research suggest that the study areas, though representing urban to rural places, share experiences in healthcare service provision and common responses to challenges met and solutions envisioned. To this effect, future studies that remove scale but emphasize similar characteristics, dynamics and responses may lead to a re-imagining of the pre-emerging immigrant gateway that this study suggests are warranted.

REFERENCES

Arcury, T.A., A.H. Skelly, W.M. Gesler, M.C. Doughtery. (2004) "Diabetes Meanings among those without Diabetes: Explanatory Models of Immigrant Latinos in Rural North Carolina," *Social Science and Medicine*, 59: 2183, 2193.

Barcus, H. (2006) "New Destinations for Hispanic Migrants: An Analysis of Rural Kentucky, in *Latinos in the New South: Transformations of Place*, eds. H.A. Smith and O.J. Furuseth, 89-110, Ashgate Publishing, England and Burlington, Vermont.

Bowden, W.P., S.D. Rhodes, A.M. Wilkin, C.P. Jolly. (2006) "Sociocultural Determinants of HIV/AIDS Risk and Service Use Among Immigrant Latinos in North Carolina," *Hispanic Journal of Behavioral Sciences,* 28(4): 546-562.

Bustamante, A.V., H. Fang, J. Garza, O. Carter-Pokras, S.P. Wallace, J.A. Rizzo, A.N. Ortega. (2010) "Variations in Healthcare Access and Utilization Among Mexican Immigrants: The Role of Documentation Status," *Journal of Immigrant and Minority Health*, 14: 146-155.

Bustamante, A.V., H. Fang, J. Garza, O. Carter-Pokras, S.P. Wallace, J.A. Rizzo, A.N. Ortega. (2012) "Variations in Healthcare Access and Utilization Among Mexican Immigrants: The Role of Documentation Status," *Journal of Immigrant and Minority Health,* 14: 146-155.

Cabassa, L.J., R. Lester, and L.H. Zayas. (2007) "'It's Like Being in a Labyrinth:' Hispanic Immigrants' Perceptions of Depression and Attitudes Toward Treatments," *Journal of Immigrant Health*, 9: 1-16.

Carillo, J.E., V.A. Carillo, H.R. Perez, D. Salas-Lopez, A. Natale-Perreira, A.T. Byron. (2011) "Defining and Targeting Health Care Access Barriers," *Journal of Health Care for the Poor and Underserved*, 22: 562-575.

Casey, M.M., L.A. Blewett, K.T. Call. (2004) "Providing Health Care to Latino Immigrants: Community-based Efforts in the Rural Midwest," American Journal of Public Health, 94(10): 1709-1711.

Census Bureau. (2002) "Census Bureau Urban and Rural Classification," http://www.census.gov/geo/www/ua/ua_2k.html.

CDC (2004). Centers for Disease Control and Prevention. United States Health and Human Services. www.cdc.gov

CDC (2013). Centers for Disease Control and Prevention. United States Health and Human Services. www.cdc.gov

Cobb, J.C. (1990) "The Sunbelt South: Industrialization in Regional, National, and International Perspective," in *Searching for the Sunbelt: Historical Perspectives on a Region,* ed. R.A. Mohl. 25-46. Knoxville, Tn.

Cohen, R.A, B.W. Ward, J.S. Schiller. (2011) "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2010," National Center for Health Statistics, available at http://www.cdc.gov/nchs/nhis.htm

Continelli, T., S. McGinnis, T. Holmes. (2010) "The Effect of Local Primary Care Physician Supply on the Utilization of Preventative Health Services in the United States," *Health and Place,* 16: 942-951.

Cordasco, K.M., N.A. Ponce, M.S. Gatchell, B. Traudt, J.J. Escarce. (2010) "English Language Proficiency and Geographical Proximity to a Safety Net Clinic as a Predictor of Health Care Access," *Journal of Immigrant and Minority Health*, article published online in August 2010, DOI 10.1007/s10903-010-9425-6.

Cravey, A.J. (1997) "Latino Labor and Poultry Production in Rural North Carolina," *Southeastern Geographer* 37(2):295-300.

Cravey, A.J. (2005) "Desire, Work, and Transnational Identity," *Ethnography*, 6(3): 357-383.

Cravey, A.J., G. Valdivia. (2011) "Carolina del Norte: An Introduction," *Southeastern Geographer,* 51(2): 213-226.

Creswell, J.W. (2009) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches,* Third Edition, Sage Publications, Thousand Oaks, California.

Cummins, S., S. Curtis, A.V. Diez-Roux, S. Macintyre. (2007) "Understanding and Representing 'Place' in Health Research," *Social Science and Medicine,* 65: 1825-1838.

Cutchin, M.P. (1997) "Physician Retention in Rural Communities: the Perspective of Experiential Place Integration," *Health and Place,* 3(1): 25-41.

Curtis, S., I.R. Jones. (1998) "Is there a Place for Geography in the Analysis of Health Inequality?" *Sociology of Health and Illness,* 20(5): 645-672.

Curtis, S., W. Gesler, G. Smith, S. Washburn. (2000) "Approaches to Sampling and Case Selection in Qualitative Research: Examples in the Geography of Health," *Social Science and Medicine,* 50: 1001-1014.

Denning, S. (2009) "The Impact of North Carolina Driver's License Requirements and the REAL ID Act of 2005 on Unauthorized Immigrants," *Popular Government*, 74(3): 1-14.

Documet, P.I., R.K. Sharma. (2004) "Latinos' Health Care Access: Financial and Cultural Barriers," *Journal of Immigrant Health,* 6: 5-13.

Dorn, M., and G. Laws. (1994) "Social Theory, Body Politics, and Medical Geography: Extending Kearn's Invitation," *Professional Geographer*, 46(1): 106-110.

Drever, A.I. (2006) New Neighbors in Dixie: The Community Impacts of Latino Migration to Tennessee.

Dulin, M.F., H. Tapp, H.A. Smith, B. Urquieta de Hernandez, M.J. Coffman, T. Ludden, J. Sorensen, O.J. Furuseth. (2012) "A Trans-disciplinary Approach to the Evaluation of Social Determinants of Health in a Hispanic Population," *BMC Public Health*, 12: 10 pgs.

Dulin, M.F., H. Tapp, H.A. Smith, B. Urquieta de Hernandez, O.J. Furuseth. (2011) "A Community Based Participatory Approach to Improving Health in a Hispanic Population," *Implementation Science*, 6(38): 10 pgs.

Dulin, M.F., T.M. Ludden, H. Tapp, H.A. Smith, B.U. de Hernandez, O.J. Furuseth. (2010) Geographic information systems (GIS) demonstrating primary care needs for a transitioning Hispanic community. *Journal of American Board of Family Medicine,* 23(1): 109-120.

Dummer, T. (2008) "Health Geography: Supporting Public Health Policy and Planning," *Canadian Medical Association Journal*, 178(9): 1177-1180.

Durbard, C.A., Z. Gizlice. (2008) "Language Spoken and Differences in Health Status, Access to Care, and Receipt of Preventative Services Among US Hispanics," *American Journal of Public Health,* 98(11): 2021-2028.

Dyck, I. (1999) "Using Qualitative Methods in Medical Geography: Deconstructive Moments in a Subdiscipline," *Professional Geographer,* 51(2): 243-253.

Elliot, S.J., J. Gillie. (1998) "Moving Experiences: A Qualitative Analysis of Health and Migration," *Health and Place,* 4(4): 327-339.

Emery, M.R., C. Ginger, J. Chamberlain. (2006) "Migrants, Markets, and the Transformation of Natural Resources Management: Galax Harvesting in Western North Carolina," in *Latinos in the New South: Transformations of Place,* eds. H.A. Smith and O.J. Furuseth, 69-88. Ashgate Publishing, England and Burlington, Vermont.

Ennis, S.R., M. Rios-Vargas, N.G. Albert. (2011) "The Hispanic Population: 2010," *2010 Census Briefs*, The United States Census Bureau, no. C2010BR-04. 16 Pages.

Errico, K.M., and D. Rowden. (2006) "Experiences and Breast Cancer Survivor-Advocates and Advocates in Countries with Limited Resources: A Shared Journey in Breast Cancer Advocacy, *The Breast Journal,* 12 supplement 1: S111-S116.

Fiscella, K., P. Franks, M.P. Doescher, B.G. Saver. (2002) "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured: Findings From a National Sample," *Medical Care*, 40(1): 52-59.

Foner, N. (2008) "New York City: America's Classic Immigrant Gateway," *in Migrants to the Metropolis: The Rise of Immigrant Gateway Cities*, Syracuse University Press, Syracuse, New York.

Garcia, C. (2005) "Buscando Trabajo: Social Networking Among Immigrants from Mexico to the United States," *Hispanic Journal of Behavioral Sciences*, 27(3): 3-22.

Glesne, C. (2006) *Becoming Qualitative Researchers: An Introduction*, Third Edition, Pearson Education Press, New York.

Gentry, K., S.A. Quandt, S.W. Davis, J.G. Grzywacz, A.E. Hiott, T.A. Arcury. (2007) "Child Healthcare in Two Farmworker Populations," *Journal of Community Health*, 32: 419-431.

Gesler, W.M., J.M. Jordan, A. Dragomir, G. Luta, and J.G. Fryer. (1997) "A Geographic Assessment of Health-care Coverage in Two 'Rural' North Carolina Communities," *Southeastern Geographer*, 39(2): 127-144.

Granovetter, M. (1985) "Economic Action and Social Structure: The Problem of Embeddedness," *American Journal of Sociology,* 91(3): 481-510

Gresenz, C.R., J. Rogowski, J.J. Escarce. (2009) "Community Demographics and Access to Health Care among U.S. Hispanics," *Health Research and Educational Trust*, 44(5): 1542-1562.

Harrington, L., M. Heidkamp. (2013) "The Aging Workforce: Challenges for the Health Care Industry Workforce," *The National Technical Assistance and Research Center Leadership Center,* www.ntarcenter.org.

Haverluck, T.W. and L.D. Trautman. (2008) "The Changing Geography of U.S. Hispanic from 1990-2006: A Shift to the South and Midwest," *Journal of Geography*, 107(3): 87-101.

Herrick, H. and Z. Gizlice. (2004) "Spanish-Speaking Hispanics in North Carolina: Health Status, Access to Health Care, and Quality of Life," a special report series by *State Center for Health Statistics*, a branch of North Carolina Department of Health and Human Services, 143: 1-9.

Horwitz, R.H., L.W. Roberts, T.D. Warner. (2008) "Mexican Immigrant Women's Perceptions of Health Care Access for Stigmatizing Illnesses: A Focus Group Study in Albuquerque, New Mexico," *Journal of Health Care for the Poor and Underserved,* 19: 857-873.

Jacobs, E.A., D.S. Lauderdale, D. Meltzer, J.M. Shorey, W. Levinson, R.A. Thisted. (2001) "Impact of Interpreter Services on Delivery of Health Care to Limited-English-proficient Patients," *Journal of General Internal Medicine*, 16: 468-474.

Johnson-Webb, K.D. (2002) "Employer Recruitment and Hispanic Labor Migration: North Carolina Urban Areas at the End of the Millennium," *The Professional Geographer*, 54(3): 406-421.

Johnson-Webb, K.D. (2003) *Recruiting Hispanic Labor: Immigrants in Non-traditional Areas,* LFB Publishing, LLC, New York City.

Johnson, Jr., J.H., K.D. Johnson-Webb, and W.C. Farrell, Jr. (1999) "A Profile of Hispanic Newcomers to North Carolina," *Popular Government*, Fall issue.

Kandel, W.A., E.A. Parrado. (2006) "Hispanic Population Growth and Public School Response in Two New South Immigrant Destinations," in *Latinos in the New South: Transformations of Place*, eds H.A. Smith and O.J. Furuseth, 111-134. Ashgate Publishing, England and Burlington, Vermont.

Kearns, R.A. (1994) "Putting Health and Health Care into Place: An Invitation Accepted and Denied," *Professional Geographer,* 46(1): 111-115.

Kearns, R. and G. Moon. (2002) "From Medical to Health Geography: Novelty, Place and Theory After a Decade of Change, " *Progress in Human Geography,* 26(5): 605-625.

Ku, L., S. Matani. (2001) "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs,* 20: 247-256.

Kuchar R., R. Suro, S. Tafoya. (2005) The New Latino South: The Context and Consequences of Rapid Population Growth. 1-85. Washington, DC. Pew Hispanic Center Report.

Lichter, D.T. K.M. Johnson (2006) "Emerging Rural Settlement Patterns and the Geographic Redistribution of America's New Immigrants," *Rural Sociology*, 71(1): 109-131.

Lichter, D.T., K.M. Johnson (2009) "Immigrant Gateways and Hispanic Migration to New Destinations," *International Migration Review,* 43(3): 496-518.

Macintyre, S., A. Ellaway, S. Cummins. (2002) "Place Effects on Health: How Can We Conceptualise, Operationalise and Measure Them?" *Social Science and Medicine*, 55: 125-139.

Marshall, M.N., D.R. Phillips. (1999) "A Qualitative Study of the Professional Relationship between Family Physicians and Hospital Specialists," *Professional Geographer*, 51(2): 274-282.

Marshall, K.J., X Urrutia-Rojas, F.S. Mas, C. Coggin. (2006) "Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women," *Health Care for Women International*, 26(10): 916-936.

McDaniel, P.N., and A.I. Drever. (2009) "Ethnic Enclave or International Corridor? Immigrant Businesses in a New South City," *Southeastern Geographer,* 49(1): 3-23.

MCHD, (2012) State of the County Health Report: An Overview of Selected Health Indicators for Mecklenburg County Residents, Mecklenburg County Health Department, 44 pages.

Mueller, K.J., S.T. Ortega, K. Parker, K. Patil, A. Askenazi. (1999) "Health Status and Access to Care Among Rural Minorities," *Journal of Healthcare for the Poor and Underserved,* 10(2): 230-249.

Mohl, R.A. (2003) "Globalization, Latinization, and the Nuevo New South," *Journal of American Ethnic History,* 22(4): 31-66.

Monnat, S.M., C.B. Pickett. (2008) "Rural/urban Differences in Self-rated Health: Examining the Roles of County Size and Metropolitan Adjacency," *Health and Place*, 17: 311-319.

NAHH. National Alliance for Hispanic Health (2001) "A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics," printed with support from the Office of Minority Health of the Department of Health and Human Services, Estella Press, 92 pages.

Peterson, L.E., A.C. Tsai, S. Petterson, D.G. Litaker. (2009) "Rural-Urban Comparison of Contextual Associations with Self-Reported Mental Health Status," *Health and Place*, 15: 125-132.

Price, M, L. Benton-Short. *Eds.* (2008) *Migrants to the Metropolis: The Rise of Immigrant Gateway Cities*, Syracuse University Press, Syracuse, New York.

Report Card. (2006) "Racial and Ethnic Health Disparities in North Carolina: Report Card 2006," prepared by the Office of Minority Health and Health Disparities and State Center for Health Statistics, 1-15.

Rhodes, S.D., K.L. Foley, C.S. Zometa, F.R. Bloom. (2007) "Lay Health Advisor Interventions Among Hispanics/Latinos," *American Journal of Preventative Medicine,* 33(5): 418-427.

Rodriguez, M.A., and W.A. Vega. (2009) "Confronting Inequities in Latino Health Care," *Journal of General Internal Medicine*, 24(Suppl 3): 505-507.

Sandoval, G.F., M. Maldonado. (2012) "Latino Urbanism Revisited: Placemaking in New Gateways and the Urban-rural Interface," *Journal of Urbanism*, 5(2-3): 193-218.

Schmalzbauer, L. (2009) "Gender on a New Frontier: Mexican Migration in the Rural Mountain West," *Gender and Society*, 23: 747-767.

SCHS. State Center for Health Statistics. (2006) "North Carolina Minority Health Facts; Hispanics/Latinos," prepared under the Office of Minority Health and Health Disparities, 1-14.

Singer, A. (2004) The Rise of New Immigrant Gateways. 1-35. Washington, DC. Brookings Institution. Center on Urban and Metropolitan Policy.

Singer, A. C. Brettell, S. Hardwick. *Eds.* (2008) *Suburban Immigrant Gateways: Immigrant Incorporation in New U.S. Metropolitan Destinations.* Washington D.C., Brookings Institution.

Sherry, S.T. (1999) "Getting the Lay of the Land on Health: A Guide for Using Interviews to Gather Information," *Robert Wood Johnson Foundation* initiative *The Access Project*. 1-17.

Smith, Barbara Ellen. (2006) "Across Races and Nations: Social Justice Organizing in the Transnational South" in *Latinos in the New South: Transformations of Place*, eds H.A. Smith and O.J. Furuseth, 235-256. Ashgate Publishing, England and Burlington, Vermont.

Smith, H.A. and W. Graves. (2003) "The Corporate (Re)construction of a New South City: Great Banks Need Great Cities," *Southeastern Geographer,* 43(2): 213-234.

Smith, H.A. and O.J. Furuseth. (2004) "Housing, Hispanics, and Transitioning Geographies in Charlotte, N.C.," *Southeastern Geographer,* 44: 127-150.

Smith, H.A. and O.J. Furuseth (2006) *Latinos in the New South: Transformations of Place.* Burlington: Ashgate Publishing.

Smith, H.A. and O.J. Furuseth. (2008) The "Nuevo South": Latino Place Making and Community Building in the Middle-Ring Suburbs of Charlotte. In *Suburban Immigrant Gateways; Immigration and Incorporation in New U.S. Metropolitan Destinations.* eds

Audrey Singer Caroline Brettell, and Susan Hardwick, 279-305. Washington D.C. Brookings Institution.

Solis, J.M., G. Marks, M. Garcia, D. Shelton. (1990) "Acculturation, Access to Care, and Use of Preventative Services by Hispanics: Findings from HHANES 1982-84," *American Journal of Public Health,* 80(supp): 11-19.

Tapp, H., H.A. Smith, J.T. Dixon, T. Ludden, M. Dulin. (2013a) "Evaluating Primary Care Delivery Systems for an Uninsured Hispanic Immigrant Population," *Family Community Health,* 36(1): 19-33.

Tapp, H. L. White, M. Steuerwald, M. Dulin. (2013b) "Use of Community-based Participatory Research in Primary Care to Improve Healthcare Outcomes and Disparities in Care," *Journal of Comparative Effectiveness Research,* 2(4): 405-419.

Torres, R.M., E.J. Popke, H.M. Hapke. (2006) "The South's Silent Bargain: Rural Restructuring, Latino Labor and the Ambiguities of Migrant Experience," in *Latinos in the New South: Transformations of Place*, eds H.A. Smith and O.J. Furuseth, 37-67. Ashgate Publishing, England and Burlington, Vermont.

Torres, R., J. Popke, H. Hapke, M. Suarez, M. Serrano, B. Chambers, and P. Castano. (2003) "Transnational Communities in Eastern North Carolina: Results from a Survey of Latino Families in Greene County,' *North Carolina Geographer,* 11: 89-109.

Tuan, Y. (1996) "Space and Place: Humanistic Perspective," in *Human Geography: An Essential Anthology,* eds John Agnew, David N. Livingstone, and Alisdair Rogers, 444-457. Blackwell Publishing, Malden, Maine.

United States Census Bureau. 2010. Uscensus.gov.

Vega, W.A., M.A. Rodriguez, and E. Gruskin. (2009) Health Disparities in the Latino Population. *Epidemiologic Review*, 31: 99-112.

Villalba, J.A. (2006) "Health Disparities Among Latina(o) Adolescents in Urban and Rural Schools: Educators' Perspectives," *Journal of Cultural Diversity*, 14(4): 169-175.

Wallace, L.S., J.E. DeVoe, I.M. Bennett, S.E. Roskos, G.E. Fryer, Jr. (2008) "Perceptions of Healthcare Providers' Communication Skills: Do They Differ Between Urban and Non-Urban Residents?" *Health and Place,* 14: 653-660.

Wie, A.V., J. Ziegenfuss, L.A. Blewett. (2008). "Persistent Disparities in Health Insurance Coverage: Hispanic Children, 1996 to 2005," *Journal of Health Care for the Poor and Underserved*, 19(4): 1181-1191.

Wilson E.K., C. McQuiston. (2006) "Motivations for Pregnancy Planning Among Mexican Immigrant Women in North Carolina," *Maternal and Child Health Journal,* 10(3): 311-320.

Zambrana, R.E. (1996) "The Role of Latino/Hispanic Communities in Health Services Research: Strategies for a Meaningful Partnership," *Journal of Medical Systems,* 20(5): 317-328.

Zambrana, R.E., O. Carter-Pokras. (2010) "Role of Acculturation Research in Advancing Science and Practice in Reducing Health Care Disparities Among Latinos," *American Journal of Public Health,* 100(1): 18-23.

APPENDIX A: INTERVIEW MATERIALS

Phone Script for provider contact

Investigator: "Hello _____ (name of person). My name is Thad Dixon and I am a Ph.D. student in Geography at UNC-Charlotte. I am conducting a study about health care provider experiences in providing care to the Hispanic/Latino community. As a provider in a place that has seen high Hispanic population growth, I am very interested in having you participate in the study through an interview that would take approximately 45 minutes. Do you provide care in any way to members of the Hispanic/Latino community, and are you older than 18?"

Respondent: Answers yes or no. If no, thank the caller and ask if they might know of any providers that do serve the Hispanic community. Ask for contact information. If yes;

Investigator: "Would you be interested in meeting to discuss these issues? (If yes) Great. (Set meeting time and date.

Email Script for provider contact

Dear _____ (name of person),

My name is Thad Dixon and I am a Ph.D. student in Geography at UNC-Charlotte. I am conducting a study about health care provider experiences in providing care to the Hispanic/Latino community. The results of this study will work towards the completion of my dissertation research requirements. As a provider in a place that has seen high Hispanic population growth, I am very interested in having you participate in the study through an interview that would take approximately 45 minutes. In order to participate you need to provide healthcare or healthcare services to the Hispanic/Latino community in the county where you practice. Additionally, you must be over the age of 18. I am attaching an informed consent form to give you further details of the study. If you are interested or have any questions, please contact me at jdixon36@uncc.edu or (206) 218-8413.

Key Informant Interview Guide
Investigator—Thad Dixon

INTRODUCTION: "Thank you for participating in this research study and agreeing to meet with me today. I have asked you here at _____ (location of interview) to discuss your experiences in providing healthcare or health-related service to Latinos in _____ (county, city, town). To begin with let's talk about what you do and who you serve."

Background

1. Please describe your position and role as a health provider?
    a. Also, describe your patients? Where generally do they come from? What kinds of jobs do they have?
2. What barriers do you encounter providing healthcare to your Latino patients?
3. Have the barriers remained consistent over time? Have new barriers emerged (or dissipated) recently? Why do you think this is?

The Role of Place

4. How do you think that place (the town, the city, community) where you do your work impacts how you do your work or how the Latino community navigates their health care?
5. What challenges do you perceive Latinos face in accessing healthcare in your city/county that they might not experience in other cities/counties in North Carolina?
6. Do you consult/work with other providers in (x) county/city to discuss issues of Latino healthcare service/access issues?
7. Do you consult with providers in other cities/counties in North Carolina or even other U.S. states?
8. What are the top three positives about providing care to Latinos in your community?
    a. What are the top three negatives?

Outcomes/Impacts

9. Have you been able to change (either personally or through other resources) your service delivery methods to reduce barriers to Latino service that you have encountered?
10. Have you had to go outside resources available in your county to seek solutions to healthcare service issues for the Latino community?
11. Do you have any questions or comments for me? Do you know of anyone else in the community that would be good to contact for inclusion in this study?

Thank you very much for your time today. That concludes the interview and I will now turn off the audio recorder.

APPENDIX A: (Continued)

Survey Questionnaire

1. General information (Please check appropriate space)
    a. Gender _____M _____F
    b. Age_____
    c. Do you speak: _____English _____Spanish _____Both
2. Employer Information
    a. What kind of provider are you? (i.e. primary, specialist, community services)_____
    b. Where are you employed? _____hospital _____clinic _____private practice _____other (Please explain_____)
    c. How many years have you been a provider? _____
    d. How long have you been providing care in your county? _____ N.C. _____
    e. How long have you been providing care to Latinos in your county? _____ N.C. _____

APPENDIX B: EMERGENT THEME EXAMPLE

Example of emergent theme process, provider leadership

First, collected all passages from transcript data related to service provision across study areas.

Service Provision

Question 1

Mecklenburg

1 Copy

I'm currently the clinical for the Latino treatment services here at (name) prevention and recovery center. So, I supervise just the treatment portion…substance abuse treatment portion. We serve the adult population, so basically anyone who's Spanish speaking and coming in with a substance abuse problem. I supervise that treatment program.
- - -
B: And that's a question I was actually trying to figure out not too long ago because there's been some changes recently with financing for out of county clients and our higher level care. Because we receive funding it's very specific to Mecklenburg County so for these out of county clients its going to be...there not going to have the sliding fee. And I was actually trying to figure that out. Luckily, these clients are on other services levels that don't have the sliding so it wont impact them.

2

I'm a registered nurse, licensed in North and South Carolina because of the compact states (?). I am the clinic manager at (removed—name of clinic) and our clinic is a free or very low cost clinic. It's not really free, but a very low cost clinic for uninsured Mecklenburg County residents from cradle to grave. And we serve a population of fifty nine countries and about fifty percent of our patients are Latino.
- - - - -
B: As far as I know it's probably the lowest cost. Um, we do have some very nominal fees. A urinalysis may cost five dollars. The injection of a joint will cost five dollars. Pregnancy test is $10. And the only reason we do that is so we can recoup some of the funds. We understand that some of the patients can't afford to pay. But the cost is so little that realistically when one person pays for a urinalysis they pay for two other people to have one. So, we're just trying to recoup the costs of actually what the test costs us. Since no granter will fund that kind of thing for a patient.
- - - -

We partner with MedAssist to help get those folks Medicare so they have full coverage. But we also have patients that are hear and are very elderly. They're in their 80s, and they're never gonna get anything. Without the free clinic, then they'll have no healthcare. And we've had em for, being around since 89 or 90 we've got a lot of elderly ones. We've got quite a few that will never get Medicare.
- - - -
B: We don't see anyone outside of (county). Well, that's not true. We have a partnership with the battered women's shelter, (agency), (agency), which are residential treatment facilities for either battered women or substance abusers and they may be from out of county residing temporarily in (county). But we see them because they don't have access to care. Now, if they have Medicaid we don't (see them). We send them to the (hospital system) and let them take care of them. But, a lot people don't qualify for Medicaid.

VN810006

B: Ok, my position is a health ministry educator. The ministry part is related to congregations. That's what we do, we train the trainor and we train the staff of the congregation in (county) and surrounding counties as well. We train people who want to be a bridge between, let's say volunteers between the hospital and the health care system, and the congregation. That's what I do. Train people, train the trainors.

A: I understand. How many, it may be hard to say, how many trainees, people have you trained?

B: This program started 2005, I started in 2009. An average of thirty people a year, probably more. I'm just counting congregations and not trainings. There are other trainings, like CPR that we do, so I would say probably sixty people a year.
- - -
B: Well, first basic training we offer is called congregational health promotion for health ministry training. It's training volunteers in the church how to be health promotors. How can they learn to be educated, a leader. It's not only giving information, we make emphasis that they have to be leadership material.

VN810022

B: My position is health educator and I'm a registered dietician so my job is to provide education to the Hispanic community. How to prevent chronic disease or how to be healthy. Not just focusing on nutrition but also health in general. And I work in public health so I go out to the community and provide services, programs, health fairs, activities, education.
- - - -
B: Well, the program is an exercise and nutrition program. The duration is 12 weeks. We get their measurements which are bmi, weight, bp, percent body fat. We do the pre and post measurements and weekly we take body weight. They exercise three times a week and they get once a week a nutrition education session. They are also taking pre and post knowledge tests and so that's what they do. They engage in physical activity in that

routine and then that knowledge. That's one of the programs. And then there are many activities that are a one time thing like a health fair or a health event. And I'm a presenter. I teach them about how to have a healthy diet. I just focus on one topic.

VN810023

B: I'm an interpreter at the hospital, and I also volunteer once a month at a free at (church). The definition of a interpreter and what we really do are a little bit different. We are more, we help with the communication between the provider and the patient. But besides that we are cultural brokers because we help providers understand some of the nuances that the Latino community might have. Some of their beliefs, we do have a lot of thoughts, like the evil eye thing and all of that. Sometimes people don't quite understand that. But we also help the patient understand how things work here. Sometimes we also have to advocate, because some providers have some ideas that might not be quite right. So we'll advocate for the patient.
- - - -
B: I am based at (the hospital). In the last year I have not been interpreting as much as I used to. But I would do inpatients, be it the pediatric setting, the adult setting. We would do some outpatient clinics be it the woman's institute, radiation oncology, cancer center, some outpatient settings. We do not go to the high volume satellite clinics.
- - - -
B: In the clinic I think they're a little more relaxed. We are more relaxed about the dos and the do nots. Sometimes I wonder if people maybe take advantage of that clinic when they could go to another place because they might have insurance or they might be "legal" and qualify for sliding scale. But they go there. What is beautiful about the clinic is that the physicians there do it because they want to. So, to me that is commendable. But you also see they're frustration because it is a small clinic and we don't have a lot of funding. We can't do a lot of things. And then they feel like they're hands are tied because they might need to refer somebody somewhere special, into a specialist, and they can't. We're just not figuring out how we can get lab work done. We're still trying to figure out how where going to get those results back to us.

DM100003

B: Ok. I function as in a couple of different ways here at the clinic. My main position is as education program coordinator. So, I essentially make sure that the education classes for the patients are taken care of. I schedule them, make sure we're providing appropriate classes for the patient and what they need for their healthcare. That's my general position. As a secondary position I also serve as an interpreter in the clinic. Here at a community clinic we all do many things. So, at any given time I could be doing check in or check out or...but primarily the two roles are running the education program and doing clinical interpreting.

A: Can you describe some of the classes you have at this clinic?

APPENDIX B: (Continued)

B: We have core classes, introduction to diabetes, and diabetes foot care. We have nutrition and label reading. And we have a Food Lion tour. In addition we do offer glucometer classes, for folks who come in and need to learn how to use their diabetes meters. All of those classes are taught in English and Spanish on different days. Not concurrently. Not with an interpreter but someone who is actually speaking Spanish and doing the class. And then in addition we do other special programming like African American programming. We do breast health education, arthritis services, heel screenings, and and arthritis health. Hiv and syphillis testing, we partner with the Health Department. The list goes on and on it depends on what is needed.

DM100004

B: I am a certified medical assistant. I help the doctors with anything. I take vitals. I do labs. I also work as a receptionist. I have to schedule the patients appointments and call them, since we open a year ago in pediatrics, we've been trying to recruit patients. And, it's one of the main roles that I have here. I need to get patients to the clinic.

A: What are some of the ways that you try to recruit new patients?

B: We have a list from Presbyterian Cruiser and there is like 800 patients. Latino patients mostly and some other countries, but it's 80 percent talking about Latinos. So basically I have to call them and tell them about the clinic, that we are a free clinic and we can provide for the children. After that we set up an appointment and then we go from there. We help them with primary care basically.
- - - -
And we cannot provide free medication. We give the medication from the four dollar from Walmart. Or we send them to MedAssist, but they need to go through a financial screening process also. And if they qualify they get free medication. So that's the two things that we tell them that we can do for them, but the Cruiser provides free medication, free vitamins. And they don't charge at all.

DM100005

B: I am a chronic disease nurse educator. Basically, what I do here is, I do a lot of teaching for prevention, and I also in the clinical area. So it's kind of like a duel role where I'm teaching and also being a provider for them. And we do the classes in both languages, English and Spanish.

DM100007 2

B: My position at the YMCA is a community health nurse. My education is a BSN registered nurse and I also have a Masters in health administration, so RSMSN. And I spend most of my time with the parents as teachers program.
- - - -

The parents as teachers is a national curriculum, so it's a curriculum guided home visiting tool that we use to go into the home and do parent education for families that have at least one child age zero to five. And basically what it does is teaches the parent through play type activities how to teach their children developmental skills like language and motor skills. Things they can do in the home to prepare them for school. And we have four parent educators who are bilingual. And then myself who's the nurse, I serve as the health resource for that team and for the families. Right now we serve sixty families and it's about a hundred and twenty children age zero to five. So if you add in other siblings it's in the two to three hundred range. For our funding focus it's the parents primarily the mothers who are at home, and then the children who are home.

A: And how often over a set period of time will you visit a family?

B: The curriculum, the parent educators are visiting the families a minimum of once a month to do the lessons. So for example if you have a two year old daughter. A YMCA parent educator comes into your home and does a play type activity that's going to enhance their developmental skills for that age once a month. And then it goes based, it's an age based curriculum. The ages and stages, ASQ is another piece, it's all just a preventative approach making sure that these kids are functioning at the right developmental level before they get to our formal education system, so age zero to five. I'm sure we'll get into it but a lot of families are very isolated. They don't have access to childcare or preschool. And formal kind of play type settings. So this is a way that the parents can learn things they can do in the home besides sitting them in front of the television that can activate brain development.

- - - - -

And then right now, and I can pretty much say over the past three years, over the past one year of functioning and in the past three years, the number one referral source has been word of mouth. So if we work with a family, go into the home, there going to go to their neighbor and say the YMCA just came and taught me x, y, and z. And so the next time we go to Maria's house, oh my friend Laura, she has a daughter and a son. It becomes a domino effect. And they actually become our best referral. Which is a way a lot of businesses work, if you go to a good doctor you go to a good coffee shop, it's word of mouth. And that's, especially effective with the Latino population because that's their main communication avenue. And we consider that to be a great thing when it comes from families who may already have a connection point with each other. We're their support but they're also their own support. And then the other community organizations. People who know about us being a home visiting program. There's a pamphlet I should have brought you as well, that's kind of a continuum. Nurse family partnership is another example run through community health services, Care ring. They work with first time moms, from age zero to two. So then you see at age two, that family may still need support so then they know our program to age five. So that's another example is just...En Lace, knowing the YMCA still has this program another colleague calling up and saying, I have this family who would be a good fit for your program.

A: Are you able to fill the need or do you find the demand is higher than the supply?

The demand is higher than we have capacity for. We just hired a new parent educator because we received additional funding from Smart Start which is a big success environment when most people are getting cuts. So, we're serving twenty five more families starting right now in 2012 to reach a total of I think 80 families. Sixty was last year and now it's eighty. So, the case load is one parent educator is responsible for one twenty five families, and that is considered a full case load. So, yes, we do have a waiting list. And as families graduate, openings come up, or other areas are, some families are transient and may leave or go back to their country or move to another city, and then other families who aren't a good fit. And that happens in the program. And they committed and we can't get a hold of them. They aren't in it for the right reasons. So...

DM100007

B: Ok. Actually, until this year this clinic provided services for adults 19 and over. Earlier this year we started our first pediatric clinic. I am not a provider in that clinic but we did start it for uninsured children. We currently have about five hundred kids in that. There's a pediatrician and a nurse practitioner part time. On the adult side we have about three thousand unique patients right now.

Chatham

VN810003

B: We haven't had one yet but the projection for the end of this month is 70 patients in one day between the four doctors that are going to be there.

A: The one doctor coming from Mexico and have doctors coming from other places?

B: There all UNC-Duke affiliate positions.

A: So, coming from Raleigh, Durham, Chapel Hill. How long is an average visit with a client?

VN810005

B: Ok. I'm a mental health therapist. Im a licensed clinical social worker, and I work two days in community clinics, one in Chatham County Siler City, and one in Carrboro and Orange County. The other three days I work at a mental school here in Siler City.

VN810032

We do HIV STD prevention through prevention curriculums. And then we have non-traditional testing where we go out into the community and test, we do substance abuse testing where we go into substance abuse centers and test. And then we have three research projects with Wake Forest University.

APPENDIX B: (Continued)

VN810036

: My name is (name) and I'm a certified midwife and I'm actually starting to be the lead provider here. And I've been working in this community since 98.
- - -
B: Women. Midwifery in North Carolina is primary care. So, pas and nurse practitioners have to be supervised by a physician but I'm directly reimbursed by Medicaid and insurance. And anything that is primary care for women I can do. (personal comment excluded by request). I can see thirty days or younger both genders but or women of any, I have 12 year old patients because they're sexually active already, through the whole life span. So, it's anything, prenatals, papsmeres, family planning is my big love.

Greene

VN810008

We also do provider outreach, which means we take mid-levels, family nurse practitioners or physicians assistants and go out to the camps where the workers live. And do healthcare on site, right there were they live and work. I've been doing this for about fifteen years. And I do still go out on a regular basis, out to the camps on a regular basis even though I'm director I probably still spend forty to fifty percent of my time providing health education, case management, services like that to the farmworkers, mainly latino farmworkers.

VN810013

B: I'm a physician assistant. I'm been in primary care here for three years. I mainly provide care to the Hispanic community.
- - - -
Usually I can just check blood sugar, and their ears. And so I'll check the family's blood pressure and make sure they don't have any medical issues, and then we're done for the night. We may see ten or fifteen patients a night.

VN810017

C: Ok. I'm a medical office assistant. And what I do is, when the patients come to the clinic, if they're new we give out what's called a sliding fee form. That helps the patient to qualify for a discount, so we ask for proof of income, the two most recent stubs from their job, sometimes they don't work but they'll get disability or food stamps, that's proof. If they qualify, the patient pays twenty five dollars every time they come to the clinic. And the sliding fee discount is good for one year. That's what I do. I get information from them and put into the computer. And then I have to print out a form which I give to the nurse and when she's ready for the patient she calls them. And she's the one doing the vitals, why are you here questions, if it's a physical exam or something simple like a cold

or pain. When we're really busy, there are times we'll have five patients at the same time, (name) does vitals and I'll, if it's Hispanic patient I'll go in the room and interpret with PA. At this clinic we have three rooms, and once they're all full, we'll take vitals and then they'll wait until there is a room available for them. We go in the room, sometimes I interpret when she is really busy. Because she has to do the lab work, she has to decide if this patient is going to need...

- - - -

C: I'm the one in charge...if (PA) decides someone who is having back pain for six months and we gave him medicine and it didn't help him. Then the next step is a referral appt. (PA) tells us to help the patient as much as we can because, going to the specialist is kind of expensive, especially for migrant patients who don't have insurance. So she always tries to do what's in her hands. She always get a second opinion from the doctor that she works under, and then she has to give me an order that contains the patient's diagnosis, and the reason why she's sending the patient to a specialist. Then I have to call first, and let em know, my name is x, I'm trying to make an appt for this patient and I fax the medical records. And they'll always give an appt for maybe the week after the referral. The other thing with the Hispanic patients is when I call to make the referral I have to make sure they have an interpreter. But sometimes they don't always have an interpreter. So we do have, farmworker, healthcare promoters, and they offer transportation and interpretation for Hispanic patients. So when the patient don't have an interpreter I try to get in contact with the promoter...

VN810019

B: Ok. I'm a medical family therapist, that's the description. And the medical family therapy part, the therapy part is because I'm working in a medical setting. It's called integrated care, which is basically, Greene County Healthcare offers the mental health aspect as a normal part of their service. And so it's integrated during pretty much any medical visit.Whether it's just a routine visit or a walk in for an ingrown toenail, it doesn't. We try to see as many patients as we can during their medical visit. And we usually go in before the providers, and we just assess, or join to assess basic things like why are they here, what is going on?

VN810020

B: I'm one of the pediatricians for Greene County Healthcare. I have been here two and a half years. My role is, I only see children from new born to 18 years of age. Along with me there is another part time pediatricians. The rest of the doctors are family medicine doctors. So they also see children but also adults. Then there is internal medicine doctor, he only sees adults.

VN810028

B: I'm an outreach person for Greene County Healthcare. Basically, my job is to go around to the migrant camps and ask them, do they have any problems with health? And if they do, we try to offer them the best service that we can that is affordable to them.

Cheaper medicine, if they don't have any transportation sometimes we transport them to the clinic. And we offer service where we go out there once a week, a couple times a week with our Pas, and we check their blood pressure and sugar. That's free, and lots of time its better because we can find out who has high levels or problems with health. And the quicker the better so they can get help. We basically offer the most help we can get them.

VN810029

B: My name is (name) and I work for Greene County Healthcare and my position is outreach, healthcare promoter.
- - -
B: Communities, camps, homes, everything, wherever to reach the Hispanic community.

Question 2

Mecklenburg

1 Copy

I'm the clinical supervisor but sometimes I have to fill a lot of different roles within this...because, you know anything Spanish speaking I have to take the responsibility because these people need my services

DM100004

B: I also work once a month with the adult clinic. I work the primary care at night. In there we have a different number. We have Latino is probably fifty percent, but we have African American, we have white, we have some Asians. We have some, I think Asian Indians.

A: So, with the pediatrics populations it mostly Latino?

B: Yes, because one of the main reasons they thought about creating the pediatrics was because of these kids that was in need, of you know, to have a primary care doctor. But we have some that are from Asia, and we have some from Africa, also. But, the majority is Latino.
- - - -
B: We have a doctor who provides counseling. And we, when we have cases we think they need the more intensive health, we refer them to a different clinic. We refer them to (clinic name) and they do a lot of counseling and psychiatry.
- - - -
B: They do. Because since I'm a native speaker my community, so I'll go, don't worry. I mean, nobody's going to do something extra with the information you're giving me. And it's only for the care of your child. We don't care about anything else. And they'll be like, okay. And they're so thankful at the end that we call them.

APPENDIX B: (Continued)

DM100005

So it's kind of like, I have to spend a lot more time with them to be able to get them focused and understand and it's like giving them information little by little and it gets to a point where it makes sense for them.

DM100007

Access to medications was a huge issue, we are fortunate in this county to have Medassist pharmacy that helps us to get free medicine for the majority of our patients. That it is becoming more and more difficult as the drug companies who provide those medications require ssn and put more and more restrictions on age and financial limit. Increasingly the cost of medications to our facility is getting higher.
- - - -
B: Actually, not much, honestly. I've been pleasantly surprised, case in point, this lady is a perfect example of that. A sixty two year old woman from a very small town in Mexico came here with her family. She's undocumented, she's diabetic, she didn't get care for along time, she came to our clinic three or four years ago and her diabetes had been way out of control for along time. She had kidney and eye problems. And every time her kidney problems got worse she needed dialysis. When you're undocumented you can't get medicated so she could never get dialysis. She died Christmas day of kidney failure. But I saw here the week before and explained to her family that she's not getting any better and I actually called our local hospice and they said, sure we'll go see her. And she's undocumented but they didn't flinch. At least we were able to offer her some supportive care. The difference is, in the CMC system if you're undocumented they charge you full price, which is to bill you and bill you and bill you. The Presby system they will put you through their charity care application and try to write off as much as your bill as possible, but they'll still bill you but at a heavy discount.

Chatham

VN810005

One of my strategies about the economic crisis is to not pay attention (laughing). I just serve my clients.
- - - -
B: In the school, I'll do the group. And one group has seven kids, the other group has thirteen kids. Then I'll usually see four patients after that. I am limited because I'm only allowed to take kids out during their specials, art, p.e., music, band. Which is fine because a lot of my kids are not doing well in school. So I don't want to take them out during math or reading, or..and so, if I don't have group I'll usually see five kids in a day. And the sometimes teachers refer crisis kids who are not on my caseload. And then at the clinic I work a nine hour day so I think I see up to eight patients a day.
- - -

A: So, pretty much the capacity of what you're able to handle is what you see.

B: Yeah, and even though it's eight patients a day, they can be very heavy trauma. So, emotionally, it's hard to take on more than that a day. Particularly at the clinics. It's just straining, it's horrible stories out there.

VN810032

But our, it's really interesting because I had a woman her four years that was bilingual, a young girl from UNC Chapel Hill, great person, would go out and no one would speak to her, even in Spanish. Because they could just tell, she had this different air about her. I had to convince the board to let me hire this person, this person actually left to go to research at Chapel Hill, and I had to hire a new outreach coordinator which was suppose to be a Latino outreach coordinator and I hired white woman. And the board was like, why would you hire a white woman that doesn't speak Spanish to do a Latino project. I said because she has a personality that everybody will love and people will talk to her. Around her, the Latino people know enough English they'll speak to you if they trust you. Within the first week we're talking to her. The wives were talking to her. So our staff were doing it so long and know enough conversational Spanish to be able to talk with people. But, 90 percent of the Latino people know enough to speak to you. It's a choice. Whether they speak to you or not. But they'll talk to my outreach workers because they have that personality.
- - - -
But my staff is non-judgemental and that's the main thing. They accept people for who they are. They don't care if you're high on crack or meth and whatever. They'll still be your bud, and if you want to get tested and if you're in the right frame of mind we'll test you, and if you're hungry we'll feed you, we have a lot of people come to us for services beyond that. We have people come to us because they know us and they'll say, we don't have any clothes for our kids for the winter. We go find them, we don't have any furniture, my husband's getting out of jail, I haven't been able to put furniture in a house, can you help us out. And we'll go find furniture for them. So we've become a resource agency for folks.
- - -
Because there are people out there that are judgmental. There are people out there that run agencies and...because people that come here and test with us they can be doctors, they can be lawyers, they can be homeless, they can be drug addicts, they could be prostitutes, they could be school teachers or ministers, and they need to be able to come in her and know that a, we're not going to tell anybody, and b, that we don't judge them. So, there are agencies across the board that do have good staff that way. But there are some agencies that need to get rid of their staff because they're very judgmental.

A: Do you think that part of that judgement falls under larger debates about immigration or just whole thing with being undocumented?

B: Some of it does. I know agencies out there that say, oh, we're Latino friendly. They have one person on call that speaks Spanish and that makes them Latino friendly, that

doesn't make them Latino friendly. You need to go out and meet people and get to know them and, that 's the whole reason we can go to the Mexican Consulate and other people have tried and tried and can't get in there. The Mexican Consulate likes us. We're not going to judge people. We don't care if you're coming here and undocumented or not. We're gonna to treat you like anyone else. There are other agencies that say that they are Latino friendly, but they're not. Just because you have a Spanish speaker on staff, you now, ten hours a week doesn't make you a Latino friendly agency.

VN810034

B: It's costly. But we do that. We arrange activities all through the year. Last year we did about sixteen activities. And the Latino families are so eager to participate, and have their kids participate. This summer we sent a bunch of kids to camp. And even though there's a lot of paperwork. Our staff helped kid's parents fill that out. That's something we try and do is give them access to cultural experiences, we took a group to the civil rights museum in Greensboro. We got money this year, so we're taking kids to the planetarium, Chapel Hill, we'll go to life and science in Durham, those things.

Greene

VN810010

Our first year was 2003, and we saw, we had about thirteen hundred encounters. Last year we topped fifteen thousand. So, we're really growing. We're doing well. We had four employees our first year, we have thirty one now. At the same time, we are not taking new patients at this site because we're so full. Even with three full time dentists and five part time. We decided, of course we'll take emergencies. We'll do that. But as far as for routine treatment, the needs are so great...you know one person walks in and you go, whoa!

- - -

B: And these are people who are good people! There not slackers, maybe ten percent are trying to game the system. Our system is set up so you can't game it. People still have to be responsible, they have to show up for their appointments, if they don't, they're out. So, we have people who are just struggling to make it. So we have a lot of respect for our patients. And we just ask for them to respect us and our time also. And it works pretty well.

VN810013

B: It took me awhile to not take personally that they're lack of compliance was not a reflection on me, it wasn't my problem. My job was to give them my advice and if they didn't take it that was there issue. I'd get upset because I cared about them. You're diabetes is scaring me and I want it good. So I would explain it to them and they would usually understand that.

VN810019

APPENDIX B: (Continued)

Probably, in the traditional, it has been done, but I think it is harder. And for the patient, it's hard for them to completely open up, because not only are they having to share with one person. It's difficult enough with somebody else. And some people don't have a problem with it at all. They just say I'm here to get help. And they just share, but there's others that feel that it's hard enough with one person, let alone having to share through the interpreter. And sometimes what is described, you don't know if the message is, you don't know what the patient is saying is being interpreted correctly, and what the therapist is saying in the beginning. And then with some of the therapy things, they're very delicate things, there's a lot of things you don't want to miss. So, I think in the medical setting, integrative care for prescreens and stuff I can see how that could, it probably, you can do okay to get a general idea, for traditional, it would be better to have a full Spanish speaking therapist. It's a lot better. They feel more comfortable, culturally speaking. They feel safer

VN810028

A: Do you think the medicine available to them is accessible?

B: Yeah. There's a program we have, we try to get them medicine somewhat cheap, on a discount. And they go to the pharmacy and they get it, and I would say it's readily accessible. Whatever the doctor prescribes, they can get at the pharmacy.

Question 3

Mecklenburg

VN810023

A: Right. For the providers, does age have anything to do with that? Does that play into their role in this?

B: I don't think so. I think it's more their personality, the way they are. And many times the more arrogant they are the tougher they are to deal with. I'm thinking of a neurosurgeon.

DM100004

B: It is. And interpreters are volunteers. We usually have two or three. Depending how many Spanish speakers we have. On the pediatric side, the kids they speak English the parents don't. At the same time we do interpretation too. We go with the doctor and we have to interpret everything because we need to let the parent what's going on. So, it's time consuming because we don't have that.

Chatham

VN810005

B: I think it's been a slow building effort but we've been working a lot with UNC school of social work and doing a lot of teacher trainings around race and difference and how to work better with Latino kids and understand where they're coming from in the mental health issues that kids face. And it's been a long road. For about three years my predecessor was involved with that but I think that we're finally getting payoff from that work.

VN810026

A: I don't want to take all of your time. But maybe if you both want to take a turn. With those fears, and you're trying to build trust, what are some of the things when you're trying to recruit participant or consultant to get over the fear barrier?

B: Well, being a Latino helps. If someone else from a different ethnicity it doesn't, eventually speaking Spanish helps if you're not Latino. But being friendly and letting them know you're not hostile. If you explain to them and be friendly about their options in accessing services. Talking one on one is better than in a group setting.
- - - -
And even if you're a Latino now, and there are Latinos working for immigration. And just to give you another example, I was recruiting my first group of participants, I had 20 guys and one of them stood up and said are you really who you say you are. So I had to, it was like ten thirty at night, and I said, well you are welcome to visit my office and there were like fourteen of them that came with me to my office at that time. Like ten miles away from where we were. So, because they don't trust even if you're Latino, so you really have to become friends with them. You have to build that trust and make them understand the importance of the study you're doing for them. You want them to consider to participate.

VN810032

B: I think there is, because a lot of time we can do things for people that are undocumented that other agencies can't or won't. So we don't care if you're documented or not, we'll still do your test. We'll help you out with that. I think it's hard here,

Greene

VN810008

But we have new camps every year where there's actually, there are camps that are new where it might take us three or four times to go out there before they, you know it might just be a five minute visit where I say, here's my card, here's our hours, if you need anything. A week later we'll go out there and they'll be stand offish, and then the fourth time, we'll be like, you know we have a provider, can we come by. And she'll do finger

sticks or blood pressure and it's all free. And then once that happens the barriers are knocked down. So, it was a challenge but not as much as I thought. Now that I look back. It wasn't a big barrier, as far as the challenges of getting to the camps, and trust, it wasn't as big a barrier as I would've thought it would've been.
- - - -
A: Sure. And do you get a lot of agencies, do they contact you for advice, do they try to get in touch with you about how they can bolster their provision?

B: Not really (laughs). I mean, a lot of them can't afford to offer discount services and they don't want to. For a lot of reasons: one) we start serving this population that means we're going to have to go out and hire people that are bilingual. Or hire an interpreter which we don't have money for. So a lot of them, it's not just as easy as serving this population. You talk about, now we need somebody to speak Spanish. Before we didn't need that. Now, they're only able to pay twenty five dollars and we're actually losing money. So, you know, it's not necessarily that they don't want to it's just they can't afford to.
- - - -
We do depend on those funds, and they are taxpayer funds. So, we're trying to use them the best we can. At the same time, I've gotten stretched to the limit because we're given so much money, and that helps pay for providers, I've expanded the providers, but we haven't expanded the money. So, we try to get them paid for. In other words, to answer your question, to go back to that, I don't have major plans for expansion. Now, in the back of my mind, if funds came along I'd have a plan for you tomorrow. I know exactly what I want to do. But there are not in stone, we're not writing them down right now and expanding.

Question 4

Mecklenburg

1 Copy

I don't know how the laws have changed, for right now we have to be careful how we approach that situation because these people need treatment but at the same time its not a goal that they have. So, trying to motivate them to see how they can change their life or how this can help in the long run is a little bit more challenging. I don't know if that answers the question…

VN810023

A: Have you ever heard a story from a patient about being taken advantage of by these places or maybe from other providers? I have wondered the same thing.

APPENDIX B: (Continued)

B: It's just little inuendos you hear. I know a physician who has a practice and offers you infertility treatment. But then he sends them to another institute to do a lot of the stuff. He does it, and then just sends them back to me later.

Question 5

Mecklenburg

VN810006

B: That would be challenging. I would tell the person, it takes work be prepared, first. You have to be a person that is perserverent and you have to be where the community is. Where is the community? First, it's going to be painful, he or she has to go to the church level where the meetings are. In the beginning I had to do that, you know, going to congregations where you don't know what they're talking about. One day I had to wait four hours to do a presentation in ten minutes. I was like gosh, it was a Monday night! You have to go to the community, don't wait with your phone going like, oh they haven't called me yet.

DM100004

B: I think the funds went down a lot these past three years, because of the economy. There are ups and downs. You know how these people are, one door closes the other opens. They fight, and they look for help. That's why we're still here because they work so hard to keep this clinic open. And it's amazing what they do. And the volunteer do such an amazing job. The doctors at the night clinic, they come from different churches. They come from (hospitals and clinics names). We have like 80 percent of the people who come here are volunteers. And it's amazing the help they provide to us and the community. And they come from everywhere. And they are Latinos, they are African American, they are white. And a lot of them speak Spanish and are the interpreters.

Greene

VN810010

B: Um, yes. As far as access and everything. We're two different types of sites. They're a combination community health center and health department, so they're part of the county. They're focused on phase 1 treatment. Which is mainly children and pregnant women, which is basically Medicaid eligible populations. We're very much into phase 2, treatment here, which is comprehensive care. We do all the phase one things, and I don't know if you know...?
- - - -
B: Okay, phase 1 is fillings, extractions, and cleaning. Exams, nice low level but good dentistry handles emergencies and things like that. Phase 2 is like, you know, phase 1

you're taking teeth out, or you're filling them. Phase 2 you're putting them back. You're taking the next step. Now you're doing dentures, partial dentures, a lot more adult care.

VN810020

B: You have to learn to know the community that you're serving. You have to find ways to communicate with them because they're some words I use that are common in my country but there's other words that other people from other Hispanic countries, there's words I've heard parents use that in my country are a bad word. So, I have to change instead of being shocked I have to ask them, what do you mean by that word? Maybe like giving, being a pediatrician to the patients in every place you really don't change the healthcare part, per se. But what you have change is communicating with the population because every place I've been is a different population. So that's the changes, being able to communicate, what works when you talk to them, what doesn't work. How to approach different situations. People are different. That basically has been the change. Even when you talk about diagnosis or treatments, it's different with each population because you have to try to use the right words or change things so that they can understand what you're trying to say. If I talk a certain way in the other places before here and they understood, here maybe I have to do changes because they may not understand because they do not understand in the same way as in other places. So, those are the things that are changes. I have to adapt to a different community so that I'm able to transmit the message and get to them so that I can help them. If they don't understand what I'm trying to say they won't be able to follow instructions. What I want them to do to help them out.

Question 6

Mecklenburg

1 Copy

A: Ok. So you've already answered part of this question. This has to do with how you might consult or work with other providers in Meck County about healthcare service or access issues. It sounds like in a lot of ways that there aren't as many referring agencies as you would like there to be….there's not enough supply for your need.

B: Exactly

2

A: Ok. And do you consult or work with other health care providers in Charlotte to discuss issues of Latino healthcare?

B: Yes, and we have a great relationship between (hospital system name), between the community advisory board, from the residences at CMC that come over here. From the church groups that volunteer. We try to collaborate...we try to use personal favors...for

doctors to come so we can get ear, nose, and throat patients seen. We call on these people and ask them to help our patients.

DM100005

B: They do. And we actually have a book with resources. And it has listings. And we give, for example, counseling for depression, domestic violence, sexual abuse, drug abuse, there are different places they can go to and if I see the need, if a patient is coming to me and maybe they have a need that we don't have here in the clinic, then definitely we do refer them out. So they are aware of the resources and we also try to bring in information like we've had ICE come and talk to patients, to us, just to get a better perception of what's really going on out there, more updated information. We do provide patients with resources. A lot of them though are scared to go to the resources. Because when they do go to the resources they encounter difficulty communicating. Or the people, you can say a lot with your facial expressions, the people don't have to talk. But how you perceive someone or let them perceive you means a lot and they might take someone like getting annoyed or not understanding, maybe they're not being judgmental it's just frustration, but they way you come across sometimes can kind of be a way of putting resources out of reach. And certain places don't have those resources where they have an interpreter. We work with PRO, and they don't accept anyone that doesn't speak English. I understand the funding but that's being a little racist to me if you can't provide for different cultures or races.

- - -

B: Yes. We do. The good thing here is we have wonderful doctors, healthcare providers, that we work with who are willing to donate their time to free services like a patient who needs a colonoscopy. Sometimes we can get that done free of charge. They cannot afford it. There's agencies that we work with as well, like (name) for patients with cancer, we can refer patients to them and they can work with them. They don't have to be documented or have insurance, they'll still see them and give them counseling and services like that. There's (name) that we also work with. We have some patients here that have renopathy or they are legally blind and we've had their services as well. So there are many agencies that we work with, MedAssist is another one for prescriptions. They provide patients with free prescriptions.

DM100007

B: There is a group called Medlink that our director is a part of that meets on a regular basis and there are representatives from a lot of the community services to help to address those problems. We try to, the idea has always been we will try as a community to take care of the population.

Chatham

VN810005

APPENDIX B: (Continued)

B: Not really. Some of the colleagues relationships I've made are just very supportive of the work I do and are part of a colleague, equal basis. I think as far as consulting, I'm just trying to keep up with overwhelming need and so I don't have time or energy often to reach out to other constituencies.

A: Sure.

B: I used to go to this Chatham county youth collaborative meeting once a month. I can't go anymore (laughing)

A: Not enough time...

VN810036

A: That makes sense. In general, the uninsured people in Siler City, do you see yourself as the main safety net clinic for the uninsured people?

B: Yes, we are. Because we have people that call, we had a lady a week or two ago, she calls, she says this is the first time in our life we don't have insurance, and my son needs to see somebody. I called all these offices and I have money but they still won't see us. Will you see us, of course.
- - -
A: Any approximation of how much bigger it's gotten? Maybe over the last year?

B: I don't know, it just keeps growing. Well, the doctors, each doctor there's six. If they're full time the caseload can be like 1,200 patients. So, but it always moves, you have people who die. People who don't like you. People that move, you know, that kind of stuff. So, you always have to be adding new patients. Yeah, we're pretty much the safety net.
- - - -
B: Our safety net for one group of people that's pretty important is, people who've lost their jobs. And they don't have insurance, and they're in that age between forty-five to sixty-four, and they don't qualify for Medicare. And they don't have insurance. And yet that's the time they really need to watch their health, is when things can come up bad. So, we're a good safety net for that.

VN810036

A: Right. I'm going to some of these questions. I imagine with your connections and colleagues at Duke you still stay in touch. Do you ever consult or talk with providers doing the same thing you're doing maybe in similar clinics in other parts of North Carolina?

B: Um, I'm at a hundred-thirty percent of my required productivity. (laughing) So I see between twenty five and thirty patients a day...

A: Wow!

B: And so I don't talk much to people. I have friends on facebook from Duke and we still talk about stuff but I'm really kind of out of the loop because I have been working so hard. I'll be cutting back some on my patient time so I'll have ten percent less. But you know, I don't want to be a 110 percent, I want to be at 90 percent! (laughing) I'm not an overachiever! I want to make the world a better place without dying in the process. So we're working on that too.

B: Mhmm. But on the micro-level there's more acceptance. It's the macro-level..

A: Right. Given the time you spend at your job, do you ever work with other agencies in Siler City?

B: Yes. We're connected with the health department. I talk to their social worker often. Refer people to different places, and there's a great place called (name) for mental health services.

VN810010

B: Yeah, and we're having him partner with community health systems, if there is one in that area. And that helps with their administration a lot.

Second, created code list from the service provision passages to discover the presence of provider leadership.

Code List example

Empowered
Embedded
Religious/Religion
Leadership
Multiple Roles
Positive
Outreach
Humble
Advocacy
Availability
Confidence
Pride
Hometown
Happy
Flexibility

Values
Longevity/Service
Director
Funding

Third, extracted passages that referred to provider leadership.

> "There have been changes in leadership in some of the community agencies. We had a good ole boy mentality and we've had some people in charge in agencies for many years that hadn't changed with the times. I can think of two or three of those agencies who have new leadership and the new leadership has been open to saying what can we do to work better, and how can we make this better. And that's really all it takes is the leadership to get together. We also have in this community two major health systems that feel like they can't work together. The mile between those hospitals is like the great divide and I've never understood that." *Mecklenburg, #5*

> "Yes. I try to bond with my patients. I get to know them personally. A lot of them, just by seeing them, I know how they're doing. So I bond a lot with them and I try to let them know, I am here for you, I'm not here against you. I'm here to offer my help. If I can help someone achieve something, no money can buy that." *Mecklenburg, #10*

> "When you see that they are not getting better you don't feel so good, but if they do good you feel so happy to see that they are doing good. Those are the rewards I get. The smiles of the kids. The happiness of the kids. There was a girl today that was not very happy. So, I examined her and then I gave her three stickers, and her face just changed! And she brightened up and was happy. I myself was so surprised." *Greene, #5*

> "I love the warmth and humility and humbleness and, they're just wonderful people. I've never worked with a better community of people. Even thought their resources are so small they're still so giving. That's been the most rewarding thing about this job, the people. And the cute kids, I love them." *Chatham, #3*

> "I had one physician that was explaining cardiac problem to a parent. And this issue is taken for granted and they start talking about the heart and figure everyone knows cardiac anatomy. And it doesn't matter what language you speak, you might not know it. I told this physician, draw her a picture. He made faces…he drew here a picture and showed her what was wrong with the kid and the kid (later) presented to the ED and the kid was blue, had all these problems. Everyone was going, what's wrong? The mother whipped out the piece of paper, and then they knew." *Mecklenburg, #6*

APPENDIX B: (Continued)

"Sometimes, they go for the x-ray and they (physician) still have to wait for someone to translate for them. I used to go over and help them for eight months. I was everywhere, different areas in the lab and x-rays. Or, answer the phone. I went two weeks ago to drop off blood. And there was only one Hispanic worker, and she was with a patient in a lab. As soon as she saw me she said, "I'm glad you're here." And I said, "why?" (She said), "because you going to use your magic words." (I said), "what are you talking about?" She asked me to take a phone call with a lady to explain…a procedure that she has to do. It was that this girl knew some Spanish but not a lot of Spanish words. I pick up the phone, and the woman was so pleased. And the girl (provider) said, "Thank god! You used you're magic words!" *Greene, #4*

"I moved here years ago, being a farmworker. When I moved here, there was nobody, only a few Hispanics. There was nobody to trust there for you. I'm glad I'm here to help my people. There's a lot of help now to help you out, and it's getting better every year." *Greene, #4*

"My biggest challenge is really finding providers. That's really hard, that's what just tears me apart. It takes so much time and effort and so many times I've found the wrong providers. And I understand if they're a young person and want to come here and work for a couple of years and then ease into private practice. And that's fine, that makes perfect sense. This isn't for everybody, here. I've had many people coming here and were just looking to get whatever they could out of it, and not really get in the spirit of giving a whole lot back. And I don't blame them so much as I blame the system a little bit. We have a state that is very insular...They have their own state board. It's very hard to pass. I've talked to people all the time on the phone and they say, they would love to come to North Carolina and work, but they say, "I'm not going through that board. I'm not going to pay the money. I'm not going to go through an FBI background check." And the board has made it a little bit easier recently, but not much." *Greene, #8*

"We have several patients who call and we can see them that day. Or they can make an appointment. We always give them the option. You want to come back today or when do you want to come in? So for physicals, all appointments in a week or two or less. In the other clinics it's months…we're very flexible. We always say, yeah you can come in. Or if I know the patient I'll say, you be here in ten or thirty minutes or you be here at 2pm…things like that. But we always treat all the patients the same." *Greene, #4*

"I've been living in this area for 25 years…and everyone knows me and is looking for me at the clinic. And sometimes you carry the patient's concerns with you. You take it home with you to the house. And sometimes it's not good, but we are human and it's hard to not have feelings." *Greene, #4*