**Immigrant Health and Renal Replacement Therapy (Learner Guide)**

Author:

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**Learning goals:**

* **Explore the history of U.S. immigration policy and increase awareness of its effects on Mexican immigration and immigrant health.**
* **Introduce specific phrases and approaches to utilize during a patient interview to uncover potential structural or social determinants of health that affect immigrant populations.**
* **Define the immigrant health paradox and how health outcomes change over time for the immigrant population.**
* **Describe distinct ways local and state health systems address renal replacement therapy for undocumented immigrants.**
* **Identify various ways to advocate for improvements in immigrant health, including measuring one’s own unconscious biases toward patients and other healthcare team members.**
* **Share an approach to evaluating state-level policy as a way to advocate for improved immigrant health.**

David is a 46-year-old man with history of hypertension who is admitted from the emergency room (ER) to an internal medicine inpatient ward service for a creatinine of 6.8 mg/dL, with no recent lab values for comparison. You are a medical student on the ward team and David is assigned to your census. You review the chart and discover he was first hospitalized in your healthcare system five years ago for an ankle surgery after a bicycle accident. During that hospital admission, he had high blood pressures and his labs showed a creatinine of 1.5 mg/dL. Consequently, the discharge team referred him to a post-discharge clinic for follow-up.

He has been to a few urgent care appointments sporadically in the past five years and was prescribed hydrochlorothiazide at one time for his blood pressure, which was not subsequently refilled.

He presents to the ER at this time with 6 months of malaise, nausea, and decreased appetite. On further history, he has also noticed a progressive decline in his urine output over the last year.

You also note the electronic medical record indicates David’s preferred language is Spanish and in a prior social work progress note you discover he was born in Mexico and is undocumented.

1. *How have the demographics of the immigrant population in the United States changed over the last two centuries? What policies have shaped those changes?*
2. **(***T/F) Most immigrants are Latinx.*
3. *(T/F) Most Latinx are immigrants.*
4. *What percentage of U.S. immigrants have Limited English Proficiency (LEP)?*
5. 25%
6. 33%
7. 50%
8. 66%
9. *What are possible reasons David could appear uncomfortable?*
10. *How could you explore the reasons he may be uncomfortable and make David more comfortable?*
11. *What structural determinants of health may affect David’s desire to share information about his social history?*
12. *Could David’s immigrant status be affecting his health?*
13. *Generally speaking, which group has the best overall health in the U.S.?*
14. Recent Latino immigrants
15. Native-born whites
16. Native-born Latinos
17. Native-born Asian Americans

You realize David may have experienced trauma at any point during his immigration process which could be affecting his health. You want to provide a safe space for him to confide but you are unsure what to do.

1. *How should you approach David?*
2. *What is the best way to respond to the information David shares?*
3. *What are questions you can ask to explore David’s perceptions of what affects his health and how his health affects his life?*
4. *Could implicit bias play a role in how physicians treat their patients? How?*
5. *What other mentioned social determinants of health are affecting David’s health?*
6. *How could transportation play a role in David’s health?*
7. *What are possible insurance options for unnaturalized immigrants (noncitizens) and how have those policies changed over the last few decades?*
8. *How can you approach shared-decision making with David?*
9. *What are David’s options for renal replacement therapy and how would it be funded?*
10. *How does the diversity of the healthcare team affect health outcomes?*
11. *What are ways you can improve health for immigrants?*

**Immigrant Health and Renal Replacement Therapy (Facilitator Guide)**

Author:

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1. *How have the demographics of the immigrant population in the United States changed over the last two centuries? What policies have shaped those changes?*

In the early 1900s, immigration laws were predominantly based on quotas and greatly restricted the immigrant population, which was largely composed of Northern and Western white Europeans. After World War II, some in the United States felt it was unethical to disavow communism, yet not accept immigrants escaping from communist regimes. At the same time, the U.S. was experiencing labor shortages and Mexican laborers were encouraged to migrate to meet these needs. These historical events combined with the Civil Rights Movement led to The Immigration Act of 1965, which abolished national origin admission quotas and continued to exempt family members of U.S. citizens.

The number of immigrants as a percentage of the U.S. population reached a nadir of 4.7% in 1970, but this rate exponentially grew as gaps between the developed and less developed world widened. Immigration from Asia, Latin America and the Caribbean greatly increased.

In 1986, the Immigration Reform and Control Act granted legal status to many undocumented immigrants living in the US, encouraged Mexican guest farmworkers to come to the US, and tightened border security. When NAFTA was enacted in 1994, many Mexican farmworkers became unemployed after U.S. multinational corporations moved into Mexico, which resulted in increased migration to the U.S. [1]

1. **(***T/F) Most immigrants are Latinx.*
2. *(T/F) Most Latinx are immigrants.*

Answers to both are FALSE.

Currently, one-quarter of the U.S. population are immigrants or children of immigrants, with Asians outnumbering Latinx. Similarly, approximately 25% of the population of U.S. children have one immigrant parent. Over the last decade, the Mexican immigrant population census has declined with 67% of Latinx now being native-born. [2]

You meet David in the emergency room, and you begin to think how you want to conduct the interview given his preferred language is recorded as Spanish in the EMR.

1. *What percentage of U.S. immigrants have Limited English Proficiency (LEP)?*
2. 25%
3. 33%
4. 50%
5. 66%

Answer C[2]

Studies have shown that amongst LEP patients, communication problems can lead to a higher rate of adverse events, including lower rates of preventative screening and higher rates of drug complications. Poor communication can also lead to patient dissatisfaction and reduced adherence to physician recommendations. Standard of care, as recommended by the U.S. Department of Health and Human Services (DHHS), is to utilize trained interpreters, not family members or volunteer staff. Even when using trained interpreters, one study found that alterations to provider communication can have negative unintended circumstances. [3]

You ask David, “What language are you most comfortable speaking?” He indicates Spanish. You call an interpreter employed by the hospital. You ask David about his history of high blood pressure and his previous medical care. You notice David gives short answers and you sense he is uncomfortable. You are unsure why.

1. *What are possible reasons David could appear uncomfortable?*

Answers to discuss are both medical and structural: his underlying kidney disease and the burden of symptoms that affect his quality of life, fear of deportation, low health literacy, mistrust of the healthcare system, etc

1. *How could you explore the reasons he may be uncomfortable and make David more comfortable?*

One approach to conducting any interview is to start with attentive listening, which involves paying attention to both non-verbal and verbal communication. Look for clues that may indicate if a patient finds certain questions inviting or intrusive.[4] It is equally important to be aware of unconscious biases that may cause you to first jump to stereotyping patients. [5] Studies have shown that our medical curriculum can reinforce these biases which can lead to inequities in healthcare. [6] Ask open-ended questions with a spirit of curiosity and avoid assumptions. Specifically, explore domains of structural vulnerability within life experiences and circumstances such as level of education, food security and transportation among many others. [7, 8] During the interview, certain conditions or events should trigger screening questions for social determinants of health. For example, prior missed appointments could indicate difficulty with transportation, housing security, lack of insurance, or financial security. [9]

* Possible questions [4, 10]
  + *Where were you born? Where did you grow up?*
  + *What is the highest level of school that you have finished? Do you have a high school degree?*
  + *In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food?*
  + *Are you worried that in the next 2 months, you may not have stable housing?*
  + *In the past three months, how often have you experienced childcare breakdowns?*
  + *Are you regularly able to get a friend or relative to take you to a doctor’s appointment?*

For additional screening questions and tools, go to [*American Academy of Pediatrics Screening Tools*](https://screeningtime.org/star-center/#/screening-tools)*.*

You ask David about where he was born. He is initially hesitant, but he tells you he was born in Mexico and moved here over 20 years ago.

1. *What structural determinants of health may affect David’s desire to share information about his social history?*

If David is an undocumented immigrant, he may be concerned about deportation. In 1996, the Illegal Immigration Reform and Immigrant Responsibility Act, the Antiterrorism and Effective Death Penalty, and the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) made it easier to deport and deny welfare benefits for undocumented immigrants and for lawfully present residents (green card holders, etc). This led to increased discrimination and stress for immigrants living in the U.S. In 2016, detention incidence was increased by 40%, but removal from detention was not equally increased, which led to longer detention times. [1] Multiple newspaper articles, in 2019, have chronicled the overcrowding and poor sanitation at various migrant detention centers that is affecting young children and adults.[11, 12] In 2018, a proposed change to Public Charge policy could prevent non-citizens who accessed various forms of public assistance from legal permanent residency status in the future for themselves and their children. These targeted policy restrictions have led immigrants to fear accessing medical care.[13]

1. *Could David’s immigrant status be affecting his health?*

YES

1. *Generally speaking, which group has the best overall health in the U.S.?*
2. Recent Latino immigrants
3. Native-born whites
4. Native-born Latinos
5. Native-born Asian Americans

Answer A[1]

Newly relocated immigrants have decreased rates of adult and infant mortality, are less likely to die from CV disease and have less incidence of obesity and depression. These statistics are despite immigrants having less access to health care. This phenomenon has been coined ‘the immigrant health paradox.’ However, after five years these advantages decline and rates of disease worsen the longer an immigrant resides in the U.S., eventually leading to increased mortality and incidence of hypertension, diabetes and obesity.

Second-generation immigrants also experience this decline in heath. Possible reasons for the decline in health are structural. Varied restrictive state policies have led to discriminatory practices such as racial profiling. These actions lead to increased psychological distress, chronic activation of the fight or flight response, and chronic diseases such as hypertension. Further restrictions to healthcare access and healthy resources compound the deleterious health effects. These stressors not only affect the immigrant population but also their children. Evidence shows that children of undocumented parents have increased mental health issues and decreased levels of cognitive development.

Becoming a naturalized citizen can be protective as that population has been reported to have better health later in life as opposed to those immigrants who do not acquire citizenship. Unfortunately, the rates of naturalization in the U.S are much less than in other developed countries due to complex and expensive processes. [1, 14]

You realize David may have experienced trauma at any point during his immigration process which could be affecting his health. You want to provide a safe space for him to confide but you are unsure what to do.

1. *How should you approach David?*

Trauma is common for many adults, not only immigrants, and it has lasting effects on health outcomes. Trauma should always be discussed in private. Some experts recommend using the “4 Cs” to approach discussing trauma.[15]

* Be **c**alm – this can be emotionally regulating and cultivate healing.
* **C**ontain the interaction – you do not need to ask for a detailed account. After someone shares with you, provide referrals to address their experiences. This is a good place to ask your social worker or other colleagues for available resources.
* **C**are for the patient and yourself – provide empathy for the patient and yourself. Normalize any adverse coping mechanisms from trauma, such as substance use, overeating, and depression.
* Focus on **c**oping – inquire about ways the patient has overcome difficulties in the past and encourage them on their resilience.

You gently ask David, “Some of my patients who immigrated have had difficult life experiences. Do you feel like any of your past experiences affect your physical or emotional health?” He shares with you that he has had family members who have died while crossing the border, and that he feared for his own life when he crossed the border. When he came to the U.S., he left his family in Mexico. Initially, he was planning only to stay in the U.S. for five years; however, after border security increased it became harder for him to go visit his family and he felt isolated. Eventually, his family crossed the border too so the family could be reunited. You initially are unsure of how to respond after he shares this information with you.

1. *What is the best way to respond?*

The best response to a disclosure of trauma is empathy. For example, saying something like, “I am sorry this happened to you. Thank you for sharing with me. Stress can definitely affect your health and this information can help me understand how to best care for you.” You make note to discuss with your hospital social worker so David can be referred to the appropriate resources if he is agreeable. [15]

You thank David for sharing his story with you and ask if he is okay with talking to a social worker about potential community resources to help him cope with his experiences. He says he thinks that would be very helpful.

You begin to ask again about his past medical history. He tells you he was told he had high blood pressure and was given a water pill to treat it. You are unsure of his understanding of his health conditions or level of health literacy.

1. *What are questions you can ask to explore David’s perceptions of what affects his health and how his health affects his life?*

One framework gives examples on ways to ask patients to describe their health problems and how it may affect their identity and their relationships. [4]

* What is at stake?
  + *What do you most fear about your medical condition?*
  + *What concerns you about the treatment?*
* The illness narrative – based on the explanatory models approach
  + *What do you call this problem?*
  + *What do you believe is the cause of this problem?*
  + *What course do you expect it to take? How serious is it?*
  + *What do you think this problem does inside your body?*
  + *How does it affect your body and your mind?*
* Psychosocial stresses
  + *How is this affecting your family?*
  + *Is your health or coming to the doctor affecting your work?*

You ask David, “What do you believe is causing you not to feel well?” He tells you he worries it is his kidneys. When he went to the urgent care clinic a few years ago, he was told his kidneys were a little injured. He has a father-in-law who has kidney problems and is on dialysis and he is worried about the same thing happening to him. You realize his health literacy is quite good and he knows a lot more than you initially thought.

You ask him does coming to the doctor affect his work? He shares with you that he works in construction and his job is not always supportive of him taking off. When he has been able to make it to the clinic, he has had to pay out-of-pocket since he does not have any health insurance. The free clinic is far from his house and his family has only one car, which his wife uses to go to work every day since her job is farther away. David rides his bicycle to work as he has for many years even after his bicycle accident five years ago.

1. *Could implicit bias play a role in how physicians treat their patients? How?*

YES

The biomedical field has its own culture that influences the patient-physician relationship.[4] Medical education focuses on teaching training physicians the importance of demographic risk factors and the need to quickly categorize information. Furthermore, many trainees work in underserved and vulnerable populations where prior-learned stereotypes are reinforced by only seeing the unhealthiest of populations. Physicians also may overestimate their ability to be objective due to their scientific background. These biases are not often explicitly recognized but may be unconscious, or implicit. Research has shown that implicit biases contribute to decreased quality of care and can harm patient-physician relationships. One study showed that if physicians were aware of implicit bias they could undergo interventions to reduce their bias. Another study showed the more a physician consciously focused on the objective data of a clinical case instead of a patient’s race or gender, they increased their chance of avoiding a diagnostic error. [16]

1. *What other mentioned social determinants of health are affecting David’s health?*

Answers include transportation, lack of insurance, under-employment, etc

1. *How could transportation play a role in David’s health?*

Limitations in transportation is a well-known barrier in accessing health care. This is especially true for people who have low-income or are uninsured or underinsured. A lack of transportation can be reasons for missed appointments or delayed appointments and should always trigger screening for a need for further resources. Some neighborhoods lack adequate sidewalks or street lighting which makes riding a bicycle much more dangerous. In fact, bicycling fatality rates are 23% higher in Latinx persons than white non-Latinx persons. [17]

David states he has no insurance.

1. *What are possible insurance options for unnaturalized immigrants (noncitizens) and how have those policies changed over the last few decades?*

7% of the U.S. population were noncitizens in 2018. Non-citizens are 2-5 times more likely than citizens to be uninsured. This population is made up of legal permanent residents (i.e. people w/ green cards, temporary working or education visas, refugees, asylees, etc) and undocumented immigrants. Decreased insurance coverage is also an issue among citizen children of a non-citizen parent, with a 2x likelihood of being uninsured. As discussed before, increased fear of deportation and the use of healthcare access data to deny immigrants future legal residency status is a looming obstacle. Undocumented immigrants are twice as likely to be uninsured than legal permanent residents (LPRs).

Many reasons exist for the decreased insurance coverage:

1. Despite the fact that noncitizen families are more likely than citizen families to have an employed adult living in the house, their jobs are more likely to be low-income with lower rates of employer-sponsored coverage. High costs of individual market insurance make it unlikely for immigrants to be able to afford coverage.
2. Governmental insurance coverage through Medicaid and CHIP are restricted to LPRs with “qualified” immigration status only. Restrictions include a five-year wait for green card holders, ineligibility for immigrants with temporary protected status and undocumented immigrants. States can eliminate the wait for LPR children and pregnant women who are within the five-year waiting period, but half of the states have not expanded this option.
3. ACA Marketplaces can receive subsidies for coverage for anyone who is 100% to 400% of the Federal Poverty Line (FPL), except undocumented immigrants. Despite the 29% and 43% of LPRs who are eligible for Medicaid and tax credit subsidies, respectively, many remain uninsured due to confusion surrounding policies and enrollment, language barriers and fear.

This leaves local safety-net healthcare systems and state-funded programs as the only healthcare access for undocumented immigrants.[18] These programs tend to focus on emergent care due to federal funding through the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 and have limited preventative services, which greatly affects the quality of healthcare provided to immigrants.

This lack of healthcare funding is despite the fact that 94% of working age immigrants are employed, make up 17% of the civilian labor force and contribute $11.74 billion toward state and local taxes annually. $2.4 billion goes to Medicare and analysis has shown undocumented immigrants contribute more than they withdraw from the Medicare Trust Fund, whereas U.S. born-citizens do the opposite.[2, 19, 20]

During the interview, you want to prepare David for the renal consult team who has been called and the possible treatment options in a shared-decision making approach.

You ask David, “So I can make sure our team is explaining your condition well to you, please tell me what your understanding is about the treatment we’re considering?” He tells you he is not sure he understands what the options are, but his father-in-law is currently on dialysis and hates it. The family feels no one ever explained the options well to them and before they knew it his father-in-law had a surgery to have an AV fistula in his arm. His father-in-law is still embarrassed and feels the surgery disfigured him.

1. *How can you approach shared-decision making with David?*

When approaching shared decision making on serious healthcare decisions with patients there are certain frameworks that can be utilized. One proposed framework incorporates techniques to explore prior experiences and preferences:[21]

* + Respond to inequities in care
    - *I wonder whether it’s hard for you to trust our medical team?*
    - Ally yourself with the patient and/or family and ensure they know you will work together.
  + Communication/language barriers
    - Avoid medical jargon
    - *So I can make sure I’m explaining this well to you, please tell me what your understanding is about your illness and the treatment we’re considering?*
    - Use trained interpreters
  + Religion and spirituality
* *Where do you find your strength to make sense of this experience?*
* *How can we support your needs or practices?*
  + Truth telling/Informed refusal (helpful in terminal or life-threatening conditions)
    - *Some patients want to know everything about their condition, others prefer that the doctors mainly talk to their families. How would you prefer to get this information?*
  + Family Involvement in decision-making
    - *Is there anyone else that I should talk to about your condition?*

You ask David, “I wonder if it’s hard for you to trust our medical team given your experiences?” David nods affirmatively. You comfort David and let him know that you and the medical team will do everything you can to ensure him the best medical care possible. You ask David, “Would it be helpful if I have our medical team explain all of your treatment options with a medical interpreter?” David again nods affirmatively. You remember to include his family in the decision-making process. “Is there anyone else that we should include in the meeting?” David asks that his wife be present as well.

1. *What are David’s options for renal replacement therapy and how would it be funded?*

Answer: It depends on where you live! It is highly variable from state-to state, and even within states.

Recent statistics estimate there are approximately 6500 undocumented immigrants with end-stage renal disease (ESRD). The undocumented immigrant population is highly concentrated in 4 states: California, New York, Texas and Florida.[19] ESRD care is covered for nearly everyone in the U.S. under the 1972 Medicare ESRD entitlement program or Medicaid, except undocumented immigrants. EMTALA mandates the provision of emergency care for all uninsured individuals, including undocumented immigrants, however the definition of emergency care varies greatly state-to-state. In some states, ESRD patients are forced to wait until their burden of symptoms reaches a life-threatening level and only then are they treated with emergent-only hemodialysis (EoHD), yet in other states, kidney transplants are an option. Here is a summary of various renal replacement therapy options and details regarding their delivery:

* Kidney transplant – currently the standard of care for ESRD patients as research has shown it decreases mortality and improves quality of life, all while being cost-effective. Studies have shown that undocumented immigrants have better transplant outcomes when compared to U.S. citizens and are more likely to have a living donor. EMTALA specifically excludes transplantation which makes transplant access even more difficult for undocumented immigrants. Critics have argued that undocumented immigrants are allowed to donate organs, accounting for 17% of all transplanted organs, yet are recipients of <1% of all transplanted organs. Presumably, renal transplant would also allow undocumented immigrants to contribute more to society by rejoining them with the workforce.[22] California, New York and Massachusetts perform the most transplants for undocumented immigrants through state-funded programs.
* Scheduled Hemodialysis (HD) – standard, thrice-weekly, outpatient hemodialysis, through an arteriovenous fistula (AVF) or arteriovenous graft (AV graft), is the most common type of renal replacement therapy. Some states, such as California, New York and Illinois have included ESRD as an emergency medical condition therefore it is covered under EMTALA. Policymakers have argued against providing scheduled HD stating it would draw more undocumented immigrants. However, the immigrant population in California has remained stable despite publicly funding this standard-of-care treatment.[19] Recently, a study at a safety-net hospital in Dallas, TX, showed scheduled hemodialysis vs EoHD decreased 1-year mortality from 17% to 3%, while providing monthly cost-savings to the healthcare system of $5678 per person. Scheduled HD spots are funded by non-profit organizations which purchase off-exchange, private commercial health insurance plans for undocumented immigrants.[22] Another study comparing three cities in different states showed the mean 5-year relative hazard of mortality rate for EoHD patients was 14 times greater than those patients receiving scheduled HD. Scheduled HD patients also spent much less time in the hospital setting.[23]
* EoHD – Some states have not included ESRD as an emergent condition and hence EMTALA does not cover this treatment. Hemodialysis access is also not standardized with some patients receiving AVF/AV grafts and others central venous catheters (CVC) which were originally intended for temporary access only, given its high rate of infectious and cardiovascular complications. Furthermore, healthcare workers who treat EoHD patients express moral distress regarding the delivery of substandard quality of care and watching patients suffer from a loss of identity and a high burden of symptoms, such as fatigue, anorexia and nausea. [22]
* Peritoneal dialysis – A growing option for renal replacement therapy which would allow patients to complete hemodialysis at home and improve quality of life. This is an area that is largely unexplored as a treatment option for undocumented immigrants and should be further studied.

The hospital at which you work has strategic hiring practices to improve the diversity of the healthcare team and has successfully recruited a diverse workforce. You discuss David’s case with the renal social worker who is also Latinx and ask her how the team could help the patient. She has good insight into how the team can ensure David builds trust with medical team and goes to talk with him. She is able to connect David to social support groups for others with ESRD, provide him with resources for transportation to appointments and recommend he see a therapist to help him deal with the stresses of his prior trauma. The medical team sets up a family meeting with David, his wife, the primary medicine team and the renal consult team for the next day.

1. *How does the diversity of the healthcare team affect health outcomes?*

A multicultural healthcare team has been shown to provide many benefits including better access to care for minority patients and improved patient satisfaction and trust. A diverse learning environment has also been shown to improve academic performance in all health professions students from all demographics. [24, 25]

1. *What are ways you can improve health for immigrants?*

* **Remain curious**
  + ***About others***

You can learn more about the history of different cultures. This knowledge can help you know where trauma may affect trust with others and the healthcare system, gently explore potential experiences further and identify which other healthcare team members to collaborate with to provide quality team-based care (i.e. social worker, dietician, chaplain, therapist, etc.).[4 21] Remember all individuals express varying aspects of a culture, and in fact, each person is an amalgamation of many different cultures.

* + ***About yourself***

Recognize everyone has implicit biases. Project Implicit offers multiple Implicit Association Tests on many different topics (ie race, gender-career, disability, etc) at <https://implicit.harvard.edu/implicit/takeatest.html>. The results can raise your awareness regarding potential beliefs that may affect the care of your patients. Evidence has shown increased awareness of hidden biases coupled with deliberate perspective-taking can mitigate diagnostic errors.[16]

* **Communicate with empathy**
  + ***With patients***

You should practice using various frameworks, which encourage curiosity and active listening.[5 26] You should also become familiar with evidence-based trauma-informed care practices and how they can help improve the health of a prevalent experience. [15]

* + ***With yourself***

Working with healthcare disparities can lead to burnout or moral distress. Talk to other colleagues and mentors on ways they find meaning and purpose in their work.

* + ***With other healthcare team members***

It is important to be compassionate to other team members and respectful of their beliefs. As Dr. Vivek Murthy, previous U.S. Surgeon General, explains people can display a cognitive bias known as “motive attribution asymmetry,” which is the assumption that our beliefs are grounded in love, while our opponents’ are based on hatred. Unfortunately, this leads to increased divisiveness and separation and discourages civic action.[27]

* **Advocacy**

Advocacy is a necessary and powerful tool to empower the healthcare team to improve the health of diverse populations. Without it, we can often feel overwhelmed and distressed. Many different resources can be found on the National Immigration Law Center website: <https://www.nilc.org/> .

For the immigrant population, most of healthcare policy is created at a state level, in large part due to the 1996 PRWORA federal legislation. This increased state-level discretion on noncitizens’ eligibility for healthcare access and education as well as workplace regulations.[1] You can become more knowledgeable on this topic through involvement with your state medical board. Wallace et al. also proposed a state-level advocacy for immigrant framework to review state policy by focusing on the five domains that affect immigrant autonomy and betterment the most[[1]](#footnote-1):[14]

1. Health and welfare benefits – 19 states excluded medical coverage for low-income pregnant women who were undocumented or a legal permanent resident still under the five-year waiting period as per a 2019 review.
2. Higher education – some states provide in-state tuition rates, scholarships, or financial aid for undocumented immigrants, which provides educational advancement, increased employment rates for this population and an increased tax base.
3. Labor and employment – some policies restrict immigrants to hazardous occupations or low-incomes and do not include undocumented immigrants in the definition of employee.
4. Driver’s licenses and identifications – States that require a social security number for a driver’s license preclude undocumented immigrant from obtaining official governmental ID and therefore render them unable to access healthcare or obtain insurance coverage. A driver’s license also is required for access to certain economic resources, such as many banking services.
5. Immigration enforcement – States also can influence reporting and compliance with national Secure Communities, which can increase detection of undocumented vs legal permanent residents for deportation.

**Table 1**

|  |  |
| --- | --- |
| POLICY AREAS | POLICY INDICATORS |
| Policy Area 1: Public Health and Welfare Benefits | Does state provide low-income children Medicaid or SCHIP regardless of legal status? |
| Does state provide care to pregnant women regardless of legal status? |
| Does state count a prorated share of ineligible non-citizen income? |
| Policy Area 2: Higher Education | Does the state provide tuition equity to undocumented students? |
| Does the state provide access to scholarships or ﬁnancial aid for undocumented students? |
| Policy Area 3: Labor and Employment | Does the state mandate employers use E-Verify? |
| Does the state prohibit employers from using E-Verify? |
| Does state include undocumented immigrants in the deﬁnition of employee? |
| Policy Area 4: Drivers’ License and IDs | Does the state oﬀer drivers' licenses for undocumented immigrants? |
| Does the state have a statutory opposition or resolution in opposition to compliance with REAL ID? |
| Policy Area 5: Immigration Enforcement | Does the state limit participation in Secure Communities? |

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1. See Table 1 for more details [↑](#footnote-ref-1)