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Existing barriers to healthcare access for the immigrant Latinx/é community: a mixed methods study

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Dissertation

EXISTING BARRIERS TO HEALTHCARE ACCESS FOR THE IMMIGRANT LATINX/É COMMUNITY: A MIXED METHODS STUDY

by

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When you exist in spaces that weren’t built for you, remember, sometimes that just being you is the revolution.

-Elaine Welteroth-

DEDICATION

This text is dedicated to my family.

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First and foremost, I would like to acknowledge my parents for all their endless love and support. Dad, you always pushed me to be the best version of myself and always made sure you spent as much time with me as you possibly could. You always talked to me about the importance of school and how the sky was the limit as long as I put in the work. I still remember to this day when I told you about wanting to move to Boston to pursue my master's degree. You were the first person I told, and you were the first to be supportive of me despite the risk. I am forever thankful for that. Mom, I don't even know where to begin. For as long as I can remember, you have been there. Always showing me love, compassion and always there to protect me from any harm. Your strength, courage and resilience are what motivated me to keep going throughout all of these years, through all the ups and downs. Not once have you ever asked for anything in return other than my love. Being away from you all these years has truly been one of the hardest things I have ever had to do. Thank you for always being there for me, and for loving me all my life unconditionally. I could not have done this without you.

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EXISTING BARRIERS TO HEALTHCARE ACCESS FOR THE IMMIGRANT LATINX/É COMMUNITY:

A MIXED METHODS STUDY

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ABSTRACT

Latinx/é individuals are disproportionately affected by lack of access to healthcare which has been exacerbated by the COVID-19 pandemic. These barriers have resulted in worse health outcomes, especially for Latinx/é immigrants. The present study used a mixed-methods design to determine what barriers exist for the Latinx/é community when accessing healthcare in a post-COVID-19 era, where telehealth services have changed the way individuals receive healthcare. A convergent mixed-methods design that includes qualitative interviews and published surveys that assess healthcare access with Latinx/é individuals with experience in the healthcare system was employed to assess this question. Results of this study showed that there are still several barriers that exist for the Latinx/é immigrant population when accessing healthcare. Barriers included: insurance, cost, accessing specialist care, wait times/availability, lack of information/education and technology. However, results also highlighted facilitators to accessing healthcare as well, some of which, depending on context, overlapped as a barrier as well. Facilitators included: Community, insurance, information/education and technology. Implications from this study are discussed for healthcare providers to improve healthcare practice, to

better inform immigration policy and to ultimately reduce the barriers that have hindered Latinx/é immigrant community's access to healthcare.

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Chapter 1: Introduction

Statement of the Problem

Mental health disorders in the U.S. are a persistent problem, with an estimated 1 in 5 Americans struggling with some type of mental health illness in 2020 (U.S. Department of Health and Human Services, 2020). The Latinx/é [1] community is particularly vulnerable to this crisis with a high prevalence of anxiety and mood disorders (Bucay-Harari et al., 2020) and a greater risk of developing post-traumatic stress disorder than their White counterparts (Alcántara et al., 2013). Substantial research efforts have aimed to explore these disparities and improve mental health outcomes by assessing factors that predict mental health outcomes specifically for the Latinx/é population. Several studies have suggested that persistence of mental health disorders among the Latinx/é population is likely linked to factors such as race, ethnicity, socioeconomic status, social support, language competency and underutilization of healthcare services (Alegría et al., 2017; Coffman & Norton, 2010). Indeed, Latinx/é individuals are one of the least likely minority groups to have access to healthcare (Artiga, 2020) as indicated by low insurance rates and lack of primary healthcare providers (Rodriguez-Alcalá et al., 2019). As such, increasing healthcare service utilization may be one avenue for improving mental health outcomes for this community. To do this, it is first important to determine the accessibility of current healthcare programs and procedures for this

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[1] Latinx/é is important to use because it encompasses those who within Latin American cultures have been marginalized and put down by rigorous gender binaries, machismo, and colonization. Latinx/é pushes beyond gender binaries and acknowledges the intersecting identities of our incredibly diverse community. Latinx/é includes men, women, gender non-conforming, non-binary, trans, queer, agender and gender-fluid folks in our communities. For us, these are not exclusionary terms; they open the door for all the ways people want to identify (Salinas Jr, 2020).

population. Better elucidation of these issues may motivate current policies, programs, and procedures to reflect the current needs of the community and ultimately improve overall health outcomes.

The COVID-19 pandemic has presented additional challenges for this historically marginalized community. Latinx/é individuals have been disproportionately affected by COVID-19, with hospitalization rates higher than that of non-Hispanic Whites (CDC, 2020). For a community that underutilized healthcare prior to the pandemic, this has had devastating effects including greater vulnerability to economic hardships and the loss of loved ones (Noe-Bustamante et al., 2021).

Furthermore, undocumented Latinx/é immigrants have faced disproportionate vulnerability to COVID-19 as well. Undocumented Latinx/é immigrants make up a large proportion of "essential" jobs in the U.S., including the service and production industries (Dudley, 2019; Goldman et al., 2005), which increased their risk of exposure to COVID-19. Additionally, since government economic relief packages have been unavailable for undocumented Latinx/é immigrants, they are also subject to more severe economic impacts as a result of COVID-19 (Kopasker et al., 2018). However, there is little research investigating the disparate effects of COVID-19 on the psychological health of undocumented Latinx/é immigrants compared to their documented counterparts.

With the U.S. population becoming increasingly composed of Latinx/é individuals—the country's Hispanic population grew 23% between 2010 and 2020 (Funk & Lopez, 2022)—and the additional prolonged effects of the COVID-19 pandemic, there is a growing need to further understand this link between healthcare utilization and mental health outcomes, to support inclusive healthcare systems and programs that meet the needs of the diverse communities that they serve. As such, the purpose of this study was to assess the post-COVID-19 challenges related to healthcare utilization that are reported by this community, through their collected first-person perspectives on what they believe would increase access for themselves and their communities, and to assess patterns of healthcare usage among the Latinx/é community using the quantitative surveys and individual interviews that were collected. Specifically, the population for this study is first-generation Latinx/é immigrants over the age of 18, who were either undocumented or documented, living in various states throughout the United States (i.e., Massachusetts, Colorado, Georgia & Pennsylvania). The purpose of this study was multifaceted. First, it was to examine what barriers currently exist for the Latinx/é immigrant community in the United States and if there were certain demographic variabilities that influenced their access to care most (e.g., insurance statues or documentation statues). Secondly, it was to expand on how these reported barriers have changed with the onset of COVID-19. Lastly, identifying what resources/supports through their own lived experiences have either helped them or would help them increase access to healthcare overall.

Significance

The findings from this study could have a positive impact on mental health outcomes for Latinx/é first-generation immigrants by providing potential evidence to support the development of inclusive healthcare programs and policies, which have been shown to improve mental health outcomes (Escalera et al., 2022). First, these findings will determine barriers to healthcare access for the Latinx/é community in a post-COVID-19 era. With the entire landscape of healthcare services making changes to their practices as a result of COVID-19 (Jazieh & Kozlakidis, 2020), it is quite possible than many of the barriers faced by Latinx/é immigrants have changed in the age of the pandemic. It will be necessary to provide updated information on the impacts of these barriers to accurately reflect the prevailing feelings of the community. Second, this study will also provide an understanding of the needs of the community. Not only will it establish the barriers that are faced, but it will also provide an opportunity for a variety of voices within the community to discuss their specific needs and challenges. There is a great deal of variability in identities and experiences even within the Latinx/é immigrant subgroup (González Burchard et al., 2005), which speaks to the need for more inclusive research that encompasses these nuanced variabilities. By providing a record of these needs, more work may go into establishing programs and interventions that can directly address these needs. With these needs met, this will provide an avenue for better mental and physical health outcomes for Latinx/é individuals.

In addition to the benefits for the Latinx/é community, this study will also provide foundational knowledge for counseling psychology research. There is an urgent need for more research assessing the implications of public health crises on historically marginalized communities (Arriola & Grossman, 2021; Best et al., 2021). A stronger understanding of how a worldwide public health crisis specifically affects healthcare access and health outcomes for Latinx/é individuals will motivate future research into interventions and techniques that may ameliorate the effects of this crisis and create more access for Latinx/é individuals. The direct effects of the COVID-19 pandemic are likely to span several health domains including psychology, biology, and sociology (Kop, 2021). By using the knowledge gained from this study, more research may also be aimed at integrating these fields to advance our current understanding of COVID-19.

This study may have lasting impacts for work aiming to promote social justice and diverse communities. Directly addressing how the Latinx/é immigrant population is impacted by healthcare barriers and the COVID-19 pandemic will inspire greater initiative in creating equity for this community and others. Bridging these gaps in health outcomes and accessibility to healthcare are an important step to create a more equitable culture within the United States.

Chapter 2

Review of the Literature

Healthcare services are significantly underutilized by Latinx/é immigrants, and this underutilization is linked to poor health outcomes (Podewils, et al., 2020). To address this problem, it is first important to understand the current data that supports this issue. The following sections will first discuss the variability within the Latinx/é population and the current state of Latinx/é immigrant mental health will then be explored. Second, the minority stress theory will be explored, which is a framework that will partially guide the present study, and which helped inform some of the questions that were used to assess what barriers to healthcare exist for this population. Lastly, a discussion of the impact of COVID-19 on Latinx/é health and the digital age of healthcare services will be reviewed.

The Latinx/é Population in the U.S.

Though Latinx/é individuals are often classified as a single group that shares some ethnocultural background, there are a variety of races, cultural backgrounds, and social environments that encompass this classification (González Burchard et al., 2005). In fact, in the context of immigration, there is a great deal of variation in individual experiences across different Latinx/é cultures. These include the differences in language, such as differences in dialects across the Spanish language, the differences in ethnic identity such as the various cultures that encapsulate the Latinx/é community, and the differences in migration experiences (e.g., routes/avenues taken to migrate to the United States and how those experiences varied) (Guarnaccia et al., 2007). These differences within the Latinx/é community may also lead to variability in health outcomes across Latinx/é subgroups (C. Garcia et al., 2018). This variety contributes to a great diversity of unique experiences that must be accounted for when examining the systemic impacts on this community. As such, this study collected a diverse sample of Latinx/é first-generation immigrants capturing some of the nuanced differences within this subgroup, especially as they were influenced by contextual and structural factors.

Latinx/é Immigrant Well-Being and Mental Health

It is estimated that the United States population consisted of 13.6% foreign-born immigrants in 2019. Of those foreign-born, one major subgroup, consisting of 18.3% of the immigrant population, are Latinx/é individuals. Which is estimated to grow yearly (US Census Bureau, 2020). Latinx/é immigrants face specific challenges which may include language barriers, obtaining documentation, economic issues, and poor mental health outcomes (Raffaelli & Wiley, 2013; Sangalang et al., 2019). In a narrative review done by Escobedo at colleagues (2023), they reviewed 91 published articles that explored what barriers to care were identified most for the Latinx/é immigrant population. Results from this review showed that the most salient barrier that arose across studies in accessing healthcare services for this population was language barriers. They describe in this review, Latinx/é immigrants who had limited English proficiency (LEP) reported higher levels of distrust with their medical providers, increased confusion with their treatment plan and were less likely to discuss the symptoms they were feeling at the time of care.

There continues to be more research investigating the impact that documentation status can have on the overall wellbeing on the Latinx/é immigrant population. In one study examining how documentation status within a Latinx/é sample (n=391) in North Carolina impacted physical health/wellbeing overall. Results from this study showed that those who were undocumented reported higher levels of “immigration stress” (e.g., accessing healthcare, fear of deportation) when compared to those who were documented. Furthermore, participants who were undocumented were less likely to access healthcare due to their documentation status which was negatively related to their physical health (Stafford, et al., 2021). This continues to highlight that documentation statues is a social determinate of health and warrants further research. As such, it is important to continue explore these challenges to understand the impact they have on Latinx/é immigrant individuals’ well-being.

Mental health outcomes for Latinx/é immigrants are a particularly important challenge to explore. The mental health crisis in the U.S. persists, with an estimated 45 million Americans struggling with some type of mental health illness in 2018 (Substance Abuse and Mental Health Services Administration, 2018). Among the Latinx/é community in the U.S., anxiety and mood disorders are the most prevalent mental illnesses (Bucay-Harari et al., 2020). Moreover, undocumented Mexican American immigrants have a significantly elevated risk for anxiety and depression compared to the general U.S. population (Garcini et al., 2017), revealing the vulnerability of this population.

However, much of the research on Latinx/é immigrant mental health has revealed that mental health outcomes (Marks & García Coll, 2012) and mortality rates (Abraído-Lanza et al., 1999) are better for foreign-born Latinx/é individuals compared to U.S. born Latinx/é individuals. This phenomenon is termed the "immigrant paradox" (Marks & García Coll, 2012) and has been the basis for much of the research investigating Latinx/é mental health outcomes. Specifically, while recently arrived immigrants typically face more stressors due to immigration (e.g., immigration stress) subsequent generations are more likely to have fewer/eroding protective factors (e.g., community/social capital) and can struggle with intergenerational conflict grappling with their parent's old cultural customs and their new host country. With this, there has been an increased focus on the factors that contribute to these mental health disparities.

Research on mental health outcomes for the Latinx/é population has found that increased exposure to stressful events can lead to poor mental health outcomes (Perreira et al., 2015). The process of immigration and the reason for immigrating to the United States can be very taxing. It's important to note that the immigration experience can vary greatly among those who try to come to the United States, especially for those who may need to arrive without documentation. It is reasonable to conclude that there are many who travel thousands of miles by foot to the U.S. border, there are those who are exposed to extreme violence and are forced to leave their homes, and there are also those that are detained at that border and are separated from their loved ones for an extended amount of time.

These varied experiences can be incredibly impactful on one's mental health, which even upon arrival to the United States, can be greatly exacerbated by acculturative stress. Acculturative stress is defined as psychological or social stress that is experienced as a result of being an individual from a different culture which may include immigrants and ethnic minorities (Da Silva et al., 2017). For immigrant families, acculturative stress can result from challenges that are associated with immigration, which can include barriers such as changes in one's socioeconomic status, lack of knowledge of host language, disruption of family ties, discrimination, dealing with negative stereotypes, and mental health difficulties (Dow, 2011). A review from Alegría et al. (2017) established that the effects of acculturative stressors on mental health vary greatly across several factors. These factors can include race, ethnicity, socioeconomic status, social support, language competency, and healthcare access. In another study, Dillion et al. (2013) examined the impact of acculturative stress on family cohesion and overall mental health/wellbeing, a sample of newcomer Latinx/é immigrants (n=405) from various countries in Latin America were asked to fill out surveys asking whether they had family in the United States or had immigrated with other family members, a survey regarding family cohesion and another asking about immigration stress. Results from his study showed that having a sense of community or having family members in the United States reduced overall levels of acculturative stress greatly. Furthermore, participants who were older, who were undocumented, immigrated to the United States without family or having family in the U.S. reported higher levels of acculturative stress, lower English language proficiency which, in turn, negatively impacted their overall health. This study highlights the importance of community and/or having social supports (e.g., family) to help mediate the impacts of acculturative stress. As such, it is important to continue examine the effects of acculturative stressors on mental health for Latinx/é immigrants and incorporate influential factors to reveal a clearer picture that could potentially motivate possible interventions for this population. In this study, acculturative stressors such as social supports (community), language and healthcare access will be the most explored.

Minority Stress Theory Framework

While aspects of the grounded theory approach were used in this study to analyze the data which allowed for more nuance themes/codes to arise, this study is guided by a study by Valentín-Cortés et al. (2020) who adapted Meyers' (2003) Minority Stress Theory framework. Meyer (2003) explored the prevalence of mental health disorders among minority groups in the context of the LGBTQ community. They found that individuals that identify as LGBTQ have a greater prevalence of mental health disorders. As such, they describe a framework for navigating how stress and coping may affect minority mental health. The Minority stress theory framework was adapted to assess factors related to mental health outcomes specifically for undocumented Latinx/é immigrants by Valentín-Cortés et al. (2020). This framework includes 7 components that contribute to mental health outcomes. These components are circumstances in the environment, minority status, minority identity, general stressors, minority stress processes (distal), minority stress processes (proximal), coping and social support, and characteristics of minority identity.

This framework was later adapted by Valentín-Cortés et al. (2020) to apply to undocumented Latinx/é immigrants. They believed that the Minority Stress theory Framework which has been widely used to better understand the stress processes and mental health outcomes for minority communities (e.g., LGBTQ+ community) could be easily applied to the undocumented Latinx/é population in the United States. In the context of the current study, this framework provides an overarching guide to the stressors that are known to affect Latinx/é immigrant mental health. The use of this framework allows for a better understanding of how healthcare usage and a worldwide health crisis fit into the central understanding of the minority experience and how these factors may impact mental health.

The adapted framework from Valentín-Cortés et al. (2020) includes seven factors that influence mental health for undocumented Latinx/é immigrants. Each factor will be discussed and illustrated below in terms of the relevant literature.

General Stressors

There has been extensive research done exploring the challenges of immigrating to the U.S., particularly for the Latinx/é population. Many of the stressors that Latinx immigrant individuals experience are general stressors that are experienced by both immigrants and native-born individuals. These are defined as stressors that can be experienced by everyone and are not specific to those with minority statuses (e.g., family situation or socioeconomic status). Factors such as family dynamics are general immigration-related stressors can have an impact on mental health. Santos and colleagues (1998), they collected data from 135 married first-generation undocumented and documented Mexican immigrants that were participating in an ESL program in Southern California. They assessed how unhealthy childhood relationships and conflict in marriage and work relationships were related to mental health distress. They administered the Mental Health Risk Factor survey in Spanish to assess mental health and risk factors using structural equation modeling. They found that conflict in marriage was directly related to levels of mental health distress. Moreover, they found that work relationships and childhood relationships indirectly affected mental health through marital relationships. These findings indicate that marriage conflict plays a significant role in Latinx/é immigrant mental health. This also reveals a mechanism by which additional general stressors like work conflict or unhealthy childhood relationships may be influencing risk for poor mental health. This study created an extensive model through which family dynamics may influence mental health which encompasses factors like work relationships, socioeconomic status, gender, and time spent in the U.S.

However, interestingly, this study does not mention access to healthcare as a possible factor in their model. The authors discuss that other factors not included in their model that could be influencing mental health are availability of social support, the level of community integration, and discrimination. However, it is quite possible that healthcare access could also be a possible pathway through which family dynamics affect mental health. More specifically mental health care facilities can provide marriage and family counseling which could ameliorate some of the potential effects of disruptive family dynamics. Though, these considerations are not addressed in this study.

Stereotype and Prejudice Events

Stereotype and prejudice events are defined as events that happen to individuals because they have a minority status and can be discriminatory (e.g., clinicians not providing optimal care to their patients of color). Additional challenges that Latinx/é immigrants also experience are stressors related to stereotypes and prejudice events. It is argued that there have been increasing challenges related to anti-immigrant rhetoric for immigrants in the U.S. since the 2016 presidential election with Donald Trump (Verea & Verea, 2018). This continues to be important due to the upcoming presidential election as well in 2024. The political climate towards the immigrant population, particularly the Latinx/é population has become quite volatile (Krupenkin et al., 2019). There have been many stereotypes created toward the Latinx/é population for some time in the United States. There have been several hate crimes and deportations of undocumented immigrant within the last couple years in the United States (Garcini et al., 2024). These stereotypes have continued to be reinforced since the 2016 election. It is reasonable to assume that there may be cause for concern since Donald Trump is running for office again in the upcoming election.

However, the Latinx/é immigrant population have faced stressors related to prejudice and discrimination long before the 2016 presidential election. In a review from Williams and colleagues (2003), they reviewed 53 studies that explored associations between discrimination and health across ethnic groups in the U.S. They identified several mental health and physical health outcomes that were reported as a result of racial/ethnic discrimination. They found that mental health status was the most common outcome examined, with 32 of the 53 studies assessing mental health in some way. Twenty-five of those studies looked at relationships between discrimination and mental health. Twenty of those studies found a positive relationship between discrimination and distress. Four studies looked at whether perceived discrimination was related to a diagnosis of major depression. Three of those studies found positive relationships. The authors chose to exclude studies in which the outcome measure was an aspect of medical care. Though not specifically stated, it is possible this decision was made to distinguish between actual health outcomes and healthcare outcomes, as it is still possible for individuals to receive healthcare and have poor negative health outcomes.

It is worth noting that none of the studies that they looked at found a negative relationship between psychological distress and discrimination. It is reasonable to hypothesize that ethnic and racial discrimination is a stressor that likely contributes to poor mental health outcomes for Latinx/é individuals. Specifically exploring these effects for first-generation immigrants, Szaflarski and Bauldry (2019) explored how perceived discrimination affects first-generation immigrant and refugee mental and physical health. They collected data from 5285 first-generation immigrants and 421 refugees that were at least 18 years old who participated in the National Epidemiological Survey of Alcohol and Related Conditions survey (NESARC). Their sample of first-generation immigrants was 57% Hispanic. The NESARC assessed detailed information about acculturation and immigration and mental health. Perceived discrimination was measured by asking participants how often they experienced discrimination (in relation to race or ethnicity) during the previous 12 months. Some specific situations that they were asked about were healthcare, jobs, school, and in public. They found that discrimination in healthcare had a significant effect on overall health and that general discrimination had a negative effect on mental health. They also found that social support indirectly mediated the relation between discrimination in healthcare and in general with poor mental health. These findings indicate how general discrimination in a variety of situations can foster poor mental health outcomes for first-generation immigrants and also points to how discrimination in the context of healthcare specifically can be related to more mental health outcomes for first-generation immigrants. However, more detail about forms of discrimination in healthcare would be useful for supporting intervention efforts.

Expectations of Rejection

In addition to the negative effects of the actual discrimination and prejudice events, mental health outcomes for Latinx/é immigrants may also be negatively affected by stressors related to these events, like expectation of rejection. These are defined as instances of minority individuals having expectations to be rejected by others because of their minority status (e.g., fear of deportation). In a study by Arbona and colleagues (2010), they assessed whether there were differences between documented and undocumented first-generation Latinx immigrants in the prevalence of immigration-related challenges: family separation, traditionality, and language difficulty. They recruited 416 documented and undocumented immigrants from Mexico and Central America that were living in Texas. They used the Hispanic Stress Inventory-Immigrant form to survey about questions related to acculturation and stress. They also assessed feelings about fear of deportation with a 7-item questionnaire. They found that men and undocumented immigrants reported higher rates of fear of deportation and that fear of deportation was strongly associated with extrafamilial stress independent of documentation status. This study indicates how fear of deportation can be a source of anxiety for both documented and undocumented Latinx/é individuals. These authors briefly discuss how fear of deportation may discourage undocumented immigrants from seeking help for challenges like employment and healthcare and how this may exacerbate feelings of stress surrounding these issues. This is quite a valid point, and though it is addressed as a result of their findings, these authors did not include any questions surrounding access to healthcare that would have given them better insight into these relations in their sample.

Expectation of rejection in the form of fear of deportation can have other negative effects on mental health as well. Fleming and colleagues (2019) used qualitative methods to assess the impact of the 2016 Presidential election on the health of Latinx/é immigrants in predominantly Latinx/é neighborhoods in Detroit, Michigan. They conducted interviews with 28 staff members across three community resource sites that were frequently utilized by the Latinx immigrant community. They found 3 major themes across their interviews: 1.) There was an increase in pervasive fear of deportation and family separation among the clients based on the reports from the staff members, 2.) the anti-immigrant climate had disrupted community cohesion, and 3.) fear of deportation has impacted utilization of healthcare services. The staff members reported that these stressors had a detrimental effect on the mental health of the community. When discussing underutilization of healthcare services as a consequence of the fear of deportation, one staff member reported, “...they're stressed. They're depressed. They have anxiety. People that don't want to come out of their house. People that are afraid to go shopping for groceries because they don't want to put themselves at risk.”

It was also found that in the weeks after the 2016 election, Latinx immigrants changed their behaviors to conceal their documentation status by avoiding leaving their homes. They also stopped coming to social and health service appointments to avoid possible confrontations that could lead to their deportation. The authors discuss how this lack of access to healthcare could be a possible pathway through which fear of deportation affects mental health. The results of this study reveal that fears of deportation were a primary concern of Latinx/é immigrants when an outspokenly anti-immigrant President came to office and that this fear was associated with stress, depression, and anxiety and may potentially lead to concealment behaviors that result in decreased utilization of healthcare.

Concealment

With the weight of stresses related to discriminatory events and fears of deportation, and theorized in the minority stress framework, Latinx/é immigrants may conceal their immigrant identity (Fleming et al., 2019, Valentín-Cortés et al., 2020). Concealment is defined as a minority individual’s response to prejudice events by concealing their minority status (e.g., avoiding healthcare visits so that they do not need to disclose their immigration status). This may manifest as avoiding activities that they deem non-essential. One of these activities may be seeking healthcare. Vargas Bustamante and colleagues (2012) identified differences in healthcare access and utilization among first-generation adult Mexican immigrants by documentation status. The researchers used a subset of data from across-sectional telephone survey to acquire data from 2600 documented and 1038 undocumented Mexican immigrants. The participants were asked questions about healthcare access, like whether they had a usual place of care, and also about utilization, like whether they had visited a doctor in the previous year. They found that undocumented immigrants from Mexico were 27% less likely to have a doctor visit in the previous year and 35% less likely to have a usual source of care compared to documented Mexican immigrants. They also found that undocumented immigrants were more likely to be uninsured compared to documented immigrants. However, they did not find significant differences in emergency room utilization and delay in acquiring prescription drugs. They report that one large factor that is likely to influence these differences in healthcare utilization is the fear of deportation. These differences in healthcare access can also lead to poorer physical and mental health outcomes for this immigrant group, though it is not explicitly explored in this study. This study indicates how documentation status may influence Latinx immigrants’ ability to seek out healthcare. These disparities in accessing healthcare may occur as a result of Latinx/é concealment of documentation status out of fear of deportation.

Internalized Anti-Latinx/é Rhetoric

With frequent events of discrimination, in addition to concealment behaviors, there is a potential for Latinx/é individuals to internalize anti-Latinx/é rhetoric or racism. This is defined as the idea that frequent events of discrimination and prejudice could lead Latinx/é individuals to internalize these prejudices (e.g., racism within the community).

Internalized racism has been associated with a number of physical and mental health effects including weight problems, depression symptoms, and stress levels (Hipolito-Delgado, 2010). This sort of anti-Latinx/é rhetoric could manifest itself in several ways. One potential mechanism is through how Latinx/é immigrant individuals identify with cultural groups once in the United States. Wiley (2013) assessed patterns of cultural identification among first-generation Latinx immigrants in the U.S. and how that was related to their ethnic political engagement. They collected a sample of 153 first-generation Latinx immigrants in New York City. The participants completed a survey in Spanish which assessed cultural group identification using items rated on a 7-point scale. Findings showed that perceived group-based rejections from Latinx individuals were related to lower identification with the Latinx/é culture and higher identification with U.S. culture. This study reveals how internalized rejection of Latinx/é culture may be associated with deidentification with the Latinx/é culture. It was also clear that these feelings were independent of personal acceptance.

Characteristics of Minority Identity

As a result of prejudicial events, minority individuals may also experience stressors surrounding characteristics of their minority identity. This is defined as the integration of minority characteristics into the social environment of the minority group (e.g., cultural values, only being able to speak Spanish). Immigrant individuals with low English proficiency may also experience a hypersensitivity to not knowing English when their native language is not available as an option. These hypersensitivities can be cause for a lot of stress and anxiety and lead to poor mental health outcomes. This is exemplified by Kim, Worley, et al. (2011) where they assessed differences in physical and mental health among older first-generation Latinx/é and Asian immigrant men based on varying levels of English proficiency. They collected data from a publicly available existing telephone survey called the California Health Interview Survey. Participants were asked questions about English use proficiency and were divided into three groups based on proficiency level. They were also asked questions about sociodemographic characteristics, physical health status, mental health status, and healthcare use and barriers. The researchers found that the total number of chronic health conditions were greater for Latino men with low English proficiency compared to those proficient in English. However, rates for chronic health conditions did not differ across the Asian sample, suggesting potential differences in the effects of these barriers on these different immigrant groups. They found that mental health status did not differ based on English proficiency level. However, psychological distress and risk for serious mental illness was significantly higher in both Latinos and Asians with low English proficiency.

Moreover, in this sample they also assessed how healthcare access and barriers differed based on English proficiency. First, they found that those Latinos with low English proficiency were less likely to be insured than those with proficiency in English. They also found that those with low English proficiency were less likely to report seeing a medical doctor in the past year and challenges due to barriers were exacerbated for this group as well. Those with low English proficiency were more likely to have difficulties understanding doctors and written information from the doctor’s office. This study revealed that low English proficiency among first-generation older Latinx/é immigrants is associated with greater challenges related to both mental and physical health and healthcare access. These findings bridge together how acculturative stressors can lead to poor mental health outcomes and greater challenges when accessing healthcare.

In addition to exploring how low English proficiency is related to general disparities in healthcare access in older Latinx/é immigrants, Kim, Aguado Loi, et al. (2011) also assessed how English proficiency poses as a barrier to mental healthcare access for adults with mental health disorder diagnoses by using a separate sample that included Latinx/é and Asian first-generation immigrants over the age of 18 who had any instrument-determined mood, anxiety, or substance use disorder. In a similar fashion to their previous study, they collected survey and interview data from an existing dataset, the National Latino and Asian American Study, which comprised 372 Latinx and Asian immigrant adults with psychiatric disorders. They conducted diagnostic interviews to determine psychiatric disorder status. Other questions included English proficiency, mental health, mental health services. They found that for this sample of immigrant Latinx/é adults with psychiatric disorders, though all exhibited indications of psychiatric disorders, only 19.4% of them had used any mental health services. They also found that low English proficiency was associated with decreased likelihood of using mental health services. They concluded that low English proficiency was a barrier to mental health service use among Latinx/é immigrants with psychiatric disorders. Taken together, the findings from these two previous studies (Kim, Aguado Loi, et al., 2011; Kim, Worley, et al., 2011) reveal that lack of English proficiency is related to greater prevalence of mental and physical health problems and underutilization of mental health services for both

Latinx/é immigrants with and without psychiatric disorders. This highlights ways in which this characteristic of the minority identity may pose as a stressor and exacerbated mental health issues.

Coping and Social Support

It is crucial to emphasize the coping and social support mechanisms that the Latinx/é utilizes to ameliorate the effects of these unique stressors and how those may interact with healthcare accessibility for this group. As such, it is important to highlight the importance of coping and social support for this population as well. This is defined as the social network and coping mechanisms utilized by these individuals (e.g., emphasis on family or community). Some specific coping and social support protective factors include family and friend support, racial/ethnic identity, and religious involvement (Ai et al., 2015). Previous research has revealed that family support, friend support, and neighborhood cohesion is related to better self-rated physical and mental health (Mulvaney-Day et al., 2007). When families have access to some or all of these resources there are positive mental health outcomes and Latinx/é immigrant individuals are at lower risk for mental health disorders such as anxiety and depression (Ai et al., 2015). In a study by Documet and colleagues (2019) explored how social support influenced mental health outcomes and also healthcare access for first-generation Latinx/é immigrant men. They used previously collected data from emerging Latinx/é community that was collected in the *De la Mano con la Salud* intervention-based research study. Eleven Latinx/é male community health workers were used to recruit 140 first-generation Latinx/é immigrants from the surrounding community. For all participants, they administered a 90-question baseline questionnaire in Spanish at the start of the study. This questionnaire assessed perceived social support, depression, drinking behavior, healthcare access and demographic information. They found that high levels of social support were associated with lower risk for binge drinking behaviors and lower risk for moderate to severe depression symptoms. They also found that those with high levels of social support were more likely to have insurance and visit the dentist. These results indicate how higher levels of general social support can promote better mental health outcomes for Latinx/é immigrant individuals and is also associated with greater access to healthcare. This indicates that there may be a link between social support as a protective factor, better mental health outcomes and healthcare accessibility.

As illustrated by the studies reviewed in the last sections, the adapted minority stress framework was chosen as the organizational structure for this study because it outlines the specific challenges that are known to influence undocumented Latinx/é immigrant mental health. Many of these challenges are often faced in the context of healthcare usage. For example, general stressors like socioeconomic status are often linked to healthcare usage among Latinx/é immigrants (Morales et al., 2002), prejudice events often occur in healthcare settings (Damle et al., 2022), and expectation of rejection and concealment are at the forefront of challenges with undocumented Latinx/é individuals avoiding healthcare visits (Yamanis et al., 2021).

While undocumented immigrants may face more severe consequences as a result of these challenges, many of the challenges presented in this framework are also those faced by documented Latinx/é immigrants (Marshall et al., 2005). Specifically, research has shown that general stressors (Arbona et al., 2010), discrimination and prejudice (Ayón et al., 2010), expectation of rejection (Cavazos-Rehg et al., 2007), concealment of minority identity (Mendoza et al., 2015), anti-Latinx/é rhetoric (Albright & Hurd, 2020), coping and social support (J. Lee et al., 2020), and minority identity characteristics (Tikhonov et al., 2019) are all challenges that affect documented Latinx/é immigrant mental health. Taken with the understanding that these subgroups are often intertwined with many documented immigrants having friends and family that are undocumented (Passel & Cohn, 2008), this framework can be applicable to documented Latinx/é immigrants as well.

In addition, Valentín-Cortes' adapted framework allows for closer consideration and comparison of specific facets that have been affected by the COVID-19 pandemic. COVID-19 had a far-reaching impact on the lives of Latinx/é adults. This framework's outline of known stressors that impact Latinx/é adults provides a basis for examining how COVID-19 exacerbated each of these stressors and how, in many cases, this affected the relationship that Latinx/é individuals had with healthcare.

Healthcare Access for the Latinx/é Community

For this study, healthcare access will encompass both medical and mental healthcare services. Mental and primary healthcare are defined as licensed and authorized care related to mental or physical health. Moreover, there are different operationalizations of access to healthcare (i.e., insurance, primary healthcare provider, etc.). In this study, I will define access as "the timely use of personal health services to achieve the best health outcomes" (Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services, 1993). The four components of healthcare access include coverage, services, timeliness, and workforce (*Access to Health Services | Healthy People 2020*, n.d.). Coverage entails whether an individual has insurance and the extent of their insurance coverage. Services indicates whether someone has a usual source of care and receives routine check-ups. Timeliness is the ability to receive care when there is a need. Lastly, workforce details the quality of providers and whether they are qualified and culturally competent. For this study, any subdomain of these four components qualifies as healthcare access. For example, insurance status, distance from closest healthcare provider, and whether someone has a primary care physician are all examples of healthcare access that fit the definition for this study.

Healthcare access is a critical factor that both influences mental health and is also related to other stressors that can lead to poor mental health outcomes. Furthermore, Latinx/é are one of the least likely minority groups to have access to healthcare (Artiga et al., 2020). In a study of newcomer Latino immigrants, lack of access to healthcare, assessed through low health literacy, was associated with greater risk for depression (Coffman & Norton, 2010). Additionally, another study found that difficulties accessing healthcare were related to symptoms of both anxiety and depression for undocumented Latinx/é immigrants (Galvan et al., 2021). Moreover, socioeconomic status, language barriers, and concerns related to immigration status are factors that have not only been shown to influence Latinx/é immigrant mental health but have also been reported as barriers to accessing healthcare for Latinx/é immigrants (Rodríguez & Smith, 2020). In the context of mental health care, many Latinx/é adults rely on interactions with their primary care providers to treat their mental health needs rather than receiving specialized care (Cabassa et al., 2006). Taken together, these findings support the notion that access to healthcare may influence both mental and physical health outcomes.

The Impact of COVID-19 on Latinx/é Immigrants

In the winter of 2020, the world was struck with a global COVID-19 pandemic. COVID-19 is a deadly respiratory virus that is spread through contact between individuals (Ciotti et al., 2020). This pandemic led to a global shutdown of in-person interactions and a new wave of digital communication while a vaccine was being researched. COVID-19 largely impacted essential workers in positions like the service industry, construction, agriculture, and healthcare services because of the inability to perform these jobs remotely (Gwynn, 2021). This led to many individuals needing to put themselves at risk of contracting the virus on a daily basis to maintain a stable income (The Lancet, 2020).

COVID-19 has had a lasting impact on the Latinx/é community. Latinx/é individuals have disproportionately higher hospitalization rates due to COVID-19 compared with that of non-Hispanic Whites (Acosta et al., 2021). The CDC reported that Latinx/é individuals had almost two times the likelihood of dying from COVID-19 compared to White communities (CDC, 2020). It has been theorized that the disproportionate number of deaths are related to social determinants of health (i.e., access to healthcare), which are economic and social factors that affect individuals and influence their health status (Greenaway et al., 2020). For a community that underutilized healthcare prior to the pandemic as a result of acculturative stressors, COVID-19 has widened the gap in negative health outcomes for the Latinx/é community (Podewils et al., 2020).

Many recent studies have examined barriers to healthcare access for the Latinx/é community (See Escarce & Kapur, 2006, for a review) and the effects of the COVID-19 pandemic on health outcomes for this marginalized community (Behbahani et al., 2020; Martínez et al., 2021; Podewils et al., 2020; Riley et al., 2021). Escarce and Kapur (2006) report that lack of health insurance, low socioeconomic status, lack of usual source of care, cultural differences (including language), and distance to medical care were among some of the most prominent barriers to accessing healthcare for Latinx/é individuals. They emphasize that these barriers have led to underutilization of services. Further, Martínez and colleagues (2021) discuss the impact of COVID-19 on vulnerable communities. They report that those Latinx/é individuals that were most impacted by COVID-19 were those living in crowded households, only spoke Spanish, and worked as essential workers or food service workers. With many of the factors that exacerbated health impacts of COVID-19 also being factors that diminish access to healthcare for Latinx/é immigrants, it is important to investigate the combined impact of these challenges.

Digital Health Services post-COVID-19

While many jobs and functions have resumed in-person after the discovery of the vaccine, the COVID-19 pandemic has still had a lasting impact on the world. More specifically, healthcare systems operate quite differently from their pre-pandemic operations. Many clinicians are continuing to conduct services via telehealth appointments (Shaver, 2022), patients and clinicians are often required to wear masks during their visits (World Health Organization, 2020), and the systems have put more reliance on digital health charts and programs (S. M. Lee & Lee, 2021). While these changes have been useful, they have also shed light on the inequities within these systems.

With the additional prolonged effects of the COVID-19 pandemic, and in the context of the research reviewed here, there is an increased need in the development of programs and models that can promote healthcare utilization to meet the needs of diverse communities. With many in-person services becoming unavailable, the COVID-19 pandemic fostered the introduction of several medical programs and services to make healthcare accessible from a distance. These have included a large increase in mobile medical units which are mobile doctor’s offices that can travel to communities that do not have access to these services (Attipoe-Dorcoo et al., 2020), telephone services which connect patients and clinicians through the phone (NeJhaddadgar et al., 2020), and nearly a complete shift to online telemedicine and teletherapy which are full-scale healthcare visits conducted via secured web conferencing or phone calls (Talevi et al., 2020). This shift to telemedicine has prompted researchers to examine the effectiveness of these medical/mental health models. Though some studies have demonstrated the effectiveness of telehealth services in increasing healthcare access for the general population, they have cautioned the use of these services in marginalized communities as the drawbacks like limited access to advanced technology and limited knowledge on the use of digital healthcare services may widen health disparities for these communities (Mahtta et al., 2021). With this in mind, it remains an open question whether telehealth services reduce or exacerbate barriers to accessing healthcare in the Latinx/é community.

The Utility of Mixed Method Research with the Latinx/é Population and Conclusion

Research of healthcare access barriers for the Latinx/é community has consisted of a relatively even contribution of quantitative and qualitative research. For quantitative research, many of these studies have used meta-analysis methods to quantitatively assess the prevalence of different barriers across studies. This has been beneficial for revealing a general consensus on the list of barriers (Rivers & Patino, 2006; Timmins, 2002). Qualitative studies have allowed for more in-depth descriptions of how these barriers have uniquely impacted health outcomes from the perspectives of Latinx/é individuals and healthcare providers. For example, qualitative studies have not only supported identification of these barriers, but have also found that Latinx/é individuals may turn to family members or unlicensed healers to avoid healthcare settings and risk of deportation (Raymond-Flesch et al., 2014). This provides better insight into how Latinx/é individuals may respond to health problems in the presence of these barriers. Additionally, qualitative studies have provided an understanding of how better access to healthcare may be achieved. When assessing utilization of mental health services among Latinx/é individuals, one such study found that Latinx/é-serving clinicians reported a strong need to provide more information about mental health conditions and bilingual therapists to generate more access (Martinez-Donate et al., 2022). Together, the findings from these studies converge to provide a wealth of knowledge about the shared barriers that Latinx/é immigrants face, and the experiential accounts of potential resolutions to these barriers.

Most importantly, however, have been the results recorded from studies using a combined approach through mixed-methods studies. For example, Apesoa-Varano and Hinton (2013) used a mixed-method approach to assess the effects of attitudes about depression for health outcomes in older Latinx/é men. They used a quantitative approach to collect a comprehensive sample that accurately represented their population of interest, older men with a history of depression symptoms who had experience with the healthcare system. They then used qualitative approaches to assess attitudes about depression and healthcare. Their findings reveal knowledge about attitudes towards mental health within older Latinx/é males that would not otherwise be achievable through other methods. Examples such as this help further strengthen the rationale for the utilization of a mixed methods approach taken in this study.

This section reviewed the current literature that exists highlighting how the Latinx/é immigrant population in the United States significantly underutilizes healthcare services and how this is linked to poor health outcomes. First, the variability within the Latinx/é population and the current state of Latinx/é immigrant mental health was discussed. Secondly, the minority stress theory was explored in depth and how this framework would be utilized for the purposes of this study. Lastly, the impact of COVID-19 on Latinx/é immigrant health and the digital age of healthcare services was reviewed. Finally, the aims of this study and what steps were taken to explore these questions will be discussed in the upcoming chapter.

Chapter 3: Methods

Positionality Statement

Positionality statements have become increasingly more important in contemporary research. Their purpose allows researchers to acknowledge their own bias and identities which may influence how a researcher conducts their study and/or relates to the research that they are doing. However, in a study by Massourd (2022), they found that a statement of positionality can also enhance the validity of the empirical data that is collected as well as the theoretical contributions. Furthermore, it is important for researchers to acknowledge this potential overlap in their research so that we continue to recognize and acknowledge that this bias exists.

I am a bi-racial, heterosexual, cisgender male. Although I am a first-generation college student; I acknowledge that I am privileged for being a male in academia. I was privileged to grow up in a middle-class home and I had opportunities provided for me, like attending a 4-year university, that may be harder to obtain for others of low socioeconomic status.

My passion for researching mental health outcomes for documented and undocumented Latinx/é immigrants stems from my family background. My mother and her siblings came to this country undocumented when they were very young, and they would tell me about the challenges that they endured growing up in the United States. Learning about their previous hardships and those that they still face is what continues to make me passionate about this work.

I acknowledge that as the son of an immigrant who was born in the U.S. I may introduce biases into my research practices. While I acknowledge this bias, I also acknowledge and recognize how my own bias provides a unique lens in which I am able interpret/understand the data. For example, because the question of healthcare usage in a marginalized community is often complex and difficult to address with entirely quantitative data, previous literature from Regnault et al. (2018) has recommended the use of a mixed-methods design to address these types of complex questions. The integration of qualitative research methods in my investigation of Latinx/é immigrant mental health gives a stronger voice to the population of interest and allows these individuals to tell their stories and provide various perspectives. The questionnaires outlined in this proposal were chosen because they directly assess the challenges that my research questions aimed to address and existing literature has supported the use of these measures with Spanish-speaking participants (“The ‘all of us’ research study”, 2019).

I acknowledge that academia historically has been and continues to be an oppressive institution and one that is privileged. I pledge to challenge these norms and will continue to partner with other researchers who will use academia for the purpose of supporting others. I pledge to learn more about how I can use my research to support communities and use the experiences of others to create interventions/access and other supports for others. I pledge to use my research for the purpose of equity for all. Furthermore, I pledge to continually self-reflect and understand my own biases as a researcher. This positionality is continuously changing, especially as I grow as a person and as a researcher. I state this positionality for transparency of potential biases to my research.

This study used a mixed-methods approach to address questions related to the impacts of COVID-19 on healthcare usage in this community. To date, though findings from qualitative and quantitative studies have been integrated for a comprehensive understanding of the barriers to healthcare access for the Latinx/é community, there are currently very few studies that have used mixed-methods to describe these barriers in the Latinx/é community or to assess the impacts of COVID-19 on this community. A mixed-methods approach can provide insight into the community perspectives with greater detail and nuance. The research questions that guided this dissertation study are:

1. What are the existing barriers to accessing both primary care and mental health care for the Latinx/é community post-COVID-19? What demographic sources of variability influence access to such supports?
2. How have these barriers changed with the onset of COVID-19?
3. What kind of resources do Latinx/é individuals think would improve their ability to access healthcare?

For these research questions, the term "barriers" is defined as any encountered physical, mental, cultural, or systemic obstacle that prevents a Latinx/é individual from achieving desired healthcare.

This research relies on a convergent parallel mixed-methods design (Creswell & Clark, 2017), wherein quantitative and qualitative data are collected simultaneously, and results are combined together for enriched interpretation. The aim of this design is to find converging evidence in the quantitative results that support findings in the qualitative results. Given the complexity of the underpinnings of mental health for marginalized communities, this approach provided an ability to quantify particular characteristics using quantitative data while using qualitative data to provide meaningful interpretation of these results. This convergent design (i.e. the use of both qualitative and quantitative methodologies to draw comprehensive conclusions about phenomena) was used (see Appendix A) to collect both quantitative and qualitative data simultaneously to limit the number of times participants needed to be contacted, Furthermore, this design allowed data collection to be as efficient as possible minimizing the amount of time participants needed to complete this study.

Justification of Mixed Methods Approach

A mixed methods approach was taken in this study because it allowed for both quantitative and qualitative data to inform each other which allowed for even more nuance to the data. Mixed methods research design is defined as the collection of both quantitative (e.g., surveys, questionnaires) and qualitative (e.g., interviews, observations) data, which are then combined to be analyzed together (Heyvaert et al., 2013; Halcomb & Hickman, 2015)). This approach is optimal because it provides a quantifiable direct assessment of community perspectives while allowing for the subtle nuanced individual differences in those perspectives. Connelly (2019) describes taking a mixed methods approach as the goal being to draw on the strengths and minimize the weakness of both qualitative and quantitative research. Many quantitative approaches utilize surveys that have been created to generalize across samples and are typically organized as multiple-choice-style questions. While these surveys provide valuable insight into overarching themes, they do not allow for nuanced responses to these questions. Furthermore, there has been an increase in literature that has utilized a mixed methods approach while having an overall small sample size (Noyola et al, 2020). While the quantitative data was interpreted with caution due to the small sample size, when paired with the qualitative data it created much more richness in the results. This allowed for the quantitative results to better inform the qualitative results and vice versa.

Currently, research assessing the impact of COVID-19 has largely used quantitative research methods as the ability to collect data remotely through online surveys has been well-suited for the ever-changing dynamics of the pandemic. Surveys are the easiest methodology to administer remotely as questions can be posted and easily answered online at the convenience of participants and typically require a shorter time commitment.

Participants

Inclusion criteria for the participants in this study were as follows: (1) participants identify as first-generation Latinx/é, (2) participants are over the age of 18, (3) participants are first-generation, (4) participants have experience with the U.S. healthcare system, (5) and participants have lived in the U.S. for at least two years.

Sixteen first-generation Latinx/é immigrant adults (n=16) living in four different communities in 4 different states were recruited to participate in this study (See Table 1**)**. Certain demographic information was collected from participants as well, such as documentation status (*n*= 10 undocumented, *n*= 6 documented), insurance status (*n*= 6 uninsured, *n*=10 insured) and the language(s) they spoke (*n*= 10 monolingual Spanish, *n*= 6 both English & Spanish). A 17th participant was recruited and began the interview process but due to connectivity issues they needed to leave the interview early. Several attempts were made to reconnect with this participant to complete the interview, however, it was unsuccessful. Thus, the 17th participant's partial interview was not included in data analysis. Of the 16 participants, ages ranged from 20 to 57 with a mean age of (M=39.7). Participants lived in 4 different states which further illuminated the differences among Latinx/é immigrants accessing care depending on where they lived regionally. The 4 states were: Massachusetts (*n*= 8), Colorado (*n*= 6), Pennsylvania (*n*=1) and Georgia (*n*=1). Lastly, time spent in the United States ranged from 4 years to 23 years with a mean of (M=13.8) years in the United States.

A sample size of 16 was chosen based on feasibility due to time constraints and funding limitations to adequately compensate participants for their time. Given the vulnerability of this population, it was imperative that sufficient compensation was provided for participation in this study. Through an internal grant received through the Counseling Psychology department at Boston University, a $100 Visa/American Express gift card was provided to participants for completing the interview. Participant emails were provided by a community partner. One community partner in Colorado who supports the undocumented Latinx/é population in their community by providing classes, information about resources and other supports, shared flyers about this study at their center. One community leader from this agency reached out and asked several clarifying questions and inquired about safety measures that were being taken to protect the identity of these community members. Once their concerns were eased, the flyers were shared and participants who were interested in this study, consented to have their emails shared so that they may receive a zoom invitation. Upon completion of the interview, using the same email address that was provided, gift cards were sent to the participants for their time. Once participants confirmed that they received their gift cards and were able to access the funds, their emails or any other contact information was promptly deleted. Based on these available funds and planned analyses, this sample size was the optimal range with these considerations.

Sampling and Recruitment

Furthermore, a snowball sampling approach was taken to increase community outreach and participation in this study, which lead to some participants partaking in the study who do not have any connection to a community partner or healthcare center. Snowball sampling is defined by Miles, Huberman & Saldana (2018) as a non-probability sampling technique where existing study participants help recruit future participants who are within their community that would meet a study's inclusion criteria. Furthermore, snowball sampling is typically used when participants are considered to be a "hard to reach" population and has been shown to be an effective way to recruit participants with the undocumented immigrant population (Polit & Beck, 2010)**.** For example, some participants asked if they could share information about this study with others, they know who might be interested in participating. This allowed for some participants who were not connected with a community agency/community clinic to share their experiences about barriers to care. Those participants who were not connected with a community agency, reached out via email or phone expressing their interest in participating in this study.

This study aimed to enroll half documented Latinx/é immigrants and half undocumented Latinx/é immigrants to ensure that the perspectives from the undocumented community were included as well. This decision was based on evidence that undocumented immigrants face disproportionate challenges when accessing healthcare even compared to foreign-born documented Latinx/é individuals (Berk et al., 2000). Once interviews were completed, there were more undocumented participants (n=10) compared to documented participants (n=6). I employed best practices for carefully assessing documentation status to minimize risk of participants disclosing information that they were not comfortable with sharing. For this, I did not directly ask about documentation status, rather, I inquired about the type of health insurance coverage that each participant had. This was an appropriate way to indicate immigration status because those who did not have health insurance, who lived outside of Massachusetts did not qualify for health insurance. Furthermore, those who were undocumented and did have health insurance coverage who also lived in Massachusetts had state insurance called “MassHealth limited”, which is strictly available to undocumented immigrants. It is worth noting that some participants were comfortable disclosing their documentation status, however, any of this information revealed during the interview was removed from the transcripts to protect the confidentiality of the participants or it was disclosed to this interviewer before recording of the interview had commenced. If their documentation status was not freely shared, insurance status was used as an indicator for documentation status.

Table 1. Demographics of Participating Individuals (N=16)

Demographics	M*(SD); N* (%)
Participant's Age	39.70 (9.86)
Participant's Sex	
Male	3 (18.8%)
Female	13 (81.3%)
State of Residence	
Massachusetts	8 (50.0%)
Colorado	6 (37.5%)
Pennsylvania	1 (6.3%)
Georgia	1 (6.3%)
Language	
English	0 (0.0%)
Spanish	10 (62.5%)
Both English and Spanish	6 (37.5%)
Documentation Status	
Documented	6 (37.5%)
Undocumented	10 (62.5%)
Insurance	
Insured	10 (62.5%)
Not Insured	6 (37.5%)

Due to the challenges of accessing this population, it was essential to partner with community agencies and health centers which are embedded within their communities that serve the large Latinx/é immigrant population. Using established connections with these community partners through mentors and colleagues that work closely with these organizations, they were able to share flyers (See Appendix F**)** for this study with a health center and different community organizations. Flyers were created for this study both in English and in Spanish (See Appendix F.2**)** which detailed the aims of this study, the inclusion criteria (See Appendix F**)**, the compensation for participating in the one-hour interview and the contact information for this researcher. Flyers were translated into Spanish and then were back translated by another fluent Spanish speaking researcher to ensure validity of the translation.

Measures

Two surveys and a semi-structured interviews were conducted via Zoom with each respective participant, looking at what perceived to barriers existed for accessing mental health treatment and accessing care overall in the United States. Surveys were read to each participant and responses were recorded on printed out copies of these surveys. Due to participant sample size, surveys were used to provide descriptive data on these constructs, which are expanded upon in the qualitative results.

Quantitative surveys

Perceived Barriers to Mental Health Treatment

To assess immigrant Latinx/é perceptions/attitudes toward accessing and utilizing mental health services, a survey of perceived barriers and attitudes toward mental health care developed by Garcia et al. (2014) (See Appendix B) was given to participants to start the interview. It is important to note that this survey was initially made for war veterans and their perceived barriers/attitudes to mental health treatment. However, this survey was still appropriate for the Latinx/é immigrant population because it highlights the same barriers/attitude types towards accessing mental health care (e.g., logistical barriers, stigma barriers) and gives more insight into how previously established barriers to accessing care are impacting individuals. This measure leverages previous research on barriers to accessing healthcare and prompts participants to rate these existing barriers on their impact using a Likert scale (e.g., 1 = Strongly Agree and 5 = Strongly Disagree). This survey is composed of two parts: (1) patient and institutional level logistical reasons for not keeping healthcare appointments (7 items; e.g., “there are no appointments on weekends”), and (2) attitudes about psychotherapy (9 items; e.g., “I have had therapy before and it did not help”). The possible sub-scales scores range from 7-35 on the logistical barriers sub-scale and 9-45 on perceived attitudes sub-scale which were summed together to obtain an overall score.

As a part of the grant that was received through Boston University for this dissertation study, part of the funds were allocated to hire a Spanish-speaking researcher to strengthen the validity of the translation. Fluent Spanish speakers were used for this process. One translator was knowledgeable of the survey assessment goals while the other translator was naïve to survey assessment goals to minimize bias. An unbiased bilingual translator with no direct ties to the research study was used to resolve discrepancies between the two translators if any arose. Following translation, the translated survey was reviewed by a diverse group of Spanish-speaking native community members with a wide range of educational attainment and countries of origin. This group was able to review the measures that were provided participants and agreed that they were translated in an appropriate way.

"All of Us"

To ask about participants experiences accessing healthcare overall, the 'All of Us' study by the National Institutes of Health (NIH) survey (see Appendix C) was used to explore these barriers more thoroughly ("The 'All of Us' Research Program," 2019). This 23-item questionnaire survey was developed for the goal of directly collecting a diverse and representative data repository to investigate social, clinical, biological, environmental, and behavioral determinants of health and disease (Cronin et al., 2019). It collects information on healthcare access and utilization for the general population and all survey measures and outcomes are publicly available. For example, it provides information on how frequently individuals see their physicians, what type of services they usually seek out, and types of clinicians they typically visit. Furthermore, this survey also explores what barriers exist for utilizing healthcare services which lead to delaying accessing care when it is needed. For example, it explores barriers such as cultural factors, financial burden and lack of access to services as being potential barriers to care. This survey was created by reviewing existing validated surveys and instruments and questions were chosen based on validation in diverse populations. Many of the questions came from the National Health Interview Survey ("The 'All of Us' Research Program," 2019). This survey was developed and tested in English and Spanish. The validity of this survey was tested using both qualitative and quantitative data in a diverse sample of English and Spanish-speaking participants (Cronin et al., 2019).

This survey was chosen because of its accessibility, validity of the survey both in English and Spanish, and because of its culturally appropriate questions exploring access to healthcare ("The 'All of Us' Research Program," 2019). This survey did not contain scales or subscales and total scores were not calculated. Response formats for each question varied and had several possible responses for each item. For example, when asked "During the past 12 months, were you told by a health care provider of a doctor's office that they did not accept your health care coverage?" responses were either: yes, no, don't know. Another survey question asked, "In regard to your health insurance or health care coverage, how does it compare to a year ago?" with "better, worse, about the same, I don't know" as response choices. Frequencies and percentages will be used to analyze survey data. For the purposes of this study, survey results provided descriptive statistics to further strengthen and/or highlight the narratives that arose in the qualitative data.

Qualitative Interviews

Semi-structured interviews were conducted with participants for a deeper understanding of access to care and allowed for nuances to emerge in the data that were not captured by the surveys. Participants were informed that the qualitative interview consisted of having more open-ended questions and that they could provide as much or as little information that they wanted to and with what they felt comfortable with, since questions would be asking about their own personal experiences with accessing healthcare in the United States. Qualitative interviews allow for more nuance in comparison to just using quantitative measures because it allowed for participants to delve deeper into each question and allowing participants to share their lived experiences in more detail. For example, in the Garcia (2014) survey exploring barriers to mental health care, a question asking about having “reliable transportation” can only be answered as transportation either being a barrier not being a barrier to care. However, asking about transportation being a barrier to care during the qualitative interview provides space for the participant to provide more details about what specifically related to transportation creates barriers to accessing care, which in turn can provide insight to what we can do to help minimize these barriers.

The Interview protocol consisted of 13 open-ended questions that ask about experiences with healthcare and perceived barriers to healthcare, impacts of COVID-19, and potential resolutions to challenges accessing healthcare (See Appendix D for specific interview questions). These questions were first reviewed by a community partner to examine the clarity of questions and whether they accurately gauge the desired perspectives, while also checking to make sure that questions did not compromise the confidentiality/safety of the participants. These interview questions were reviewed and approved by the community partner before they were shared with participants. These qualitative interviews ranged from approximately 35-45 minutes. Overall, the entire interview process including both the quantitative surveys and qualitative interviews that followed-ranged from 50-75 minutes in length.

To help with transcription of the qualitative interviews, an online web-based tool called “Happy Scribe” was used. Funds from the internal grant were used to help supplement the cost of this online platform. Audio files from each interview that were done in either English or Spanish, were uploaded to the platform for transcription. For the interviews that were done in Spanish, files were transcribed in Spanish, then later translated into English. This transcription service guarantees a minimum of 85% accuracy with its online transcription service. However, for further reliability/validity of the transcription, each transcript was reviewed line-by-line simultaneously with the audio file by the researcher to ensure accuracy in the transcriptions. Transcripts ranged from 26-42 pages in length depending on what the participants were willing to share about their experiences accessing healthcare in the United States. Furthermore, it’s worth noting that not only was the semi-structured interview portion of this study recorded and transcribed, but the administration of the surveys was captured as well. This provided nuance to emerge in the data and several interesting themes arose in the data when participants disclosed more information than what the survey called for.

Procedures

All visits began with Boston University IRB-approved informed consent where all the necessary materials were reviewed with participants and their understanding was ensured before collecting any data. Participants were asked to verbally give consent and if requested, they were sent a copy of the consent form. All consent and study procedures were verbally administered either in Spanish or English depending on the subject's preference with answers recorded in writing. For this vulnerable population, participant autonomy and safety were a main priority, so this step was emphasized to ensure participants were fully informed. Participants were informed that all their data will remain confidential, and they were welcome to not provide answers to any questions that may make them feel uncomfortable. Following this, a brief set of demographic questions including age, preferred language, gender, race, ethnicity, and insurance status were collected. The answers to these questions were not video recorded for further participant confidentiality.

Following consent procedures, the session began with both quantitative surveys, starting with the survey exploring barriers to mental health care and then with the NIH survey. This was done via Zoom or phone depending on the subjects' preferences. Participants had the option of either turning off or leaving on their camera for the entirety of the interview process. Each survey item was read to every participant and responses were recorded on printed out copies of surveys. This was done to help keep participants within the one-hour time frame and allowed for participants to ask for clarification on any questions that did not make sense to them. Furthermore, participants provided more information about some questions that were not within the responses provided. However, this provided valuable insight to several items and added nuance to some of their responses. Participants were asked to return to these responses during the qualitative portion of the interview and responses were noted/highlighted so that they could be returned to later. Survey data collection took approximately 30 minutes for each participant. Once surveys were completed, subjects participated in qualitative, semi-structured interview sharing their experiences thus far utilizing the United States health care system.

Data Analysis

Quantitative Analysis

Due to limited sample size quantitative analysis was limited to descriptive statistics from both surveys. For the perceived barriers to healthcare survey these descriptive statistics included frequencies at the item and overall levels, and measures of central tendency (e.g., mean and median). Item data were summed to form the subscale scores after recoding reverse scored items as necessary. Two items on this survey needed to be recoded (e.g., "this treatment will make me go crazy", "coming to treatment means I am weak"). Internal consistency of the survey sub-scales was also calculated using Cronbach's Alpha. This was done using Statistical Package for Social Sciences software (SPSS) version 29. Due to the "All of Us" survey having varied potential responses these items did not have a summed score nor were any measures of central tendency calculated. Instead, participant survey data was broken down and compared across groups (e.g., documentation status and insurance status) using cross tabulations and item frequency and percentages were reported. Quantitative data was used to inform the qualitative analysis.

Qualitative Analysis

An inductive coding approach was taken when generating codes for analysis of the semi-structured interviews. Miles and colleagues (2018) describe inductive coding as an approach where you create your codes from the data itself rather than having an initial set of codes beforehand. To do this, during the interview process, the "memoing" technique was implemented to record various themes/trends that were being noticed during the interview. Birks et al. (2008) describe memoing as technique that "assists the researcher in making conceptual leaps from raw data to those abstractions that explain research phenomena in the context in which it is examined" (p. 69). This approach was especially helpful in moving from the quantitative surveys to the qualitative interview questions. For example, several participants asked for clarification on certain questions in the surveys, answered some questions outside of the context of receiving healthcare in the U.S., and added more information to their responses. Therefore, the qualitative interviews allowed the opportunity to return to these important points during the interview process which provided much more nuance to the quantitative data.

Utilizing an inductive coding approach (Miles et al., 2018), analysis also drew on techniques from grounded theory (Chun Tie et al., 2019), including open coding, axial coding and selective coding (Walker & Myrick, 2006). First, open coding, In Vivo theory

(Khandkar, 2009) was used to generate the general themes as they arose in the data. This involved a deep dive into the data to generate codes. Specifically, once all the interviews were transcribed and deidentified, an initial first round of coding was done to identify codes that were arising from the data. Some initial codes that arose were: price/money, lack of coverage, Mexico/zoom, Stigma. Furthermore, a frequency chart was created to monitor how many times a code was talked about/brought up in each interview. For example, codes that were highlighted as barriers to care such as, technology, lack of insurance or lack of information were categorized under “barriers”. Furthermore, codes that arose which created access to healthcare such as community, were categorized under “increase access”.

Once major codes were identified, a codebook was created assigning a definition of each code. Once these definitions were assigned one last coding cycle was made using these definitions to ensure they aligned with the codes they were assigned to. This coding process helped strengthen the validity of the codes that were generated and will be shared with future analyst for the purposes of inter-coder reliability. For example, when the code “cost” was generated, a definition was created that would support in identifying where this code should be assigned in the transcript. Moreover, the definition for “cost” was; “whenever a participant mentions/discusses the price of care”. When this arose in the transcripts the code “cost” was assigned to it. This process was done with every code that was generated from the data.

CHAPTER 4

Results

In this section, quantitative results of both surveys will be presented first, followed by qualitative findings. As noted earlier, due to the small sample size, descriptive statistics of survey responses will be presented and discussed as a way of providing additional information from which to interpret the qualitative themes. In preliminary analyses, chi-square analyses were run to determine whether variables such as documentation status and/or insurance status impacted whether or not participants were able to access care or delayed receiving care in the last 12 months; this is an important question that strongly relates to the overall study objectives. Although the chi square statistic was significant on two survey items, these are not included in the results here due to limited ability to interpret such significance with confidence.

Perceived Barriers to Mental Health Treatment Survey

Quantitative results for both surveys provided interesting insights to the barriers in accessing healthcare for the Latinx/é immigrant population. Results of the “Perceived Barriers to Mental Health Treatment” (Garcia, 2014) survey was divided into two sections, which together contribute to an overall score of perceived barriers to mental health treatment. Because total scores are less meaningful here, descriptive results are discussed in terms of each sub-scale. The two categories were: logistical barriers and psychotherapy attitudes. Mean scores are presented in Table 2 below (see Table 2). As shown in the table, the mean score for logistical barriers was (*M*=22.44) with a median of (*Mdn*=23.00). Furthermore, scores for psychotherapy attitudes had a mean score of (*M*=20.62) with a median score of (*Mdn*=21). The possible sub-scales scores range from 7-35 on the logistical barriers sub-scale and 9-45 on perceived attitudes sub-scale.

While the second survey used here ("All of Us") provided a more extensive exploration of logistical barriers to accessing care, participant responses to the Garcia (2014) survey were interesting as well. Frequencies of all survey questions on each subscale are presented in Appendix B.3. Here, the most prominent responses from each subscale are discussed. For logistical barriers scale, the most noticeable responses that arose in the data were participants reporting that the biggest logistical barriers to care were not having appointments after work and not having appointments on weekends. When asked about not having appointments after work, ten participants reported that this was a barrier to accessing mental health care appointments and six participants disagreed with this. Furthermore, when participants were asked about not having appointments on the weekend, nine participants stated that this was a barrier to accessing their appointments and seven participants disagreed with this. These findings suggest that many participants in this study, struggle with finding time throughout the work week to attend their mental health appointments. This is especially important for mental health appointments because they typically require more frequent appointments (e.g., weekly or bi-weekly appointments) and not being able to find a time to make it to their appointments could be a substantial barrier that clinicians must attend to, especially with populations such as this one.

Perceived attitudes to psychotherapy can be particularly interesting because of the well-known feelings of stigma that exist around mental health and accessing mental health services in the Latinx/é community (Benuto, et al., 2019). However, when examining participants responses that asked directly about stigma related to receiving mental health care, results were surprising. When looking at item 10 of this survey (see Appendix B), when asked do you believe “this treatment will make me go crazy”, 87% (14/16) of participants disagreed with this. Furthermore, when analyzing item 11 of the survey (see Appendix B), when asked if they believe “Coming to treatment means I am weak”, 93% (15/16) of participants disagreed with this.

Table. 2

Descriptive Statistics for Perceived Barriers to Mental Health Treatment

	Mean	Median	Min	Max	Cronbach’s Alpha
Logistical Barriers	22.44	23.00	14.00	31.00	0.83
Psychotherapy Attitudes	20.62	21.00	14.00	31.00	0.70

These results highlight that stigma around mental health within this sample of Latinx/é individuals could be trending downwards, which could be crucial in supporting this population with accessing both healthcare and mental health care services. However, even though stigma around accessing mental health services could be improving, this does not equate to improved access to care for this population. As attitudes towards seeking out or receiving mental health services continue to improve, we must deepen our understanding at what other barriers continue to exist for the Latinx/é immigrant population when trying to access care.

One finding that was noteworthy and warrants further discussion was based on some participants' responses to the survey questions. Three participants asked for clarifications during the survey questions asking whether or not these surveys were referring to providers in general or just in the United States. These participants reported that they were either receiving their healthcare from a general provider or their mental health treatment or both from a provider in Mexico using Zoom to connect to them. They cited having no access to care in the U.S. as their primary reasons for seeking out treatment outside of the country. This finding was interesting because it highlights the inflexibility that quantitative surveys can have that allow for little to no nuance in participants responses. This is something that future researchers should consider and be mindful of when collecting similar data using only quantitative methods.

Telehealth & Providers Outside the U.S.

Finally, an interesting finding arose during the quantitative portion of the interview process for a few participants that warrants further discussion and exploration in future studies. When administering one of the surveys to participant G001 who is undocumented, they asked for clarification on several items around receiving mental health services. Ultimately, participant G001 asked specifically:

> "When answering these questions, are we talking about providers in the U.S. or the providers that I am seeing in Mexico? Because I am answering these questions thinking it's about my providers in Mexico".

When participant G001 elaborated on this more, it was discovered that due to the anti-immigrant policies in Georgia which barred them from accessing any kind of healthcare services, they were forced to see providers outside of the United States using applications like Zoom and WhatsApp. Furthermore, there were two other participants that expressed the same need due to the lack of access in their communities and because of their immigration status. This finding is important because it not only provides a better understanding about what some Latinx/é immigrant individuals are forced to do to access the healthcare that they need, but also highlights the importance of qualitative data which allows for nuance to emerge in the data such as this. Implications on future research will be explored further in the discussion.

"All of Us" Barriers to Accessing Healthcare

The "All of Us" survey explored in more depth what logistical barriers exist for accessing both healthcare and mental health care in general within this past year (12 months). Descriptive statistics were used to create frequency tables based on participants' responses, especially on key variables around their general patterns of utilizing care, and the barriers to this. First, in response to the questions that asked whether they had seen a general doctor in the past 12 months, all 16 participants (100%) reported that they had seen a general doctor at least once in the past 12 months. When participants were asked if they had seen a nurse practitioner in the past 12 months, seven participants (43.8%) reported that they had, six participants (37.5%) and three participants (18.8%) reported that they did not know if they had. Lastly, when participants were asked if they had seen a mental health professional in the past 12 months, 10 participants (62.5%) reported that they had at least once, and six participants (37.5%) said they had not in the past 12 months.

Next, crosstabulations were computed to examine participant responses to questions regarding reasons for delaying care in the past 12 months, according to insurance and documentation status, respectively. These variables were chosen for examination since they are ones that can critically impact access. First, results from participants' responses who were insured vs. not insured will be in examined (see Table 3). Secondly, results from participants responses who were documented vs. undocumented will be examined to see if this had an impact on accessing healthcare overall (see Table 4).

Insured vs. Uninsured

Overall, there were differences in accessing care when comparing participants who were insured to those who were not. The number of participants who were insured were (n=10) and those who were not insured were (n=6). It's worth noting that all participants who did not have healthcare insurance of any kind were undocumented. However, not all participants who were undocumented were uninsured. There are some state programs like the one in Massachusetts (e.g., MassHealth) which provides healthcare for all regardless of documentation status which allowed for some of the participants who were undocumented to have access to healthcare coverage.

The most notable differences when comparing those who were insured to those who were not insured was the number of participants who delayed receiving care because they could not afford the co-pay, because they could not afford the deductible and because they would have had to pay for all/most of a procedure out of pocket and could not afford it. Those who were insured reported significantly fewer delays in receiving care (10%, 1/9) because of these costs, while those who were not insured or did not have coverage were much more likely to delay care (83.3%, 5/6). It's worth noting that while participants who were uninsured were much more likely to delay care or completely not receive care because of the cost, even participants who were insured reported either delays in accessing care or have completely forgone seeing their provider because of the cost of care.

Table 3
"All of Us" Survey Barriers to Healthcare: Health Insurance vs. No Health Insurance

	Health Insurance		No Health Insurance	
	Yes	No	Yes	No
In the past 12 months have you delayed getting care because you couldn't afford the co-pay?	0 (0%)	10 (100%)	5 (83.3%)	1 (16.7%)
In the past 12 months have you delayed getting care because you couldn't afford the deductible?	1 (10%)	9 (90%)	5 (83.3%)	1 (16.7%)
In the past 12 months have you delayed care because you had to pay out of pocket for some or all of the procedure?	1 (10%)	9 (90%)	5 (83.3%)	1 (16.7%)
In the past 12 months have you needed prescriptions but didn't get it because you could not afford it?	1 (10%)	9 (90%)	3 (50%)	3 (50%)
In the past 12 months have you needed emergency care but did not get it because you could not afford it?	1 (10%)	9 (90%)	1 (16.7%)	5 (83%)
In the past 12 months have you needed to see a general doctor but didn't go because you could not afford it?	2 (20%)	8 (80%)	3 (50%)	3 (50%)
In the past 12 months have you needed follow-up care but did not get it because you could not afford it?	4 (40%)	6 (60%)	6 (100%)	0 (0%)

Results show that there continues to be inequity in access to care for the Latinx/é immigrant population withing this sample. This is especially true for those who are undocumented and live in a state that denies access to healthcare coverage to those who are undocumented. However, even those who are insured or have limited access to health insurance still report having delayed care or not accessing care altogether due to the high cost. This highlights that even with coverage, the cost of care can still be too high for the Latinx/é immigrant community. This should be further explored when looking at access to specialist care as well. Considering that mental health and other services can be considered specialty care, this disproportionate gap in accessing care could be even greater.

Documented vs. Undocumented

Overall, when comparing responses from participants who were documented to those who were undocumented (see Table 4), there was not a striking difference in accessing healthcare. However, those who were documented reported much less frequency in delaying care due to cost and less frequency in not accessing care at all due to cost in comparison to those who were undocumented. It is worth noting that when needing follow-up care, all participants who were undocumented reported not accessing follow-up care due to the cost within the last 12 months. This potentially shows that while participants who are documented or undocumented are able to make it to general appointments, this becomes more challenging if appointments warrant follow-up because of the financial barriers.

Table 4

"All of Us" Survey Barriers to Healthcare: Documented vs. Undocumented

	Documented		Undocumented	
	Yes	No	Yes	No
In the past 12 months have you delayed getting care because you couldn't afford the co-pay?	0 (0%)	6 (100%)	5 (50%)	5 (50%)
In the past 12 months have you delayed getting care because you couldn't afford the deductible?	1 (16.7%)	5 (83.2%)	5 (50%)	5 (50%)
In the past 12 months have you delayed care because you had to pay out of pocket for some or all of the procedure?	1 (16.7%)	5 (83.3%)	5 (50%)	5 (50%)
In the past 12 months have you needed prescriptions but didn't get it because you could not afford it?	1 (16.7%)	5 (83.3%)	3 (30%)	7 (70%)
In the past 12 months have you needed emergency care but did not get it because you could not afford it?	0 (0%)	6 (100%)	2 (20%)	8 (80%)
In the past 12 months have you needed to see a general doctor but didn't go because you could not afford it?	2 (33.3%)	4 (66.7%)	3 (30%)	7 (70%)
In the past 12 months have you needed follow-up care but did not get it because you could not afford it?	4 (40%)	6 (60%)	6 (100%)	0 (0%)

Overall, results of the preceding questions that address financial barriers showed that such barriers are potent for the present Latinx/é sample. Due to high costs of healthcare, even those who have insurance still report delaying care or not receiving care altogether due to the cost. Furthermore, these results show that those who are uninsured and do not have access to healthcare coverage are reporting much higher rates of delaying care or forgoing care altogether.

As noted earlier, those who were uninsured or did not have access to health coverage at all were also undocumented which means they currently lived in states in the United States that have policies that deny many resources to this community which puts them at greater risk. The cost of care at baseline can already be extremely burdensome for families and without any kind of healthcare coverage this only increases the financial strain on these families. With so many foregoing follow-up care due to the cost, this could potentially explain some of the barriers that arise within the Latinx/é immigrant community accessing mental health services as well. Mental health appointments typically require increased frequency in attendance (e.g., weekly/bi-weekly sessions) which could put more financial strain on families. Since the sample of participants in this study was small, findings must be interpreted with caution. However, these results point to future important areas that should be studied.

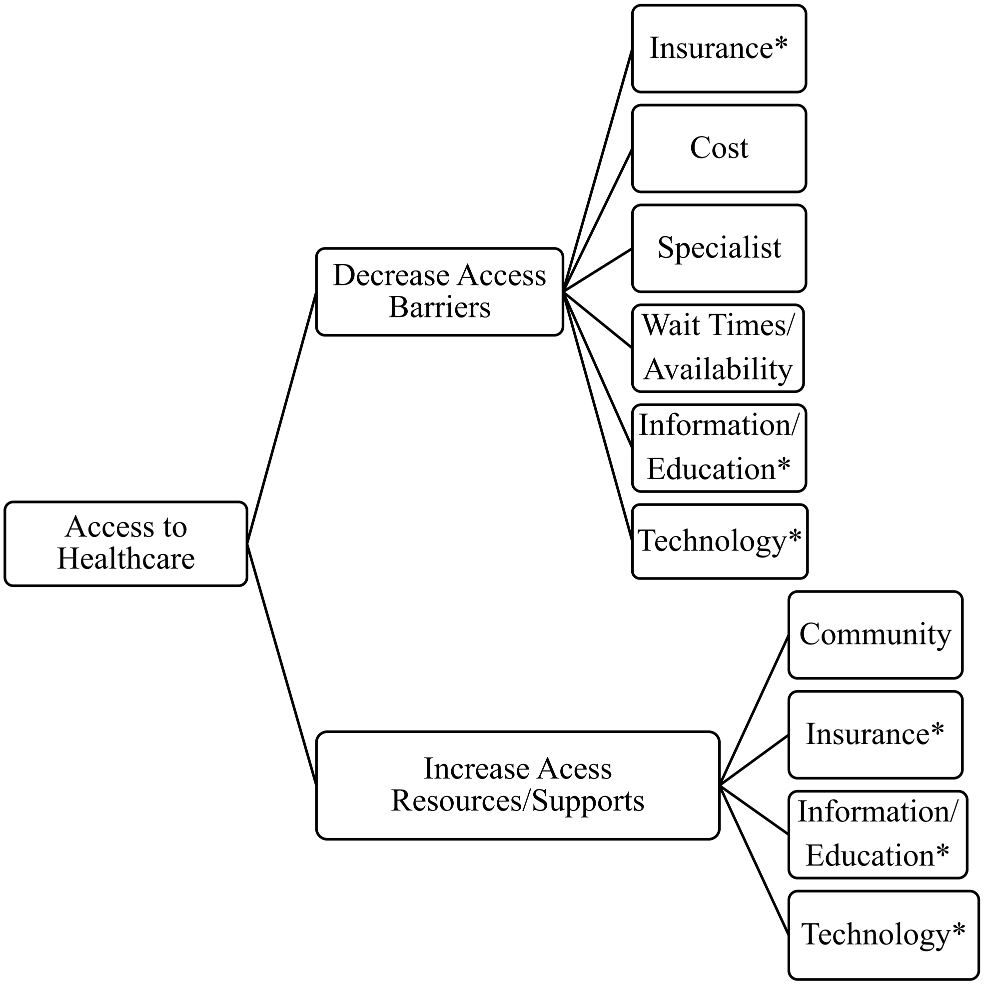
Qualitative Results

Qualitative analyses revealed six themes related to participants' access to healthcare that arose across all 16 participant interviews. These included: insurance, cost, specialist, wait times/availability, information/education, technology, and community (see Figure 1). Participants experienced these themes differently, with some increasing access to healthcare and others decreasing access to healthcare. Furthermore, there were themes that arose that both facilitated access to healthcare and decreased access to healthcare. The two major categories (increase access and decrease access) were created based on what the participants shared about what made accessing care more difficult and what had helped them access care in the past. Thus, the themes were organized into two sub-categories of “barriers” and “resources/supports.” First, themes that arose that were described exclusively as barriers to healthcare will be discussed: Cost, Specialist, Wait times/availability. Secondly, themes that arose that solely were described as resources and supports which increased access to care will be examined: Community. Lastly, there were three themes that arose which were described as both facilitators and barriers to accessing care depending on the participants’ experiences: Insurance, Information/Education, Technology).

Figure 1

Codes that Decreased Access & Increased Access

** = Codes that emerged as both decreasing and increasing access to care*



Barriers to Care

Overall, there were various themes that arose from participants’ narratives and experiences in accessing care and what specific challenges arose while trying to access the care that they needed. However, there were 3 themes that arose multiple times in each interview and throughout either all or a majority of the participants’ experiences in this study. These 3 major themes were: Cost, Specialist care, and Wait times/Availability. Each barrier will be discussed in more detail, including nuances that arose within each theme based on the experiences of multiple participants who lived in different states.

Cost

One of the first major themes that arose when discussing the barriers to accessing healthcare was the cost of care. Cost was reported by 87% (14/16) of participants as a substantial barrier to accessing care. Furthermore, this was regardless of insurance status. However, this was reported with more frequency from participants that did not have insurance. There were several different aspects of cost that arose when discussing this barrier with the participants in this study. Not only were costs associated with the medical appointments themselves but also with the resources that were being used by participants who did not have insurance. These entailed the “side costs” of attending appointments such as paying for an Uber, paying for parking, or taking other public transportation. Furthermore, appointments were generally not affordable. This was further exacerbated when patients needed to have a follow-up appointment due to there not being enough time to discuss everything they wanted to at the initial appointment. This created additional barriers for cost when participants reported having to schedule a follow-up appointment to address all of their concerns.

There were five participants without health insurance coverage who reported having “discounts” to alleviate some of the burden associated with cost for the medical appointments. However, they highlighted that even these discounted rates—or discounts that have to be reapplied for every year—go up in price regularly, making them harder to afford. Participant C002, who lives in Colorado, shared their experience with discounts:

> Well, in the clinic they offer us a discount, it’s a clinic, well, I don't have social security and they do it through a discount. I bring my income and they give me a discount based on my income. Sometimes, now they have increased by more than half the co-pay. So, it is a little bit difficult to attend appointments or to make an appointment. It is the same with the therapists, there is also a co-payment, and it has also increased in the last few months.

For participants who don’t have access to private insurance or have access to a state funded insurance, 83% (5/6) participants in Colorado reported having access to this discounted plan while one participant had private insurance. However, the increase in cost continues to go up increasing the financial burden for families. Those who have been utilizing this discount and have access to both general care and mental health care, like participant C002, are being priced out of these services that so many desperately need.

These costs of care continue to rise for all participants especially for those who do not have healthcare coverage, and the lack of clarity on what an appointment will cost has become a barrier for many as well. It was reported by 75% (11/16), of participants that clinics are not upfront about their charges and at times they are charged more than they anticipated. For some participants in this study, created distrust and hesitation because of the financial strain this can put on families. Furthermore, it was reported that clinics have even delayed care or withheld crucial test results that patients need unless they pay up front first, without the option of a payment plan. Participant C006 shared their distressing experience highlighting this:

> Yes, although it is not much, you really say, but I have discounts, yes, but you have to pay 100 dollars and so on, like 100 dollars and you have to pay it on the spot. Previously we would receive the service and if we couldn't pay on the spot, they would send the bill to our home, to our address. But on one of my last appointments, I found out that if I couldn't make the payment, they would reschedule my appointment for when I could make the payment. So, I said, how? I'm not going to get the service because I can't pay for it? I can pay for it later. I even let the person who attended me know, because it was over the phone, I was waiting for some results and they could give it to me over the phone, but I had to make the payment for that service. So, I said no, I have my credit card to make the payment now, but later I can go to the clinic and make the payment in cash, and he said okay, I suggest you reschedule your appointment for another day and I said how? I need to know; I need the results of those studies and I can't wait. So, that's frustrating too.

Participant C006 later discussed that they did not want to use their credit card because of an experience that they had previously where their credit card was charged for an appointment from over a year ago. This charge was unexpected, and they did not have the means/funds to cover those additional costs. These examples highlight the importance of being able to sit down with patients to be as transparent as possible about the costs that are associated with their appointments. Furthermore, having payment plans available for patients—especially for patients who have minimal resources available to them—is essential. This is further evidenced by one participant who shared their experiences and discussed the challenges of paying for transportation for appointments and about the "fear" they felt not knowing how much they would be charged for their next appointment. Participant B007 shared:

> Of money for transportation, for those of us who get around paying every time we take the bus, for example, or the train. There are people who do have the access to pay for a monthly pass, but there are others and that can also be a big barrier, not having the financial availability to be able to, or the fear of how much one will be charged on the next bill. I think. On co-payments, the fear of co-payments.

The "fear of co-payments" is a telling narrative about the fear that families have when attending their general provider appointments due the ever-increasing cost of healthcare in the United States. While participants who had insurance reported accessing care due to co-payments or deductibles much less than those who were uninsured, this was still a prominent theme when discussing mental health care or when participants discussed accessing specialist care. For those who did not have insurance and lived in a state that had strict anti-immigrant policies like participant G001, who lived in Georgia, the cost of care for mental health treatment or even having access to a dentist was described as impossible. Participant G001 shared his experiences living in Georgia:

> Yeah, a [barrier] to access healthcare is the price. The, it's just too much even for medicines… But access to, dental, Mental [health]…The general, the basic, I mean basic access is difficult but the others? are.. impossible. There's no way to have small surgeries without being bankrupt, we without and I'm talking about very small, like dental [procedures] to remove, to do a root canal or other type of things that cost hundreds of dollars.

Participant G001 shared their heart wrenching experience explaining how access to mental health services or accessing specialists like a dentist are completely inaccessible to them because of the substantial cost of care. Furthermore, participants sharing the "fear" of not knowing what their co-pay may cost or their deductible, are further distressed by this when discussing specialist care like mental health. This is because when accessing services like mental health treatment, you typically attend sessions with more frequency (e.g., weekly or bi-weekly) which means more co-payments that patients must cover. This finding leads to the next theme that arose in the data: the increased challenges in accessing specialist care.

Specialist

One of the most noteworthy themes that arose in the experiences of the participants in this study were the substantial challenges participants faced when trying to access specialist care. Specialist care was considered to be mental health providers, dentists, and any other specialist doctors that required more expertise in treatment than a general primary care doctor could provide. Out of the participants in this study, 100% (16/16) reported barriers/challenges when trying to access specialist care. Not only were the costs higher than those of a general provider, but the wait times to see them were even greater. Those who did have access to providers (those who had limited insurance) reported lower levels of quality care by their specialist because they could not afford better treatments due to financial limitations. Furthermore, these barriers were exacerbated due to the lack of availability of Spanish speaking providers who could communicate with patients who are monolingual Spanish speakers.

While barriers to general care were reported as being very high and unaffordable to those who did not have insurance, these financial barriers were increased twofold when discussing specialist care. Appointments for specialist care/treatment were reported to have higher co-pays and for those relying on discounts, highlighted that those did not apply to appointments with specialists. For those who did not have access to healthcare coverage or resources to help supplement the cost, accessing specialist care was nearly impossible, and adding in the cost of medication, was simply not an option. Participant G001 who is undocumented, shared their experiences that provide insight into how parents who need treatment have to make decisions between providing meals for their children or paying for the medication that some desperately need:

> The co-pays especially for mental, dental. I think other thing, people suffer a lot from is back pain so cure practice and people have other conditions that they have from their countries. In my experience [From what I've seen] there are people trying, who have multiple conditions, they have a lot of medicines to buy. So, the co-pay for them is is just too much. Maybe they have one or two. That would be okay. I can access. I have enough to pay, but for most of the working class is

> either like, okay, should I pay for the food for my kids, or should I pay for my medicine? So, of course, they choose the food for their kids.

This is a vivid example of the decisions that parents/family members must make when they do not have the resources to help supplement the cost of care or the cost of medications. These are decisions that families should not have to make; however, this is their reality. Undocumented Latinx/é families that live in states that don't allow them to utilize resources or supports through the state experience a physical and emotional toll. However, the quality of care or access to proper treatment did not necessarily improve for undocumented Latinx/é participants who had limited insurance and, therefore, limited access to coverage. For example, dental insurance typically is purchased separately to medical insurance at an additional cost to the insured. While undocumented Latinx/é participants had access to limited insurance in some cases (e.g., MassHealth) this did not mean that they had coverage for specialist care such as the dentist. Those who have limited coverage still do not have access to better treatments or quality care. Participant B008 shared their experience trying to access a dentist because of the pain she was in due to one of her teeth:

> And for example, it happened to me with my teeth. Because of the same limited insurance I have, I have to pay for the root canal because the insurance does not cover them. And then I had a tooth that was killing me with pain. So, the doctor could have saved my tooth, but he didn't save it, he chose to take out my tooth because I had limited insurance. And I was always supposed to have my teeth

> cleaned, I was supposed to go to the dentist periodically and the more my teeth were rotting, the more my teeth were getting damaged.

Even when having insurance, due to it being very limited, undocumented Latinx/é participants reported not getting adequate care. Participant B008 shared this experience where more treatment could have saved their tooth, but due to the cost and lack of coverage that their insurance provided, the cheapest approach was taken by the dentist which required their tooth to be extracted. This highlights that while having some healthcare coverage is better than not having any at all, more supports must be put in place to provide adequate care, especially when needing such things like dental treatment.

Lastly, when trying to access specialty care, for those who were fortunate enough to cover the cost of these appointments, participants reported very long wait times to access these providers. Every participant who had access to a specialist reported having to wait over 6 months for their initial appointment. Furthermore, when trying to access mental health providers, most reported waiting over 12 months after their referral was placed by their primary care doctor. Participants who were monolingual Spanish speakers highlighted that these wait times could extend even longer when looking for a provider that was Spanish speaking. Participant B006 shared the challenges of finding a Spanish speaking provider and how challenging it can be when trying to find a specialist who can communicate with them in their preferred language:

> It is more difficult. Yes, it is more difficult, it takes longer. You want to have a specialist who can communicate in Spanish or be able to speak a little more in Spanish, but as far as specialists go, it is very difficult. Most of them are in

> English. So, in general medicine you have to speak Spanish, but in specialists you don't find many who speak Spanish.

This experience accentuates the increased need for access to specialists and the increased availability to these providers as well. When trying to access general providers, there are already limitations on times for the Latinx/é immigrant population, especially for those who are undocumented due to the challenges with barriers such as taking time off work. Thus, access to specialist care is even more challenging due to decreased availability of these providers, which arose as another prominent barrier to care.

Wait Times/Availability

More generally, participants highlighted the lack of availability there currently is when trying to access general healthcare and mental health care. This availability continues to become scarcer when trying to find providers who speak Spanish or at minimum have interpreter services, when trying to find specialist who accept discounts or insurance that is limited in its coverage, or when needing to find a specialist who can see you during irregular work hours due to the challenges the Latinx/é immigrant population faces in taking time off work. Furthermore, those who are undocumented rarely receive paid time off; sick leave and missing a day of work typically means missing one day’s salary. Of the 16 participants, all 16 (100%, 16/16) reported barriers to care due to the excessive wait times and lack of availability in their communities. Those who did not have insurance coverage at all reported having even longer wait times when trying to access care, especially when trying to access a specialist. Participant P001shared their experiences and the immense difficulty they encountered when trying to schedule an appointment so far in advance and not being able to take time off of work because she could not afford to miss one day's salary:

> Yes, for me, it's the language, the cost and sometimes the time. Because, for example, sometimes they give me an appointment, we would say in three months. And in those three months, I mean, I can't get away from my work, sometimes there are changes. Then, when the day of the appointment arrives, sometimes unfortunately because of the need to work and there is no possibility to go to my appointment, then I miss it. And what happens is I have to wait another three months to go for a check-up.

When discussing the barriers to care shared by participant P001, they described experiences that they share with so many other undocumented Latinx/é who do not have basic human rights afforded to them like paid sick leave. They also elucidate the amount of time they need to wait for a simple check-up appointment. One missed appointment like this could potentially cause delay of care for an additional 3 months. Furthermore, as previously noted, these wait times noticeably increase when trying to access specialist care such as mental health services. Participant B003 shared their experience accessing their therapist and how long they had to wait for an appointment to be scheduled:

> The biggest thing is just like some things like there are very long wait times like for a therapist. I was on a wait list for a pretty long time, until I actually got someone assigned to me. So I mean, that's my biggest issue. But it's I think, yeah, but I think the process probably just needs to get you know, Improved…it took about a year. They called me a year after the referral.

This was just one of several other experiences shared when discussing the long wait times when trying to access specialist care for the Latinx/é immigrant community. With these very long wait times comes a delay in care, which can be detrimental for some. One participant shared an experience talking about a knee injury that they sustained that required an appointment to see an orthopedic specialist; however, due to the minimal availability, their injury healed improperly on its own and now will cost the participant substantially more to repair it.

Lastly, while participants expressed increased challenges in accessing these appointments, they also highlighted the small amount of time they have once they are in their appointments to fully discuss everything they need/want to. Moreover, they expressed that it is challenging to attend these appointments because of the amount of time it takes to see the provider. It can take hours past their scheduled appointment time to see their providers which disrupts their entire day. Participant C005 shared their experience with this:

> The experience sometimes is not very pleasant, because the service is not as you expect it to be. Sometimes there is a long wait while you go to the appointment, they don't respect your schedule, even if you arrive 10 minutes early, they don't always attend you at the time you have the appointment. It does affect you because you already have your routine settled. I regularly try to make my appointments when my children are in school, my teenagers, because they are no longer children. So, I make it to pick them up and if I'm late, I'm late or sometimes I've had to leave because I won't be able to pick them up. And they

> have to schedule another appointment. Yes, a few weeks. Or sometimes even months.

There are various examples about strict policies, for example that patients must arrive to their appointments 15 minutes early, but providers do not show participants the same respect when their time is equally as valuable/precious. As noted by participants, when providers are late to their appointments they still try to rush through the appointment while not providing enough or adequate information that the patient needs. Participants expressed “feeling rushed” in their appointments because providers have to move onto their next patient quickly, which leaves many feeling more confused or completely uniformed about their treatment. When this happens, this can impact trust that patients have with their providers and cause more financial strain on families because follow-up appointments need to be made if they want to have their questions answered.

Resources/Supports to Care

Community

In my analysis, I identified several themes that spoke to the kinds of resources and supports that helped the Latinx/é immigrant participants in this study create better access to healthcare and mental healthcare. However, there was no greater impact than the power of community and community stakeholders. This theme was the only one that was uniquely associated with resources and had a positive impact in creating access to healthcare. All participants in this study (16/16) reported community supports, whether provided by community agencies, community members or community health centers that were imbedded within their communities, as resources to accessing care and reducing barriers to care. For example, participant C004 talked about a community organization that supports older Latinx/é immigrants in teaching them how to use technology to help them schedule appointments or access their emails since the clinic where they access care does not offer this support. Participant C004 shared this:

> I think so. In fact, here in Colorado, where I am on site, there is a community organization that gives computer classes for people starting from scratch and I have volunteered and I have seen people, most of them are 40–45 years old up to 65 years old that have been taking these classes, because it is difficult for them to make an appointment through the computer, the phone, to answer an email and I feel that it is affecting them. And through the clinic they don't offer that service, but they do offer it through another community resource. Okay.

Not only does this suggest that education around technology is a noticeable need for the Latinx/é immigrant community, especially for those whose are older, but how the community stakeholders have recognized this and have created classes to help support them in accessing this technology. Not only do community supports provide classes in accessing care but they are also valuable supports in connecting to resources that help supplement the cost of care. It was reported by participants that clinics continue to struggle to disseminate information about resources/supports to the community. Participant C005 explained how they were able to access more affordable care through talking with others in their community:

> And the other community resources I have learned about because I have been meeting people in the community and they tell you, "Well, go to this place, there are services for mental health, health services that are a little more accessible at the health clinic, no questions asked, and sometimes it is 50 percent cheaper than at the health clinic… as I said, I never found out about these services in the community from the clinic until I met people from the community who told me, but not from the clinic or the hospital.

Participants expressed that health centers/community clinics/hospitals need to continue to find ways of disseminating information out to the Latinx/é community. Not only would this foster trust but would also help encourage others who may be more reluctant to access healthcare to seek out services that they may desperately need. These healthcare centers need to continue to find creative ways to get this information out to the communities that they serve. When participants expressed having this information/education more readily available, they reported increased access to care.

Both Facilitators and Inhibitors to Healthcare Access

There were three themes that arose consistently as both facilitators to accessing healthcare and as barriers to accessing healthcare depending on the participants' experiences. These three themes were: Information/Education, Insurance, and Technology. Each theme will be discussed individually, first as it appeared as a barrier and then how it was described as a potential facilitator to accessing healthcare services.

Information/Education as a Barrier

The lack of information that participants reported spread across various domains and impacted access to care substantially. Lack of information presented itself in the narratives of participants in the form of providers not sharing enough information about treatment (e.g., risk/benefits of medications), not providing this information in an accessible way (e.g., language) and not providing information on how those who are undocumented or newcomers to the United States can access healthcare should they need it. Information arose as a theme that could create access to both healthcare and mental health care, while having a lack of information created some of the most barriers to care. Of the 16 participants, 93% (15/16) reported that not having information or the education on how to navigate applications like the ones their clinics utilize to access medical records was a barrier to care.

While participants in this study reported increased feelings of trust with their providers and receiving care had lower frequency levels of stigma, there were still instances reported in the experiences of participants that had negative experiences with their providers. One of the most reported negative experiences were the participants who felt like their providers never provided them with enough information about their treatment (e.g., medications prescribed) or did not provide enough time for participants to have all of their questions answered. Participants shared that they felt more confused after leaving their appointments and unclear as to why they were taking certain medications. Participant B008 shared their experiences when this happened to them. Furthermore, B008 spoke to the experiences of the Latinx/é community and shared what they believed would help improve trust between both providers and the Latinx/é population that they serve:

> Yes, they didn't educate me on that [medication], they didn't tell me. And then, and I think something that we should educate our population, more than all Hispanics, Latinos who come from other cultures, that we follow the same pattern. We are prescribed the medication and we take the medication and sometimes we self-medicate because we don't have the information on how we are going to use the medication or the possible side effects. Because one thing I have learned is that, well, from what I have read, that for example, all medications have a side effect. There are medications that will solve one problem, but they can ruin something else. And doctors don't say that. Pharmacists don't say that. They send you the prescription, you take the prescription from the pharmacy, and you take it and that's it. For example, I had gastritis problems, I was taking omeprazole. They told me, "Okay, take that omeprazole for your gastritis.” But I was taking the medicine for my gastritis, but it was damaging something else.

This example illuminates the need for providers to thoroughly talk through their treatment options with their patients. This is especially important with the Latinx/é community since there is a history of distrust/stigma when accessing care within the United States (Podewils et al., 2020). When providers do not provide this information about things like medication or treatment, patients are often led to finding this information online or from other trusted members in their community.

Not only do providers/clinics need to make sure to provide this information, but they also need to do so in an accessible way. For example, if information is provided in English when patients are non-English speaking then this information remains inaccessible. This is especially true for those who are undocumented Latinx/é immigrants because of the increased likelihood that they may have little to minimal understanding of the English language. Moreover, they are less likely to have resources available to translate these materials correctly. Participant P001, who is undocumented, shared their experiences trying to access the paperwork/summary of their appointments when they go to see their provider:

> Because also sometimes, whether in my daughter's case or in my case, sometimes when they give us the registration or the papers with the summary of when you went to see the doctor or all that, then these papers are all given to us in English, knowing that we don't speak English, but sometimes I translate it. And it is more difficult because sometimes the Google translation does not give you what is correct. Sometimes the words vary and for one word it changes a lot of things.

Again, this demonstrates another barrier created that denies access to information for this participant and so many other Latinx/é immigrants, both documented and undocumented. When support is not provided, then they must rely on their own means to try and access this information. As participant P001 shared, they were forced to use google translate to interpret doctor summary reports which is very likely to lead to misinterpretation and incorrect translations.

Having information about where to receive care, how to access that care and, just as important, how to access supports to help cover the costs of that care are crucial.

Participant B007 shared their experience as a newcomer to the United States who recently immigrated here and how they desperately needed support and care:

> Well, at the beginning, as a newcomer, it was much more difficult for me because of the lack of information, the lack of connections, the language barrier. So, I didn't know where to go or which clinic to go to. I didn't know anyone and sometimes I had moments of depression during pregnancy. And at that time, I didn't have good experiences with access to healthcare or mental health care.

As the preceding quotes illustrate, participants' experiences show the importance of making this information more accessible for the Latinx/é immigrant community in the United States, especially for those who have recently arrived here. There are many who believe that in coming to the U.S., they do not have any access around receiving care that is affordable, or that they do not have access to healthcare coverage whatsoever. While this may be true in some states, especially those with increasingly restrictive anti-immigrant policies being implemented (e.g., driver's license revoked, no access to federally funded programs), there are several states such as Massachusetts that do provide healthcare coverage options to anyone who lives there regardless of documentation status. However, even with those crucial resources available, many do not know how to access them or know that they even qualify for these resources.

Information/Education as a Facilitator

Information continued to be a theme that arose consistently through participant interviews when discussing what has helped them access healthcare services. Many participants highlighted the need for information about resources that may be available to them. Furthermore, participants shared how they were confident there were certain resources that must exist but that they did not know how to access them or what they were specifically. Moreover, participants shared that whenever their providers/clinics helped support them in accessing this information or provided education on what treatments they could access, this improved access to care and helped build trust with their providers. Participant B005 talked about their experience when their community clinic provided information about resources they offered, which alleviated the burden of cost when needing transportation, as described in a previous section. Participant B005 talked about the "hospital bus" as a resource stating:

> Sometimes I am not able to make all of my appointments in day, because of transportation, because sometimes you have to be able to go and even if it sounds bad, sometimes you don't even have enough money for the bus fare…I found out through [my clinic] that there is a hospital bus. This bus takes me to all my appointments, and it is free of cost, this is something I use all the time now.

Examples like these show the importance of providing resources for this community and how impactful they can truly be. While the first step should be to create these types of supports like the "hospital bus" described by Participant B005, the second step should be to inform patients about these resources, especially for those who have minimal resources readily available to them to begin with.

Furthermore, resources and information need to be disseminated in a way that is accessible for the Latinx/é immigrant community, which starts with language. When providers/healthcare centers put in effort to make sure this information is accessible to the community that it serves, this not only increases access to care but also helps improve trust with the community. Participant B007 shares their experiences with this and the positive impact it has had on them accessing care:

> Wow. I sometimes think, my God, what have I done to deserve people being so nice? I can tell you that nowadays, I can't complain about the healthcare that I'm getting. And you know if they have said some medical terms, they give me the option, You'd rather we call an interpreter to explain it to you, I don't want you to misunderstand anything, they give me that option. They give me that option. What does this mean? It means that they have the interest that I am clear with the information they have given me.

This example helps demonstrate the impact on patients when steps are taken to ensure that patients are receiving all of the information that they need accurately and that they not only receive this information but understand it as well. The more that providers/clinics continue to provide this education on treatment/care the increased chances there are that patients will be able to access care well.

Insurance As a Barrier

There can be a misconception about healthcare coverage and about the belief that once you have it, you have immediate coverage to care. However, while having healthcare coverage certainly is better than not having coverage at all, having healthcare coverage does not remove all barriers to accessing care for the Latinx/é immigrant community in this study. Moreover, having healthcare coverage creates barriers of its own and those who had healthcare coverage reported similar barriers to care as those who did not have healthcare coverage at all. Of the participants in this study, 93% (15/16) reported healthcare insurance as a barrier to care, regardless of whether they had healthcare coverage or not. Again, themes around cost of care with or without insurance arose, for example, that the co-payments and/or deductibles were still too high. Furthermore, not having information about insurance was another important theme. Participants reported not knowing what their insurance would or wouldn't cover and expressed concern about the cost of care, while those who did not have insurance reported not having information about how to access healthcare coverage, citing both as substantial barriers to healthcare access. Participant C003 who has healthcare insurance shared their experiences accessing care with it:

> I have never passed the deductible, but it is scary to pass, it is scary to pass because I don't know, I don't know what is going to happen, I don't even know what the repercussions are, or what I am going to pay, or what I am going to pay myself. So, yes, like when you have an accident, I don't know what happens. Of course. But there is a lot of people like it is your responsibility, like ay, it is because you have not read it, it's because you have not been informed….[but] I have tried, but I do not understand. I read it and I can't seem to understand anything, and it makes me more desperate not to be able to read it.

As the above quotation shows, participants experiences having healthcare coverage still highlight their concerns with the cost of care and feeling scared about going over the deductible. Furthermore, they highlight the lack of information they have and/or understand about their healthcare coverage. Insurance policies are made to be exceedingly challenging to understand and lack clarity about the coverage that you have, making them nearly impossible to understand for those who are not well versed in health insurance coverage. Participant C003 shared their feelings of desperation trying to understand what their insurance covers so that they are not charged for care that they cannot afford. While some of those who were undocumented did have access to healthcare insurance, this coverage was considered to be very limited. As discussed previously, access to specialist care such a therapist or dentist was noticeably more challenging for some, even those who had limited access insurance. Participant B005 discussed their limitations in accessing these specialists with their healthcare coverage that had limited coverage:

> Yes, to have access to all medical services. You need dental, you need gynecologist, you need vision, and you don't use them because you don't have the best resources. I have a dental problem because I suffer a lot from sensitive teeth, and I don't go to the dentist because insurance doesn't cover it and I don't go because my earnings are not enough to support it. Yes, I think they [should] have to give you the insurance coverage.

Participant B005 called attention to the limitations of this coverage that they qualify for. While some of the basics of care are covered, treatments as crucial as dental care are not and remain almost completely inaccessible for those who are undocumented and/or cannot afford treatment and/or do not qualify for more insurance coverage. Furthermore, when participants reported having no coverage or limited coverage, they reported increased likelihood of delaying care or not receiving care completely just as participant

B005 shared when needing to go to the dentist.

In addition, it is important to note the barriers of accessing emergency care and the immense stress/fear brought on by the cost of going to the emergency room, especially for those who do not have insurance. Participant B002 shared their vivid experience when their family did not have health insurance and was reluctant to take them to the ER due to the fear of cost:

> It was at a time when my parents did not have health insurance, which was kind of the first time where I sort of started noticing that we didn't have insurance because we couldn't pay for it and so I think that was kind of my like insurance awakening…I remember when I was 16 and I had terrible stomach pain….my parents called an emergency hotline to see what we should do [because we were worried about going to the emergency room]…. It was so scary. Yeah. And that was such like a core memory for me. I think at that at that point, and I don't remember feeling like fear or sadness. I remember feeling like my parents worry that like we could not front that emergency room charge.

This realization that B002 shared was a reality that many face in the Latinx/é immigrant community, especially for those who are undocumented and do not have access to proper health insurance (Escarce and Kapur, 2006). This was a "core memory" for this participant and one that impacted them greatly — noticing the immense worry on their parents faces thinking that they need to go the emergency room. Fortunately, her parents were able to Google resources online to help them navigate/support their decision to take their child to the emergency room. This was also an example of how technology can create access to care/information when there is some understanding on how it can be utilized. However, technology also presents with its own challenges/barriers for the Latinx/é immigrant population, as described in an upcoming section.

Insurance As a Facilitator

While healthcare coverage certainly provided its own challenges/barriers to care for the Latinx/é immigrant participants in this study, results showed from both the quantitative and qualitative results that those who had insurance had higher rates of accessing care compared to those who did not have insurance at all. Participants who had insurance coverage were able to see how much it has helped them in comparison to when they did not have coverage. Furthermore, they were also able to see the impact it had for other community members when they were allowed to receive healthcare coverage. Participant C001 shares this experience and discusses how it has helped in paying for appointments and even medication costs:

> [Insurance] has helped me is that I am not paying for my medication or my consultation, even if it is 15 dollars, I am not paying. I no longer apply for the discount; I am no longer charged 15 dollars and it has helped other people a lot because I found out that another lady was put on the waiting list for a kidney transplant because she receives dialysis, because with this insurance she can do it. And another little girl from around here got sick and said, my belly hurts a lot and it hurts a lot. Oh, well, go to the hospital, you have insurance. And she went to the hospital because of colic pain.

Not only does having healthcare coverage support receiving medications that they may need and reducing the cost for consultations, but it also helps create access to specialist care which was discussed earlier as being a substantial barrier due to its cost. Participants who reported having private insurance as well, due to having a job that provided this insurance, acknowledged that they access care more readily since this was an option for them. Participant B004 discusses this and shares how they are more comfortable in accessing care more frequently because having private insurance helps covers this cost:

> I will say pretty like, even though, like I do have to pay after, I mean, I'm also like much older, and I can make my own decisions. So now, if it's like a cold that I feel like I can't really take care of at home, like I am gonna go to urgent care like it's and I am going to the doctors for, like I mean, I feel like I'm getting paid. So, I'm paying insurance, so I should take advantage of it as like as much as I can so if there's anything that I feel like I shouldn't read on the Internet, I do text my doctor. I do call. I do make appointments. Just because, like yeah.

Examples like these demonstrate the importance of having healthcare coverage that helps supplement the costs of accessing care. However, as discussed previously, having access to healthcare coverage did not remove all barriers to accessing care and even created barriers of its own. But when participants are educated in what their coverage consists of and what they have access to they may feel more confident in using their insurance without the fear of paying out of pocket for treatment. With this major shift in accessing care with the increased utilization of technology, people within the Latinx/é immigrant community are recognizing the potential benefits in accessing care using tele-health services and the use of medical online portals, once they are taught how to use these applications.

Technology As a Barrier

The biggest shift in how patients access care since the pandemic that was reported by participants has been the increased utilization of tele-health services and the use of “portals” that allow patients to access their medical information online. All participants in this study (16/16) highlighted this increased implementation of telehealth services and portal-based communication. Furthermore, 81% (13/16) of participants reported having more challenges in navigating technology and not having the opportunity to learn how to utilize this technology, expressing that technology created more barriers to care. For the Latinx/é immigrant population, especially for those who are older, they have much less opportunity in having access to technology (e.g., smartphones, tablets, computers) which in turn, means less exposure/opportunity to learn how to use these devices. Many participants in this study reported this digital divide that exists, and the increasing difficulty participants face when trying to keep up with the use of technology at their health centers/clinics. Participants reported having a lack of education in how to utilize technology to access their appointments and that places where they received healthcare offered no support to teach them how to access this technology. Participant P001 shared their experience about the challenges they faced during and after the pandemic and how they leaned on the support of their children to teach them how to use video conference services such as Zoom:

> Sometimes it's also like the knowledge that you don't have about how to use the Zoom application. I had to learn a lot of things in the pandemic. I hadn't learned anything. Then, my children helped me and taught me how to use the Zoom platform. So, that was something that was difficult for me. But yes, yes, I learned how to use it.

Experiences like the one shared by P001 illuminate this digital divide that exists within the Latinx/é immigrant community (Saeed & Masters, 2021), especially for those who are older. They rely on others in their community or in their household to help teach them how to use this technology. The challenges that older patients face with the increased use of technology is further evidenced by what participant C006 shared and has noticed in their community. When asked about if they thought that technology created access to healthcare for the Latinx/é community, they had a revealing response.

> I think so, but I also think not, because many people, let's say senior citizens or adults of 50 and above, do not know how to use technology as we do, because before the pandemic everything was without technology and from 2020 onwards pure technology. And I feel that many people would be affected.

These experiences shared highlight the increased need for support in how to access/utilize technology so that patients can fully utilize its benefits. Many participants saw the value in having technology implemented more in their care; however, they did not feel confident in what they currently know to fully maximize these benefits.

However, it is worth noting that a majority of patients 93% (15/16) preferred to have their medical appointments in-person rather than on Zoom or any other video conference application. Not only was knowing how to navigate technology a barrier, but once accessed, participants felt that the quality in care by their medical providers went down when it was done via Zoom or other video-conferencing applications. Furthermore, when the quality of care that they received went down, then it increased the likelihood of mistakes being made which can be detrimental for families, especially for families who have more vulnerabilities than others. Participant C006 talked about these limitations when seeing their medical provider via zoom which led to a mistake in their assessment and greatly impacted their family:

> It is complicated, but I really would not like and I do not want the option of a consultation by phone or even by Zoom, because these are health issues and sometimes it is so delicate that the doctor with his profession, with his study, with time, with experience, is the one who can say what is happening. For example, we had an appointment over the phone with my daughter, I think about a year ago, and the experience was that over the phone the doctor suggested that my daughter needed to be taken immediately to the hospital because she possibly needed appendix surgery. When it was really alarming, I called my husband at work and I said you have to come home because the child has to go to the hospital because she is very bad and the doctor said she has that and we went to the hospital, but it turns out that it was something totally simple, it was a pain, they gave her medicine because they checked her there. So, I really consider that for me it is not feasible either a phone call or a Zoom call, no, I prefer it to be [in person] physical.

These mistakes in clinical care can always potentially occur and there is no such thing as “flawless” care. However, though technology has many benefits in supporting this community in accessing both medical care and mental health care, there are inevitable drawbacks to using technology for appointments and extra attention must be given to how we can continue to provide quality care for families that so desperately need it, especially when using tele-health services or application based “portals”. While there were barriers reported by the Latinx/é immigrant participants in this study from various regions of the United States, there were also several themes that emerged from their experiences that helped increase access to healthcare for themselves and their communities. Some of these themes were distinct from the ones discussed previously, while others were themes that both decreased *and* increased access depending on the circumstances.

Technology As a Facilitator

Technology has become a big part of everyday life for younger generations and, as a whole, society is seeing the increased utilization in technology, with healthcare services not being an exception. However, the digital divide continues to increase, creating bigger inequities to accessing healthcare services (Saeed & Masters, 2021). While many participants in this study reported challenges in navigating this shift in technology utilization, a majority of participants, 87% (14/16), expressed potential benefits of increasing access to care for the Latinx/é immigrant population living in the United States. Not only did participants report increased access through providers utilizing their web-based portals, but they also recognized the impact technology could have on cost, the increased access to specialists, being able to schedule appointments with more flexibility, and the increased amount of time providers seem to have when doing their appointments through video-conferencing applications such as Zoom. Furthermore, while participants expressed wanting to be in-person for medical appointments, all the participants in this study (16/16) indicated that they would more than likely prefer to use tele-health/video conference technology due to the increased frequency in appointments associated with psychotherapy. Participants who were comfortable navigating their patient portal expressed increased access to their providers as they were able to have simple questions answered and were not required to pay for these responses. Participant C003 shared their positive experience using their clinics patient portal, stating:

> Well, I think it became more common [using online portal]. For example, now I know that I can make appointments online. We also, like our culture is a lot about them seeing you and they can give you a diagnosis through Zoom or you speak for them and, for example, they don't charge you. So, sometimes there are things that are much simpler to do that way.

While they shared that in Latinx/é culture, many more people prefer to be seen in person, especially by their medical providers, the benefits of utilizing this patient portal are undeniable. Once comfortable using this application, scheduling appointments becomes easier, less time consuming and you are able to reach out to your providers with questions without being charged for a full consultation. This helps to alleviate the financial stressors that are associated with accessing care.

Furthermore, not only has online patient portals created more access to general care providers, this also can be utilized to connect with specialists. Participant B003 discussed their experiences accessing their patient portal and how they were able to connect with a specialist provider who responded promptly to their message:

> [The online portal] they're using a lot more like if like, if I need to meet my like a specialist, I could just message him on there and then make it back to me at a reasonable time. I don't have to like schedule a follow up appointment like in person to go to get an answer from them for stuff.

Again, this is another example of the potential benefits that come with being able to utilize technology for the Latinx/é immigrant community. B003 talks about their experience accessing their specialist by being able to send messages/questions to them via the portal at no cost to them. Furthermore, participants highlight that with this option available to them, they don't need to schedule a follow-up appointment as frequently. Quantitative results of the "All of Us" survey showed that whether participants were insured or not insured, 62% (10/16) of participants did not schedule up a follow-up appointment because they could not afford it. Being able to access specialist care by being able to communicate with them using a patient portal at no extra cost could have a positive impact for those in the Latinx/é immigrant community who have little to no access to specialist care.

Lastly, while participants shared that they would most often prefer going to their medical appointments in person, all participants shared that mental health appointments would be much more accessible to them if they were done via tele-health services. The flexibility of tele-health appointments benefitted many who stated that they would not be able to take time off of work to go to their therapy appointments. Several participants stated that they are able to do their appointments from the comfort of their own home without needing to rush to the clinic after work, some were able to do their sessions during lunch time, while others were able to use their mornings after they drop their children off at school to attend sessions. Participant B003 talked about the convenience of doing their therapy session via tele-health and how they would not be able to see their therapist if they had to attend appointments in person. Participant B003 shared their experience:

> I do prefer [using telehealth], it's convenient with my like schedule. [Therapy] it's after work. So, I can. I can drive home. I don't have to like Rush home or anything like it's a it's a you know, a set time where, like, I can know, I can get there comfortably at home. and to, you know, do the appointment…. if it was strictly in person, it would definitely be a lot harder to attend especially depending on like where the location would be…. Yeah, I mean, primarily, it would be like location wise because I work. I work in [City], and then I'd have to commute home to [City] that my mental health specialist works in [City]. So, if it was in person? I have to go to [city] to [City] at like 5 PM. Which it would be a lot of traffic, you know, just to get there. Probably be around an hour. you know, and it would probably be like a very late meeting. It might be like after her hours. So, it would definitely be like a scheduling conflict. Definitely like the online makes it a lot lot more convenient for me and I'm not. I'm not like rushing to a specific location, or

> or rushing like due to time constraints or anything like that…honestly, if there was not an option for telehealth, I would probably stop going altogether.

Participant's (B003) experience in the benefits of having a tele-health option highlight the potential positive impact that technology can have for the Latinx/é immigrant community in accessing mental health services. Utilizing tele-health services can help supplement transportation costs, increase flexibility in scheduling appointments and does not require patients to take a full day off to attend an appointment. Experiences like these show that there is substantial potential for creating access to both healthcare and mental health care for the Latinx/é immigrant population. However, more initiatives must be created to support this community on teaching them how to navigate/access technology so that we can first address the digital divide and close that gap.

Overall, findings illuminated various barriers that currently exist accessing healthcare and mental health services for the Latinx/é immigrant community in this study. Furthermore, findings show that some of these barriers continue to exist for this community (e.g., cost, lack of insurance) and that there are new challenges they potentially face with the increased utilization of tele-health medicine (e.g., Implementation of apps, zoom). However, participants shared how community and feeling better informed/educated about our healthcare system can potentially increase access to healthcare for themselves and their communities. In this next section, these results are more fully examined in the context of the literature, and their implications for future research and counseling practice.

CHAPTER 5

Discussion

The onset of the COVID-19 global pandemic impacted the world for two years, which caused a drastic shift in the way that we live our lives. This rings especially true with the way that we access healthcare. While the limits/capacities of our healthcare systems were continuously pushed, there were various gaps in accessing healthcare that were exposed during this time. However, although there were glaring gaps in access that were elucidated during the COVID-19 pandemic (e.g., the digital divide, access to providers/appointments), there were various programs that were created/implemented to help create access to healthcare, especially for underserved communities who were disproportionally affected by the global pandemic. One major change that took place was the adoption of tele-health services and being able to attend healthcare appointments virtually (Jazieh & Kozlakidis, 2020). Telehealth has created access for many people by implementing applications to help improve communication with providers and to schedule appointments, while also providing flexibility in appointment times due to them being conducted on laptops/smartphones/tablets (Lee & Lee, 2021). Nonetheless, there were still many people who struggled with accessing care regardless of this shift to tele-health services and having access to technology, especially impacting marginalized communities. This phenomenon is widely known as the “digital divide” (Saeed & Masters, 2021).

This study aimed to explore what barriers still exist for a small sample of documented and undocumented Latinx/é individuals, and the implications this might have on the larger Latinx/é population. Questions that guided this study included, (1) What are the existing barriers to accessing both primary care and mental health care for the Latinx/é community post-COVID-19? What demographic sources of variability influence access to such supports? (2) How have these barriers changed with the onset of COVID-19? and (3) What kind of resources do Latinx/é individuals think would improve their ability to access healthcare? Overall, participants expressed that with the adoption of tele-health services it has created access in attending appointments, especially with mental health appointments. However, there are still many barriers for this population when needing to access services. These barriers are multi-faceted and begin with barriers accessing general practitioners, accessing specialists and mental health providers along with the challenges that have come with the increased utilization of technology by many healthcare providers. In this chapter, I will discuss the study findings as they relate to general care, specialist care, and mental health care. I also will discuss the specific affordances and limitations of technology, as well as the importance of information and community to support access to healthcare. Next, I will discuss the minority stress framework that guided this study and the insights learned through the results. Lastly, recommendations for practice and research are provided on ways to continue to address these reported barriers based on the experiences of the participants of this study.

Overview of Findings

General Care

Literature shows that medical providers are the “front line” responders to connecting patients with mental health services and specialist care, especially since many in the Latinx/é community rely on them for all of their care (Cabassa et al., 2006). Furthermore, in most cases, patients’ primary care providers have to put in a referral themselves to connect patients with specialist care and for insurance companies (for those who are insured) to cover these visits. So, for many, it is essential that patients have access to a general care practitioner/primary healthcare provider. Therefore, addressing barriers to accessing these providers is crucial.

Results of this study showed that 87% of participants had access to a primary care provider regardless of having insurance or documentation status. However, there were still several barriers to care that were reported and experiences with quality of care greatly varied. Of these participants, 87% (14/16) reported that the wait time in-between appointments was considerable in length. Several participants reported appointments not being available for 6 months or more, which is much higher than the national average. In a study done by A.M.N. Healthcare (2022), which surveyed over 20 different healthcare facilities in 15 different metropolitan cities in the United States, results showed that the current wait time to see a new primary care provider was 26 days. This highlights that within this sample, the Latinx/é immigrant community has a substantial increase in wait times when needing to see a general provider. While participants indicated that appointments that were being offered through tele-health services had potentially shorter wait times, many participants reported that they preferred going to appointments in person when needing medical treatment. Many believed that they were not getting adequate care because doctors were not able to see them and do any follow-up exams if necessary. Participants reported that many staff members from their respective clinics "pushed" or highly recommended that they schedule medical appointments via zoom when possible. However, when participants would schedule these appointments via zoom, knowing they would need to be seen in person, they spoke to the challenges that came with this. For example, participants would be charged their co-payments for a tele-health visit and then would be charged again for their in-person visit. Furthermore, the in-person appointment would not be scheduled for several months, adding more wait time and delaying care that they need. This continues to elucidate the barriers of increased cost to care or follow-up care which negatively impact access to care for the Latinx/é immigrant community in the United States. Furthermore, results in this study reflect the literature that highlights the economic hardships that the Latinx/é immigrant population face post-migration to the United States (Raffaelli & Wiley, 2013; Sangalang et al., 2019).

Not only was it reported that participants have limited access to their general care appointments, but they have even more limited time/availability to attend appointments. Of the participants in this study, 68% (11/16) reported "not having enough time" in their appointments as a barrier to care. Participants stated that they did not feel like they had enough time to talk about everything that they wanted to and that many have had several providers tell them they would need to schedule another follow-up appointment.

Participants reported that several primary care providers showed up to their appointments late, seemed rushed through their appointments, and would only give them the amount of time that was left in their hour-long appointment regardless of how late they were. These experiences highlight how not providing patients with enough time in their appointments can continue to exacerbate appointment wait times and availability. Moreover, times in appointments were impacted even more when the services of an interpreter were needed or when a Spanish speaking staff member needed to be located. Language barriers continue to be an issue with many healthcare providers and with some clinics not readily having access to interpreter services. Which Alegría and colleagues (2017) highlighted as substantial stressor that could impact quality of care received and negatively impact the mental health outcomes of the Latinx/é immigrant population.

While literature has shown that there continues to be distrust/stigma with the U.S. healthcare system, especially within the undocumented Latinx/é immigrant community (Podewils et al, 2020) a majority of participants reported lower feelings of stigma around accessing care (especially when accessing mental health services) and improved trust in the U.S. healthcare system based on their responses on the quantitative surveys. However, there were still several experiences that participants shared that reportedly increased distrust in their providers and the care that they were receiving. The highest reported frequency of stigma and distrust was related to the lack of information primary care providers gave to their patients. This lack of information was coded for all participants, and all participants regardless of location reported similar experiences. There continues to be stigma around providers prescribing medications to help treat various illnesses. While it is true that medications can have other side effects this can also be less stigmatized by providing more information on the medication and the side effects they could expect. These findings coincide with the findings of Coffman and Norton (2010) who highlighted that those who had “low healthcare literacy” within the Latinx/é immigrant population, especially those who are undocumented, are less likely to trust their providers and reported lower levels of accessing healthcare services.

Lastly, as noted before, primary care physicians are the “first line responders” to connecting patients with specialist care, including mental health. Primary care physicians are typically the ones who initiate referrals to any specialist whose services are needed (Cabassa et al., 2006). There were several experiences shared that highlighted the importance of walking through this process with patients, especially those who are navigating the U.S. healthcare system for the first time or those who have language barriers as well. Several experiences were shared portraying medical providers either delaying these referrals (which could amount to over a year long wait) or simply refusing to make referrals even though the patient had requested to see a specialist. Within this sample, there was an increased need for information about the referral process, information around cost/wait times, and generally more information overall of what specialists they have access too. There is more literature emerging around the ever-increasing need of keeping the Latinx/é immigrant population better informed about diagnosis, how to connect with specialist care and how to navigate the U.S. healthcare system overall (Martinez-Donaate et al., 2022).

Specialist Care

The biggest disparity in accessing care that arose in the narratives and experiences of the participants in this study was the access they had to specialist care. All participants reported challenges with accessing a specialist regardless of insurance, documentation status or age. However, it is worth noting that those with insurance coverage did report having less concern about cost/coverage than those who had limited insurance or those who were completely uninsured. While there is literature showing that disproportionate access to specialty care exists within marginalized communities such as the Latinx/é immigrant community (Barnett et al., 2017), the results of this study highlight what these barriers may look like for some individuals more specifically. There were a variety of factors that were reported as continued barriers to accessing specialist care for this population. Some of those barriers included having a lack of information about how to see a specialist or knowing if they even have access to these providers. Other reported barriers were, not knowing about how much appointments might cost, language barriers, type of coverage (which can impact quality of care), and limited appointment availability (which can cause a delay in care). All these barriers were applicable to specialist medical care (e.g., dermatologist), dental care, and mental health care. It is also worth noting that these barriers were even greater for both participants who lived in states that had more anti-immigrant policies in place, which made accessing specialist care all but impossible for these participants.

Barriers to specialist care can be explained by imagining most barriers that participants faced in accessing general practitioners as being doubled. This is because seeing a specialist is typically more expensive, specialists have less availability which leads to longer wait times, and insurance is less likely to cover specialist services. As noted earlier, most (unless you can pay out of pocket) specialist care can only be accessed if a referral is being placed by your primary care physician. Most insurance will not cover specialist care unless the provider deems it necessary (e.g., placing referral) or if the patient has coverage that allows them to seek out this care separately, even though most specialty care clinics require a referral to be placed if you want to be seen by them. Once that hurdle has been overcome, the availability for appointments is still minimal at best. Participants that tried to see any kind of specialist reported appointments being made up to 6-12 months in advance. Furthermore, several participants reported that availability times were only during work hours which can be especially challenging for undocumented Latinx/é immigrants because they do not receive paid time off (PTO). It was also reported that appointments are made so far in advance that many forget they have appointments scheduled. If the appointment is missed or if participants are not able to get the time off or work, they often need to reschedule their appointment and have to wait another 6 months, which delays the care they need even further. Participants expressed increased concern about the cost of these appointments and the lack of clarity/transparency from providers about what the entire appointment may cost.

Mental Health Care

An interesting finding in this study was the number of participants—93% (15/16) — that reported lower levels/feelings of stigma around receiving mental health services.

This is an important finding due to the extensive literature exploring the stigma that exists withing the Latinx/é community around receiving mental health services (Benuto et al., 2019). These findings suggest that within this sample, stigma around mental health and receiving mental health services is less prevalent than previously reported. However, participants in this study considered mental health services (e.g., seeing a therapist) to be the equivalent of seeing a specialist, because of their inaccessibility (e.g., cost, long wait times). Furthermore, participants who lived in states that had more anti-immigrant policies in place reported having zero access to mental health services because of lack of insurance, high costs, and a lack of providers willing to see them without having social security numbers. Moreover, because of these restrictions, participants were required to seek care from providers/therapists in Mexico using zoom and other video conferencing applications like WhatsApp.

Co-pays and deductibles along with overall costs were substantial barriers for many within this sample, which also were barriers when trying to access mental health services. There is an abundance of research highlighting cost as a substantial barrier to mental health treatment, especially for the Latinx/é community (Dell, 2016; Sangalang et al., 2019), and the results of this study .align with these previous findings. Mental health appointments can prove to have additional barriers in comparison to general care practitioners due to the higher frequency of appointments. Typically, mental health appointments take place weekly, bi-weekly or once a month depending on the needs of the patient. With this increased frequency comes increased associated costs for appointments and increased dedicated time commuting to the health center/clinics for sessions. While the implementation of tele-health services decreases some of these barriers to care, it also creates its own challenges for many within this study as well, which will be discussed further later in this discussion. Those who did have insurance coverage, even limited coverage, had access to mental health services at discounted rates. However, many participants who had limited coverage described mental health services as being completely inaccessible and had not considered asking for them because they assumed they did not have access to that type of specialty care.

It is worth noting that even though most participants reported lower levels of stigma around receiving mental health services and increased trust with their providers, there were still some participants who reported higher levels of stigma around mental health specifically and not trusting mental health providers because of what they might disclose to others or what information they may be saving for others to see. Thus, another piece providers can be mindful of when supporting the Latinx/é immigrant population (especially for those who are undocumented) is providing more information about the sessions themselves. While confidentiality is always addressed at the beginning of mental health treatment, there could be more time spent discussing who has access to the patient's information, how documentation will be done to protect the patient, and how receiving therapy will not impact their access to receiving citizenship or qualifying for jobs.

The Double-Edge Sword of Technology

One of the biggest shifts that has been made since the global pandemic has been the noticeable increase/implementation of Zoom conference calling and tele-health services. Technology has done wonders for how meetings can be conducted and how patients can access healthcare services. Many healthcare centers/hospitals have since made shifts in how they communicate with patients. These shifts range from using applications to sharing results with patients, scheduling appointment times and even providing same-day responses to patient questions. Furthermore, technology has shifted the way that appointments are conducted, with the implementation of tele-health services. Video conferencing technology has allowed thousands of people to attend appointments virtually from home, work, and even from their cars if need be.

Tele-health has provided an increase in flexibility for many people and has been able to reduce many barriers that exist in access healthcare (Lee, S.M. & Lee, 2021). Studies post-pandemic have shown that the increased implementation of tele-health has improved wait-times, improved access to care for those who live in rural areas and have simplified ways to connect with patients' providers (Bestsenneyy et al, 2021). However, with this drastic shift in how we access care, has also brought on new barriers to accessing care. At face value, everything about the implementation of tele-health services should be increasing access to care and greatly diminishing barriers to care. However, when taking a closer look at the implementation of tele-health services it has provided challenges of its own and created barriers to care for those who are less familiar with navigating technology (Saeed & Masters, 2021). The results of this study echo these concerns around the increased implementation of technology and the challenges that come with it. However, participants in this study shared a nuanced response to this problem as well. While challenges/barriers were shared about navigating technology, participants also expressed the opportunity and potential technology can bring to accessing care, and this was especially true for accessing mental health services.

Tele-health services were adopted more widely during the COVID-19 pandemic and most medical appointments were done via tele-health out of necessity to protect patients and the healthcare workers who were doing their best to serve their communities (Shaver, 2022). Once the global pandemic "ended" these services were still being provided through in-person appointments or tele-health appointments. In this study, 81% of participants (13/16) reported having challenges navigating application/portals in trying to communicate with providers and reported not knowing how to use these applications confidently. Furthermore, when asked if participants would choose to be in-person or would see their medical providers via zoom, 100% (16/16) of participants indicated that they would prefer to go in-person rather than using Zoom or any other video conference application. Even though being able to join appointments via zoom reduced several logistical barriers (e.g., travel time, cost of transportation/parking) participants believed that they were not receiving adequate care from providers when appointments were done via tele-health and that many of their concerns required in-person attention. Participants who were forced to go to a discounted clinic due to a lack of healthcare insurance reported that often times the clinics would only provide them an option to see their doctor via tele-health as a way to see if the problem was manageable/treatable online requiring them to come in person. However, participants shared that oftentimes they would know they needed to be seen in-person to be treated and were made to attend the virtual appointment beforehand which, in turn, delayed the care that they would eventually need. Furthermore, participants expressed concern/frustration because they would be charged for another appointment. While tele-health/video conference calls can create access to care to medical providers, it was still highlighted in this study that many participants wanted to be seen in person to receive adequate care.

Although most participants expressed a desire for being in-person for the medical appointments so that they could get better physical care, one important finding was that most participants (14/16) expressed that they would rather or believe (if they had access) that tele-health would be the best option for mental health appointments. Participants expressed that due to the increased frequency of needing to travel to their healthcare centers and the increase time commitments to attend these appointments they would prefer to do them through tele-health. Participants expressed feeling more comfortable attending therapy sessions through zoom and believed that they would receive adequate care. Furthermore, the flexibility that is afforded through doing therapy through zoom greatly increases access to services. There are many who noted that they could do their sessions on their work lunch, break times, when they got off work and even in the morning after their children were dropped off at school. For those who reported having zero access to mental health services due to anti-immigrant policies in their respective states, they were still able to access mental health services using zoom to connect with therapists and other providers in Mexico. One of the biggest challenges that arose with accessing mental health services through zoom/tele-health services was the lack of knowledge on navigating the applications themselves. Many participants recognized the value/opportunity to access mental health services through zoom, however, they also expressed concern with being able to navigate applications that their clinics used like zoom or other video conference applications.

Although the implementation of technology such as applications, web portals and video-conference calls have greatly impacted healthcare access overall, the digital divide still exists for many. The digital divide is a term that refers to the unequal access to technology and digital information across various demographics (Saeed & Masters, 2021). Historically, those from disadvantaged backgrounds have had unequal access to technology compared to those who have had the resources to purchase things such as computers, smartphones, tablets, etc. Thus, we have seen many who are from older generations never having had the opportunity to become well versed in using technology (Wang et al, 2024). This becomes increasingly more challenging once you consider other barriers (e.g., language). Furthermore, participants within this study, 81% (13/16), expressed that they did not understand how to navigate their online portals, make appointments online with confidence, or join tele-health sessions without support. According to participants there were no supports at the hospital/clinic where their providers practiced to help them log on or navigate these portals. Typically, they were just directed to access their portal should they want test results, access to messages sent by the doctor's office, or if they had any follow-up questions. Some participants even expressed that their children or other community members helped them log on to these accounts but that they were not able navigate these applications unless these other people were present. While results of this study highlight that the digital divide affects the participants within this sample, it’s important to note that participants still saw a benefit to tele-health services as long as they had further support in navigating the technology.

The Increased Need for Information and the Power of Community

Overall, potentially the most substantial theme that arose through every participant’s shared experiences was how information was a facilitator to accessing care and how a lack of information could be the biggest barrier to care. All participants reported not having enough information on how they can access healthcare, which included specialist providers (e.g., dentist, therapist, etc.) and not having enough information about what resources are available to them. Participants shared that this information is not made readily available to them and that they typically learned about these resources from others in the community. This aligns with studies that have looked at the positive impact communities can have on newcomer Latinx/é immigrants, especially when accessing resources like healthcare and how there remains a strong need for more information about how to access healthcare services (Coffman & Norton, 2010; Verile et al, 2019; Martinez-Donate et al., 2022). Similarly, those in this study who reported having supports in their community, such as community programs, reported increased access to care compared to those who did not have information provided for them. Participants consistently reported that they needed more information, more knowledge about what they had access too, more understanding (for those who had insurance) about what their insurance covers, more transparency/clarity about how much their appointments will cost and more education about how to utilize technology. Many times, they are signed up for apps that contain all their medical information but don't have the understanding they need to access it. Furthermore, many of the interfaces on downloading/setting up applications are entirely in English, leaving monolingual Spanish speakers trying to find someone who is bilingual to help them navigate this technology.

For the Latinx/é immigrant population, especially for those who are undocumented and have even greater limitations to the resources that are accessible to them, their communities are their beacons of light. They lean on their communities for resources, knowledge, guidance and even protection (Buckingham & Broksky, 2021). This was echoed by participants within this study who shared their experiences with community programs that helped guide them to resources, classes on learning about technology and information about how they could access both general healthcare and mental health care services. Community was highlighted as a considerable support to accessing care by a little over half (56%, 9/16) of the participants in this study. Interestingly, this was reported by all of the participants that did not have access to health insurance in their states of residence (e.g., Colorado, Georgia and Pennsylvania). This suggests that those who did not have access to healthcare or those who needed resources to access healthcare relied heavily on their communities to connect to care. While many participants in Massachusetts did not highlight community as something that created access to care, they did highlight that there were staff at their community health centers that helped them enroll in insurance, navigate technology, and schedule follow-up appointments. Participants shared valuable insights into how healthcare centers can be more involved in their communities and how they can build trust by sharing information with the community that they serve.

Connection to the Minority Stress Theory Framework

The Minority Stress Theory framework was adapted for this study to understand collective factors influencing the stress and mental health outcomes specifically for undocumented Latinx/é immigrants. While mental health outcomes were not explored for the purposes of this study, the minority stress theory framework does provide some insight on how healthcare utilization is a part of the minority experience and how that may impact their mental health. The minority stress framework posits seven components that may impact the mental health of minority groups. As a reminder, these seven components are: general stressors, prejudice events, expectations of rejection, concealment (of minority identity), internalized anti-Latinx/é rhetoric, coping and social support, and characteristics of minority identity. While participants' experiences aligned with several of these components that could impact their mental health, some components of the framework appeared less salient to the participants in this study. First, I will discuss which of the seven components appeared most relevant within this sample and then I will discuss which components seemed less relevant to the experiences of participants. Lastly, future directions will be discussed for these outcomes. Because mental health outcomes were not assessed for the purposes of this study, these findings will be discussed more as a guide for future research.

Most Relevant Components

Of the seven components in the minority stress theory framework, five of these factors arose consistently in the experiences shared by the participants in this study. These five components were: general stressors, expectations of rejection, concealment, characteristics of minority identity and social support. It is worth noting that these components were much more prominent with the participants that lived in states that had more anti-immigrant policies in place. These components arose in a variety of ways throughout the data, however, the two more prominent factors that seemed to potentially impact accessing healthcare overall were concealment and expectations of rejection. Many participants in this study shared experiences about how they were "scared" or "fearful" to disclose their minority status to others because of a fear of deportation, especially when they first arrived in the United States. Furthermore, many participants shared experiences about not asking for help/resources/support from medical providers due to their fear of being rejected. This was especially true for those who were undocumented and living in states that had strict anti-immigrant policies. Participants shared many experiences that there were times where they did not seek out healthcare services or other supports because they did not believe they even qualified for them due to their documentation status. Characteristics of minority identity arose more consistently when referencing language barriers and cultural differences. While participants reported reduced barriers due to language (e.g., by having interpreters present) these barriers still arose much more frequently when needing to access specialist care.

Lastly, social supports arose frequently in the shared experiences of participants which was highlighted as a ‘facilitator’ to accessing care. In the adapted minority stress framework by Valentín-Cortés et al. (2020) they highlight the importance of social supports for the Latinx/é immigrant community and how not having a sense of community/social supports can have a negative impact on mental health. In this study, this was a prominent theme that arose as a way to create access to healthcare and other resources.

Less Relevant Components

While many components of the minority stress framework did present themselves in this study there were two components that appeared less salient. These two components for the framework that did not arise were: prejudice events and internalized anti-Latinx/é rhetoric. While participants shared different negative experiences that they had when trying to access healthcare in the United States, none of the participants reported believing that it was due to racism or discrimination. Rather, they interpreted these experiences as being more related to their lack of access to quality healthcare and/resources due to the legal status. Even though discussion of prejudice events did not arise organically during throughout the interview process (and were not asked about directly), it does not mean that participants have not been subjugated to these kinds of events. And yet, this trend in the findings is consistent with the literature as well. For example, in a study by Perreira and colleagues (2015) they found that Latinx/é immigrants born outside of the United States were much less likely to report discrimination when compared to those who are Latinx/é and that were born in the U.S.

Since all participants in this study were born outside of the United States, this finding is consistent with existing literature.

Lastly, participants in this study did not speak to any experiences within the community or having any kind of internalize anti-Latinx/é rhetoric/thoughts about themselves or others. Participants in this study talked about the importance of their community and the importance of supporting other Latinx/é immigrants in their communities. This is particularly important because of the known increase in anti-immigrant rhetoric over the past several years. As with prejudicial events, however, internalized anti-Latinx/é rhetoric was not directly asked about during interviews, so this finding does not imply that it was not present for these participants in other ways.

Future Directions

While mental health outcomes were not assessed for the purposes of this study, the minority stress framework did provide some guidance for future directions in theory and research. The minority stress theory framework posits seven components/factors that may have an impact on the mental health of the Latinx/é immigrant population in the United States. Of the seven components, five arose as particularly relevant to participants in this study. This suggests that future research that explores the access to healthcare for the Latinx/é immigrant population should attempt to assess for mental health outcomes as well to see how this may impact access to care. Furthermore, this should be explored with participants who live across different states in the U.S., as this diversity of experiences across contexts could potentially illuminate even more barriers to care for those who are undocumented in states with more anti-immigrant policies in place.

Implications

Overall, participants shared their nuanced experiences in accessing healthcare in the United States and what barriers currently exist for them. Furthermore, they graciously shared their valuable insight into what they believe would help improve access to care for the Latinx/é immigrant population in the United States as well. This section will discuss the implications for practice on how to potentially better improve access for the Latinx/é immigrant community by addressing medical care practices, how to improve access to specialist care, how to improve access through technology, and how to partner with communities to disseminate more information to the Latinx/é immigrants while improving overall trust. Furthermore, implications and considerations for future research will be discussed.

Implications for Practice

Medical care providers have continued to increase the utilization of tele-health services which has had a positive impact for many people in regard to accessing care. Furthermore, this can potentially support underserved communities as well. However, even with this implementation of technology and its endless possibilities, the fact remains that the cost of care continues to be a substantial barrier to accessing healthcare of any kind. This rings especially true for people who have limited insurance coverage or no access at all to healthcare coverage, like the undocumented Latinx/é population. There will forever be inequities in accessing care until more is done to address the ever-increasing cost of healthcare services. Furthermore, while these costs to care continue to soar in the United States, there must be attention drawn to how much time providers are giving their patients. There were several experiences shared in this study that illuminated just how many things could take time away from their medical appointments. One prominent example shared, was language. Several participants shared that often times in their experiences, providers would show up to their appointments late and would come without an interpreter present. This would lead to more time spent looking for an interpreter or someone who could communicate with them. It is crucial that providers are more aware that they may have several monolingual non-English speaking patients and there should be proactive steps taken in advance to avoid delaying care for their patients. When time has already been limited, then finding ways to make appointment times more efficient/helpful for patients is essential, especially for those who already have limited access to these appointments. Providers across all settings must be mindful of this and continue to provide the quality of care that every patient deserves. This includes providing enough time for patients to feel like they have received adequate care and that they are feeling informed when leaving their appointments.

While most participants reported having trust with their medical providers and trusting the U.S. healthcare system there were several instances that negatively impacted trust for the participants in this study. This was related to providers not taking the time to provide information about navigating our healthcare system as a whole (e.g., connecting to resources, transparency around cost), a lack of information around treatment plans especially in regard to medications that were prescribed and lastly, a tendency by providers to "gatekeep" or increase barriers to specialized care even when participants requested it. Providers across all domains of healthcare can always work to improve the trust that patients have with them and need to continuously work on providing information to patients so that they are well informed, including about their treatment plan. For example, when providing more information about their care, having conversations around risk/rewards can also build trust and allow the patient to make informed decisions. Several participants reported having little to no information about the medication that was being prescribed to them. They did not know what the risks were of the medication and when most patients are were asked to pick up medications at their pharmacy, everything was provided to them in English, regardless of if they spoke English or not. When this information is not provided in an accessible way, patients are left to seek out more information for themselves. Typically, this information comes from either trusted members of the community or places like the internet where they may receive more misguided information.

Lastly, providers must understand that they are 'gatekeepers' to connecting with specialist care, especially for those who have limited to no access to those providers such as the Latinx/é immigrant community. Providers must continue to reflect on their own personal biases and recognize the impact that their position of power can have, especially on marginalized communities. Again, time should be spent sharing information with patients about the referral process, addressing aspects such as wait times, what to do while they wait for their appointments, and costs associated with these appointments.

Furthermore, if providers are refusing to put in these referrals, then extra time must be spent explaining why it might not be in the best interest of the patient. However, if patients continue to express the need for such an appointment, placing a referral regardless so that the patient feels heard and feels like they are getting the best treatment/care possible is important. With this increased transparency in their care, providers can continue to foster trust with the Latinx/é immigrant population. Nevertheless, even with these improvements they still do not address the substantial difficulties that the Latinx/é immigrant population faces in accessing specialist care.

There were considerable barriers highlighted in this study when participants discussed accessing specialist providers (e.g., dentist, therapist, dermatologist, etc.). There has to be a bigger push for supporting access to specialist care overall. Just as it is crucial for primary care physicians to provide ample/adequate time for patients during their appointments this is even more critical for specialist appointments. At baseline, there are already fewer specialist providers that are available to see patients and they become even more scarce when patients need a provider who is Spanish speaking or is located at a clinic/hospital that has interpreter services. Healthcare systems all around can be better about connecting patients from underserved communities with specialists and can take steps to ensure that their appointments have enough time to provide all of the information they may need. Again, these are steps that must be made by providers/clinics by ensuring that interpreters are ready/connected by the time the appointment has started and by making sure that they provide the full amount of time that is needed for each patient. Furthermore, steps should be taken to connect patients with resources to help supplement the increased cost of specialist care while also providing estimates beforehand of what cost of care my look like. Hospitals/clinics can be more proactive to break down costs for these patients while providing more opportunity to educate patients on what their insurance covers or what resources are available to help cover the additional costs for these appointments. By providing this information and bridging that gap to specialist care, this in turn helps improve trust with the Latinx/é immigrant communities that these clinics serve, while also empowering them to advocate for themselves when they need care by supporting them to be well informed about their coverage/care. Furthermore, this allows those who are better informed to take this information back to their communities so that they can support others as well in accessing this care and support those who might not have the confidence to ask for support when they need it.

Participants in this study shared the various barriers that arose for them with the implementation to tele-health services at their respective health centers. However, they expressed the potential that technology has in increasing access to healthcare, especially with mental health services. They expressed the need for more information and access to technology and the education to help them better understand how to maximize the use of technology. Their shared experiences continue to highlight the need for education and intervention to close the gap on the digital divide. Many people still do not have the knowledge/expertise to navigate these online systems that many medical settings are using more readily. If more is not done to support these communities and finding ways to educate them in learning how to access this technology/information, then the digital divide will continue to grow. This should not s solely fall on the shoulders of our communities or on the shoulders of their children to teach them these skills, but this responsibility also falls on the hospitals/clinics that have the resources to provide additional support. Moreover, we must continue to strive to address these inequities in our healthcare systems and continue to find more ways to make it accessible for all. Clinics/hospitals that use these applications or portals should have several dedicated staff members that can provide this education for patients in English or Spanish depending on the need of the community that they serve. Most participants that spoke about technology as being a barrier to care also highlighted that they did not have anyone to help them navigate these portals or how to access them. At best, participants reported having someone from the clinical staff (e.g., nurse or certified nurse's assistant) help them download the application on their phones.

Once we start to educate communities and provide more opportunities to learn how to access this technology the more this information can be shared with others as well. While it is not the responsibility of the community to have to do all the education for patients, it is undeniable that community programs/members play an important role in supporting others trying to access care within the Latinx/é immigrant community. However, community partners continue to need support in this effort; this cannot fall entirely on the shoulders of the community. They have built trust within their communities and can better understand/highlight the needs of their people as well. That it was why it is of the utmost importance for health centers/hospitals/providers to partner with these programs so that they can better understand these needs. Participants shared various examples of how healthcare centers can disseminate more information to the communities that they serve. An example that was shared by one participant was the potential for clinics to share information at their children's schools, such as resources or how they can access healthcare services, because several members of their community pick up their children after school. This is just one example of several that were shared on how we can continue to think of ways to disseminate this information to our communities. Once we start to close the gap in digital divide, we can continue to educate/support these communities on how to access care. We must take this opportunity to utilize this shift in practice so that we can create better access for the Latinx/é immigrant population and all other underserved communities in the United States.

Limitations

While this study provides valuable insight on what current barriers exist for the Latinx/é immigrant population in accessing healthcare overall, these results should be interpreted as barriers that should be examined more thoroughly in future research. The participant sample size for this study was small (n=16) and participants primarily shared their own experiences when trying to access care in the United States. Furthermore, there were two participants who were the only ones who lived in their respective states (Pennsylvania, n=1; Georgia, n=1) that partook in this study. Although they were the only ones sharing their experiences, their stories were powerful none the less. This should lead future researchers to further investigate what barriers exist for the Latinx/é immigrant community in both states as they reported even lower access to health care overall. It is important to understand the diverse experiences of people living in different contexts/states because different laws and varying access to insurance can profoundly impact their access to healthcare.

In addition, in this study quantitative results were only used for descriptive purposes due to the small sample size. These results were used to better inform the qualitative results. Survey questions that showed any significance could not be interpreted as such because of the small sample size. Future studies may use surveys similar to the ones used in this study, but these would need to be distributed much more widely and to more participants and would continue to benefit greatly taking a mixed methods approach. As one example of the benefits of a mixed methods approach, several participants answered the survey questions about access to health care in the U.S., with the perception that this included access overall (including seeing providers in Mexico). This meant that some respondents shared that they ad seen a provider in the last 12 months; however, qualitative data provided additional insights-namely, that this access to healthcare did not take place in the United States. This was a finding that proved to be quite interesting and warrants further investigation for future studies.

Implications for Future Research

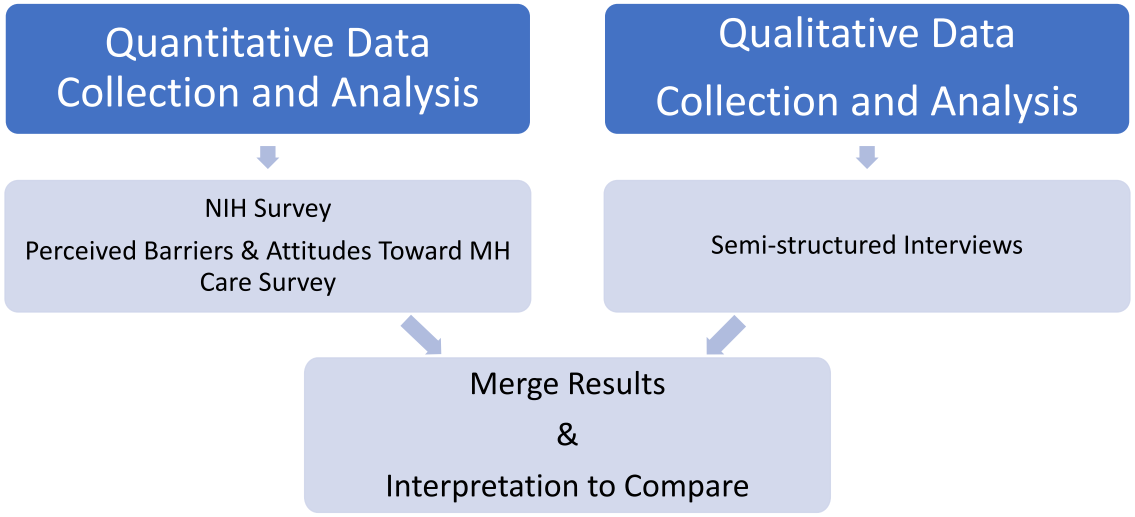
An interesting finding in this study arose during the quantitative survey data collection that warrants further discussion. While surveys were being read to participants via zoom, some interesting anomalies arose, particularly when participants asked for clarification on certain questions. For example, when administering the Garcia et al., 2014 survey on perceived barriers to mental health care, some participants asked for clarity on whether or not responses should include access to care outside of the United States. Upon reviewing participant transcripts and survey responses, there were three participants who had endorsed having access to both healthcare providers and mental health providers on their survey responses, but during the semi-structured interviews they had reported that they were receiving care exclusively from providers in Mexico. During these semi-structured interviews, they reported having zero access to healthcare in the United States due to their immigration status and had to rely on seeing providers in Mexico via zoom. This finding highlights the limitations of solely using quantitative research methods for the Latinx/é immigrant population. When solely looking at quantitative data a face value, this does not allow for nuance or flexibility in the data. Future research should continue to use qualitative and/or mixed method approaches to allow for deeper understanding of the data. Furthermore, future research exploring access to care for the Latinx/é immigrant community, should be mindful of participants who are accessing healthcare services outside of the United States. This will allow for a deeper understanding of how many people need to rely on services located outside of the United States.

Conclusion

Overall, this study aimed to explore the current barriers to accessing healthcare that exist for the Latinx/é immigrant population within this sample and how those barriers had changed since the COVID-19 pandemic. This study also aimed to elucidate which resources/supports exist that facilitates access to healthcare as a way to guide future research endeavors and to advocate for policy changes to better support the Latinx/é immigrant population living in the United States. While barriers still existed for the participants in this sample, especially for those living in states with more strict anti-immigrant policies, there were still various resources/supports that participants highlighted by these participants as substantial facilitators to healthcare access. While there is still more work to be done, these findings can contribute to the existing literature to better understand how to support this vulnerable (yet resilient) population in the United States. While there is growing concern about the upcoming presidential election and what that might mean for this population, researchers and providers can continue to use their platform and advocate for the Latinx/é immigrant community and provide them with the support that they very much deserve.

Appendix A

Convergent Design



Appendix B:

Survey Perceived Barriers to Mental Health Treatment (García et al., 2014)

Questions:	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
1. I do not receiver a reminder					
2. There are no appointments after hours					
3. There are no appointments on weekends					
4. I do not have reliable transportation					
5. Appointment time conflicts with my work					
6. I do not have childcare for appointments					
7. I cannot afford to come					
Logistical Barriers overall score:					
8. I believe my therapist really cares about me*					
9. I do not like to talk in groups					
10. This treatment will make me go crazy					
11. Come to treatment means I am weak					
12. This treatment will make my symptoms better*					
13. I should be able to handle my problems on my own					
14. This treatment takes too much time					
15. I have had therapy before and it did not help					
16. My life is too busy for treatment					
Psychotherapy attitudes score:					

* = items that are back coded

Appendix B.2

Survey Perceived Barriers to Mental Health Treatment (García et al., 2014)

Preguntas:	Totalmente en desacuerdo (1)	En desacuerdo (2)	Neutro (3)	De acuerdo (4)	Totalmente de acuerdo (5)
1. No recibí un recordatorio					
2. No hay citas después de las horas de trabajo					
3. No hay citas los fines de semana					
4. No tengo un medio de transporte confiable					
5. La hora de la cita no coincide con mi trabajo					
6. No tengo quien cuide a los niños durante las citas					
7. No tengo los medios para venir					
Puntuación general de barreras logísticas					
8. Siento que mi terapeuta realmente se preocupa por mí					
9. No me gusta hablar en grupo					
10. Este tratamiento me enloquecerá					
11. Ir al tratamiento significa que soy una persona débil					
12. Este tratamiento mejorará mis síntomas					
13. Debería ser capaz de resolver mis problemas por mi cuenta					
14. Este tratamiento requiere demasiado tiempo					
15. He tenido terapia antes y no me ayudó					
16. Mi vida esta demasiada ocupada para un tratamiento					
Puntuación de actitudes hacia la psicoterapia:					

Appendix B.3

Survey Perceived Barriers to Mental Health Treatment (García et al., 2014)

Frequency of Responses

Questions:	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
1. I do not receiver a reminder	2	6	1	6	1
2. There are no appointments after hours	0	5	1	7	3
3. There are no appointments on weekends	0	5	2	6	3
4. I do not have reliable transportation	2	7	1	5	1
5. Appointment time conflicts with my work	0	5	3	7	1
6. I do not have childcare for appointments	0	5	4	5	2
7. I cannot afford to come	0	5	2	7	2
Logistical Barriers overall score:					
8. I believe my therapist really cares about me*	0	1	2	9	4
9. I do not like to talk in groups	3	6	2	3	2
10. This treatment will make me go crazy	4	8	2	2	0
11. Come to treatment means I am weak	4	10	1	1	0
12. This treatment will make my symptoms better*	0	0	2	9	5
13. I should be able to handle my problems on my own	2	9	2	3	0
14. This treatment takes too much time	0	7	5	3	1
15. I have had therapy before and it did not help	1	13	1	1	0
16. My life is too busy for treatment	0	10	2	3	1
Psychotherapy attitudes score:					

* = items that are back coded

Appendix C

Healthcare Access and Utilization Survey (NIH)

1) DURING THE PAST 12 MONTHS, were you told by health care provider of doctor's office that they did not accept your health care coverage?
    - Yes
    - No
    - Don't Know
2) In regard to your health insurance or health care coverage, how does it compare to a year ago? Is it better, worse, or about the same?
    - Better
    - Worse
    - About the same
    - Don't know
3) Is there a place that you USUALLY go to when you are sick or need advice about your health?
    - Yes
    - There is NO place
      If 'no' is selected, skip to "About how long has it been since you last saw or talked to a doctor or other health care provider about your own health?"
    - There is MORE THAN ONE place
    - Don't know
4) What kind of place do you go to most often?
    - Doctor's office, clinic, or health center
    - Urgent care or minute clinic
    - Hospital emergency room
    - Some other place
    - Don't go to one place most often
    - Don't know
5) About how long has it been since you last saw or talked to a doctor or other health care provider about your own health?
    - Never
    - 6 months or less
    - More than 6 months, but not more than a 1 year ago
    - More than 1 year, but not more than 2 years ago
      If selected, skip to "There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS"

- More than 2 years, but not more than 5 years ago
  If selected, skip to "There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS"
- More than 5 years ago
  If selected, skip to "There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS"
- Don't know

DURING THE PAST 12 MONTHS, have you seen or talked to any of the following doctors or health care providers about your own health?

1) A general doctor who treats a variety of illnesses (a physician in general practice, primary care, family medicine, or internal medicine)?
   Help text: A provider who sees adult patients for wellness exam & treatment of diseases
   - Yes
   - No
   - Don't know
     i. **What is the total number of general doctor visits you made in the last 12 months?**
        - 1
        - 2-3
        - 4-5
        - 6-7
        - 8-9
        - 10-12
        - 13-15
        - 16 or more
        - Don't know
2) A nurse practitioner, physician assistant or midwife?
   - Yes
   - No
   - Don't know
     i. **What is the total number of nurse practitioner, physician assistant, or midwife visits you made in the last 12 months?**
        - 1
        - 2-3
        - 4-5
        - 6-7
        - 8-9
        - 10-12

  - o 13-15
  - o 16 or more
  - o Don’t know

3) A mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker?
    - Yes
    - No
    - Don’t Know
        i. **What is the total number of visits to a mental health professional that you made in the last 12 months?**
            - o 1
            - o 2-3
            - o 4-5
            - o 6-7
            - o 8-9
            - o 10-12
            - o 13-15
            - o 16 or more
            - o Don’t know

1) How often were you treated with respect by your doctors or health care providers? would you say.
    - Always
    - Most of the time
    - Some of the time
    - None of the time
    - Don’t know
2) How often did your doctors or health care providers tell or give you information about your health and health care that was easy to understand? Would you sa..
    - Always
    - Most of the time
    - Some of the time
    - None of the time
    - Don’t know

There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS?

1) Didn’t have transportation
    - Yes
    - No
    - Don’t Know
2) You live in a rural area where distance to the health care provider is too far
    - Yes

    - No
    - Don't know
3) You were nervous about seeing a health care provider
    - Yes
    - No
    - Don't know
4) Couldn't get time off work
    - Yes
    - No
    - Don't know
5) Couldn't get childcare
    - Yes
    - No
    - Don't Know
6) You provide care to an adult and could not leave him/her
    - Yes
    - No
    - Don't know
7) Couldn't afford the copay
    - Yes
    - No
    - Don't know
8) Your deductible was too high/or could not afford the deductible
    - Yes
    - No
    - Don't know
9) You had to pay out of pocket for some or all the procedure
    - Yes
    - No
    - Don't know

DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?

1) Prescription medicines
    - Yes
    - No
    - Don't know
2) Mental health care or counseling
    - Yes
    - No
    - Don't know

3) Emergency care
    - Yes
    - No
    - Don’t know
4) To see a regular doctor or general health provider (in primary care, general practice, internal medicine, family medicine)
    - Yes
    - No
    - Don’t know
5) Follow-up care
    - Yes
    - No
    - Don’t know
6) If you get sick or have an accident, how worried are you that you will be able to pay your medical bills? Are you very worried, somewhat worried, or not at all worried?
    - Very worried
    - Somewhat worried
    - Not at all worried
    - Don’t know

The following questions are about your experiences with doctors and other health care providers in the past year. Some people think it is helpful if their providers are from the same background that they are- like in terms of race or religion or native language- because they think that their doctors will better understand what they’re experiencing or going through.

1) How important is it to you that your doctors or health care providers understand or are similar to you in any of these ways? Would you say…
    - Very important
    - Somewhat important
    - Slightly important
    - Not important at all
    - Don’t know
2) How often were you able to see doctors or health care providers who were similar to you in any of these ways? Would you say..
    - Always
    - Most of the time
    - Some of the time
    - None of the time
    - Don’t know

3) How often have you either delayed or not gone to see doctors or health care providers because they were different from you in any of these ways?
   - Always
   - Most of the time
   - Some of the time
   - None of the time
   - Don’t know

Appendix C.2

Healthcare Access and Utilization Survey (NIH) (Spanish)

1) EN LOS ÚLTIMOS 12 MESES, ¿le han dicho en la consulta de algún médico que no aceptaban su cobertura de salud?
    - Si
    - No
    - No lo sé
2) En cuanto a tu seguro de salud o cobertura médica, ¿cómo se compara con el de hace un año? ¿Está mejor, peor o más o menos igual?
    - Mejor
    - Peor
    - Más o menos igual
    - No lo sé
3) ¿Hay algún lugar al que NORMALMENTE vas cuando estás enfermo o necesitas consejos sobre tu salud?
    - Si
    - No hay ningún lugar
      Si selecciona 'no', vaya directamente a ¿Hace cuánto tiempo fue la última vez que viste o hablaste con un médico u otro proveedor de atención médica acerca de su propia salud?"
    - Hay más de un lugar
    - No lo sé
4) ¿A qué tipo de lugar vas con más frecuencia?
    - Consultorio médico, clínica o centro de salud
    - Atención de urgencia o clínica de minutos
    - Sala de emergencias del hospital
    - Otro lugar
    - No voy a un solo lugar con más frecuencia
    - No lo sé
5) ¿Hace cuánto tiempo fue la última vez que viste o hablaste con un médico u otro proveedor de atención médica acerca de tu propia salud?
    - Nunca
    - Menos de 6 meses
    - Más de 6 meses, pero no más de 1 año atrás
    - Más de 1 año, pero no más de 2 años atrás
      Si selecciona este, pase a "Hay muchas razones por las que las personas retrasan el tratamiento médico. ¿Ha retrasado su atención por alguna de las siguientes razones en los ÚLTIMOS 12 MESES?"

- Más de 2 años, pero no más de 5 años atrás
  Si selecciona este, pase a "Hay muchas razones por las que las personas retrasan el tratamiento médico. ¿Ha retrasado su atención por alguna de las siguientes razones en los ÚLTIMOS 12 MESES?"
- Más de 5 años atrás
  Si selecciona esto, pase a "Hay muchas razones por las que las personas retrasan el tratamiento médico. ¿Ha retrasado su tratamiento por alguna de las siguientes razones en los ÚLTIMOS 12 MESES?"
- No lo sé

Durante los ÚLTIMOS 12 MESES, ¿ha visto o hablado con alguno de los siguientes médicos o proveedores de atención médica sobre su salud?

1) ¿Un médico general que trata una variedad de enfermedades (un médico de atención primaria, medicina familiar o medicina interna)?
   Texto de ayuda: Un proveedor que atiende a pacientes adultos para exámenes de bienestar y tratamiento de enfermedades
   - Si
   - No
   - No lo sé
     i. **¿Cuál es el número total de visitas al médico general que ha hecho en los últimos 12 meses?**
        - o 1
        - o 2-3
        - o 4-5
        - o 6-7
        - o 8-9
        - o 10-12
        - o 13-15
        - o Mas de 16
        - o No lo sé
2) ¿Un(a) enfermero(a) practicante, asistente médico o partera?
   - Si
   - No
   - No lo sé
     i. **¿Cuál es el número total de visitas que ha hecho en los últimos 12 meses con un(a) enfermero(a) practicante, asistente médico o partera?**
        - o 1
        - o 2-3
        - o 4-5
        - o 6-7
        - o 8-9

        - 10-12
        - 13-15
        - Más de 16
        - No lo sé

3) ¿Un profesional de salud mental como un psiquiatra, psicólogo, enfermero(a) psiquiátrico(a) o trabajador(a) social clínico(a)?
    - Si
    - No
    - No lo sé
        i. **¿Cuál es el número total de visitas que ha hecho en los últimos 12 meses con un profesional de salud mental?**
            - 1
            - 2-3
            - 4-5
            - 6-7
            - 8-9
            - 10-12
            - 13-15
            - Más de 16
            - No lo sé

1) ¿Con qué frecuencia fue tratado(a) con respeto por sus médicos o proveedores de atención médica? ¿Diría que...
    - Siempre
    - La mayoría del tiempo
    - Algunas veces
    - Nunca
    - No lo sé
2) ¿Con qué frecuencia sus médicos o proveedores de atención médica le informaron o dieron información sobre su salud y atención médica que fue fácil de entender? ¿Diría que...
    - Siempre
    - La mayoría del tiempo
    - Algunas veces
    - Nunca
    - No lo sé

Hay muchas razones por las que las personas retrasan el tratamiento médico. ¿Ha retrasado su tratamiento por alguna de las siguientes razones en los ÚLTIMOS 12 MESES?

1) No tuvo transporte disponible
    - Si
    - No

  - No lo sé
2) Vive en una zona rural donde la distancia al proveedor de atención médica es demasiado
  - Si
  - No
  - No lo sé
3) Estaba nervioso(a) por ver a un proveedor de atención médica
  - Si
  - No
  - No lo sé
4) No pudo conseguir tiempo libre en el trabajo
  - Si
  - No
  - No lo sé
5) No pudo conseguir cuidado de niños
  - Si
  - No
  - No lo sé
6) Cuidas a un adulto y no podrías abandonarle
  - Si
  - No
  - No lo sé
7) No pudo pagar el copago
  - Si
  - No
  - No lo sé
8) Su deducible era demasiado alto o no pudo pagarlo
  - Si
  - No
  - No lo sé
9) Tuvo que pagar de su bolsillo por parte o todo el procedimiento
  - Si
  - No
  - No lo sé

DURANTE LOS ÚLTIMOS 12 MESES, ¿hubo algún momento en que necesitó alguno de los siguientes servicios, pero no lo obtuvo porque no podía pagarlo?

1) Medicamentos recetados
  - Si
  - No
  - No lo sé

2) Atención o asesoramiento de salud mental
    - Si
    - No
    - No lo sé
3) Atención de emergencia
    - Si
    - No
    - No lo sé
4) Visitar a un médico o proveedor de atención médica general (en atención primaria, medicina general, medicina interna, medicina familiar)
    - Si
    - No
    - No lo sé
5) Seguimiento médico
    - Si
    - No
    - No lo sé
6) Si se enferma o tiene un accidente, ¿qué tan preocupado está de poder pagar sus facturas médicas? ¿Está muy preocupado, algo preocupado o no está preocupado en absoluto?
    - Muy preocupado
    - Algo preocupado
    - No estoy preocupado
    - No lo sé

Las siguientes preguntas se refieren a sus experiencias con médicos y otros proveedores de atención médica en el último año. Algunas personas piensan que es útil si sus proveedores son de la misma cultura o religión o hablan el mismo idioma que ellos, porque creen que sus médicos entenderán mejor lo que están atravesando.

1) ¿Qué tan importante es para usted que sus médicos o proveedores de atención médica lo entiendan o sean similares a usted en cualquiera de estas formas? ¿Diría que...
    - Muy importante
    - Algo importante
    - Un poco importante
    - Nada importante
    - No lo sé
2) ¿Cuántas veces pudo ver médicos o proveedores de atención médica que fueran similares a usted en alguno de estos aspectos? ¿Diría que..
    - Siempre
    - La mayoría de las veces

  - Algunas veces
  - Ninguna vez
  - No lo sé

3) ¿Cuántas veces has retrasado o no has ido a ver a doctores o proveedores de atención médica porque eran diferentes a usted en cualquiera de estas formas?
  - Siempre
  - La mayoría de las veces
  - Algunas veces
  - Ninguna vez
  - No lo sé

Appendix D

Qualitative Interview Questions

Semi-Structured- Interview questions for all participants

1. Title
    a. What race do you identify as?
    b. What ethnicity do you identify as?
    c. What gender do you identify as?
    d. What languages do you speak?
    e. What is your preferred language?
    f. How old are you?
    g. Do you have health insurance?
        i. What is your current insurance coverage plan?
2. How long have you lived in the US?
    a. What country were you born in?
3. Tell me about your experience with the US healthcare system.
    a. Probe for doctors, counselors/therapists.
4. How has the pandemic affected your experience with healthcare?
    a. Probe for access to healthcare (e.g., making and attending appointments)
5. How often do you utilize services?
6. What limits your ability to attend appointments?
7. What makes it easier for you to attend appointments?
    a. Are there resources or things you’ve seen that help with attending appointments?
8. What are some things that have been working for having healthcare appointments during this pandemic?
    a. Would you like to see these things continued post-pandemic?
9. What are some things that have not been working for healthcare appointments during the pandemic?
    a. Would you like to see these things changed/taken out completely after the pandemic is over?)
10. Have you had experience with telehealth (defined as receiving care over the phone or video)?
    a. If yes: Tell me about those experiences. In your experience what has been challenging since switching to telehealth? What has been made easier by switching to telehealth?
    b. If no: Do you know of others who have experience with telehealth? What has been challenging or made easier?
11. What are some other barriers that you have seen when you or people you know are accessing care? Are there ways to lessen these barriers or the effects of these barriers?

   a. Barriers with cost?
   b. Barriers with transportation/time?
   c. Barriers with documentation status?
   d. Barriers with language?
   e. Other barriers not listed?
12. Do you trust the U.S. healthcare system?
   a. In your opinion, what is creating this trust or mistrust?
   b. What are some ways that you think could help build trust with this system?
13. Is there a particular positive experience you had when using the healthcare system? Can you describe it?
14. Is there a particular negative experience you had when using the healthcare system? Can you describe it?
15. What are some things that you would like to see in your healthcare visits?
16. Do you have any recommendations for healthcare providers about their services?

Appendix D.2

Qualitative Interview Questions (Spanish)

Preguntas de entrevista semiestructurada para todos los participantes

1. Titulo
    a. ¿Con qué raza te identificas?
    b. ¿Con qué grupo étnico te identificas?
    c. ¿Con qué género te identifica?
    d. ¿Qué idiomas habla?
    e. ¿Cuál es su idioma preferido?
    f. ¿Cuántos años tienes
    g. ¿Tiene seguro médico?
        i. ¿Cual es tu plan actual de cobertura de seguro?
2. ¿Cuánto tiempo lleva viviendo en EE.UU.?
    a. ¿En qué país nació?
3. ¿Cuentame sobre su experiencia con el sistema de atención médica en los Estados Unidos
    a. Sonda(pregunte) sobre médicos, consejeros/terapeutas.
4. ¿Cómo ha afectado la pandemia a su experiencia con la atención médica?
    a. Sonda(pregunte) sobre el acceso a atención médica (por ejemplo, hacer y asistir a citas médicas
5. ¿Con qué frecuencia utiliza los servicios?
6. ¿Qué limita su capacidad para asistir a las citas?
7. ¿Qué le facilita asistir a las citas?
    a. ¿Hay recursos o cosas que hayas visto que te ayuden a asistir a las citas?
8. ¿Cuáles son algunas de las cosas que han funcionado para tener citas médicas durante esta pandemia?
    a. ¿Te gustaría ver que estas cosas continúen después de la pandemia?
9. ¿Qué cosas no han funcionado en las citas durante la pandemia?
    a. ¿Le gustaría que estas cosas cambiaran o se eliminaran por completo cuando se acabe la pandemia?
10. ¿Ha tenido experiencia con la telemedicina (definida como recibir atención por teléfono o vídeo)?
    a. Si la respuesta es si: Cuéntame de esas experiencias. Según su experiencia, ¿Qué ha sido difícil desde que cambió a la telemedicina? ¿Qué ha sido más fácil gracias a la telemedicina?
    b. Si la respuesta es no: ¿Conoce a alguien que tenga experiencia con la telemedicina? ¿Qué ha sido difícil o ha facilitado las cosas?
11. ¿Cuáles son otras barreras que ha visto cuando usted o personas que conoce están accediendo a atención médica? ¿Hay formas de reducir estas barreras o los efectos de estas barreras?

    a. ¿Barreras con el costo?
    b. ¿Barreras con el transporte/el tiempo?
    c. ¿Barreras con el estado de ciudadanía?
    d. ¿Barreras con el idioma?
    e. ¿Otras barreras no mencionadas?

12. [Link to related survey questions.] ¿Confías en el sistema de salud de EE.UU.?
    a. En su opinion, ¿que crea esta confianza o desconfianza?
    b. ¿Que medidas cree que podrían contribuir a fomentar la confianza en este sistema?
13. ¿Hay alguna experiencia positiva en particular que haya tenido al utilizar el sistema de salud? ¿Puede describirla?
14. ¿Ha tenido alguna experiencia negativa al utilizar el sistema de salud? ¿Puede describirla?
15. ¿Qué cosas le gustaría ver en sus visitas de atención médica?
16. ¿Tiene alguna recomendación para los proveedores de atención médica sobre sus servicios?

Appendix E

Code Book

Code	Definition
(-) Cost	Whenever participant mentions/discusses price of care.
(-) Specialist	Whenever participant mentions/discusses challenges seeing a provider other than ‘general’ provider.
(-) Wait times/availability	Whenever participant mentions/discusses a delay in care due to scheduling limitations.
(*) Insurance	Whenever a participant mentions/discusses that they do not have healthcare coverage and that it limits the care they have access too.
	Whenever a participant mentions they do have healthcare coverage and that it increases the care they have access to.
(*) Technology	Whenever a participant mentions/discusses web-based portals, applications and/or the use of other devices as a barrier to care.
	Whenever a participant mentions/discusses web-based portals, applications and/or the use of other devices as a facilitator to accessing care.
(*) Information/Education	Whenever a participant mentions/discusses not knowing about what resources/care they have access to and/or not having someone to teach them, which prevents access to care
	Whenever a participant mentions/discusses having learned/been taught about what resources are available to them which helped create access to care.

(+) Community	Whenever a participant mentions/discusses that other people and/or agencies where they live have helped/supported them in accessing care.

(*) Code was identified as a facilitator to accessing healthcare as well as a barrier.

(-) Code was identified solely as a barrier to accessing healthcare.

(+) Code was identified solely as a facilitator to accessing healthcare.

Appendix F

Inclusion Criteria Script/Questions

1. Are you over the age of 18?
2. Were you born outside of the U.S.?
3. Do you speak English and/or Spanish?
4. Have you lived in the U.S. for over 2 years?
5. Do you identify as Latino/a/x?
6. Have you tried accessing healthcare/mental health care in since living in the U.S.?

Appendix G

Flyer for Study (English)

Participants needed for a one hour interview to hear about your experiences accessing healthcare

Looking for Latino(a) who have immigrated here and have tried and/or seen their doctor.

Interviews will take around an hour and can be done via zoom. Participants will be paid $100 for completing the interview.

If you are interested please contact
Ronnie Blackwell at ronnieb@bu.edu
or at (208) 409-2118

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Appendix G.2

Flyer for Study (Spanish)

Se Necesitan Participantes Para Una Entrevista Para Aprender de Tus Experiencias Accediendo Servicios de Salud

Buscando primera generación de inmigrantes Latinx que han tratado o han visto su doctor de cabecera. Si tienes mas de18 años de edad y has vivido en los Estados Unidos por mas de dos años , las entrevistas pueden hacerse por Zoom, y va durar una hora. Particpantes que completen la entrevista van a recibir una tarjeta Visa de regalo por $100.

Si estás interesado por favor contacten Ronnie Blackwell a ronnieb@bu.edu o llama (208) 409-2118

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Appendix H

IRB Approval Letter

Notification of IRB Review: Exemption Determination

May 11, 2023

Ronnie Blackwell M.S.
Boston, MA 02215

Protocol Title:	The Effects of COVID-19 on Existing Barriers to Healthcare Access for the Immigrant Latinx Community: A Mixed Methods Study
Protocol #:	7006X
Funding Agency:	Unfunded
IRB Review Type:	Exempt 2(ii) Dear Ronnie Blackwell:

On May 11, 2023, the IRB determined that the above-referenced protocol meets the criteria for exemption in accordance with 45 CFR 46.104(d)2(ii)

The exempt determination includes the use of:

1. Up to a total of 17 participants
2. Protocol Application (version 2, submitted on May 11, 2023)
3. Consent Script
4. Screening Questions
5. Flyer
6. Instruments
    a. Survey Perceived Barriers to Mental Health Treatment
    b. Healthcare Access and Utilization Survey (NIH)
    c. Qualitative Interview Questions

If you have any questions, please contact the

IRB at irb@bu.edu.

LaNeia Thomas, MSW

Assistant Director
Charles River Campus IRB

Appendix I

Informed Consent (English)

Protocol Title: The Effects of COVID-19 on Existing Barriers to Healthcare Access for the Immigrant Latinx Community A Mixed Methods Study
Principal Investigator: Ronnie Blackwell
Description of Study Population: First Generation Latinx Immigrants who have tried accessing healthcare since arriving in the United States.
Version Date: 4/4/23

Study Summary

The purpose of this research study is to **investigate, what barriers there are for Latinx patients accessing health care during and after the pandemic, while also understanding how telehealth has either positively or negatively affected access to healthcare for this population.**

Participants who take part in this research study will be in this research study for **45–60 minutes** During this time, subjects will **connect via zoom or in a preferred private location chosen by participants one time.**

Participants taking part in this study will **receive a zoom link via email at an agreed upon time that is convenient to the participant. The call will take no longer than 60 min and will be recorded for transcription purposes. I will be conducting a semi-structured interview asking questions about access to healthcare and mental health care. Once the interview is over and the dialogue is transcribed, I will delete the recordings.**

The risks of taking part in this research study are **none. There are no risks to participating in this study and all participants will have their identity protected. All identifying factors other than their job title will be removed.**

Introduction

Please read this form carefully. The purpose of this form is to provide you with important information about taking part in a research study. If you have any questions about the research or any portion of this form, please ask us. Taking part in this research study is up to you. If you decide to take part in this research study, we will ask you to sign this form. We will give you a copy of the signed form.

The person in charge of this study is **Ronnie Blackwell & Kimberly Howard. Ronnie Blackwell** can be reached at [redacted] **or ronnieb@bu.edu. Kimberly Howard can be reached at khoward@bu.edu** We will refer to this person as the "researcher" throughout this form.

What should I know about a research study?

Participation in research is voluntary, which means that it is something for which you volunteer. It is your choice to participate in the study, or not to participate. If you choose to participate now, you may change your mind and stop participating later. If you decide not to participate, that decision will not result in any penalty or loss of benefits to which you are otherwise entitled.

Why is this study being done?

The goals of this study are to answer three questions: 1.) What are the existing barriers to accessing both primary care and mental health care for the Latinx community post-COVID-19? 2.) How have these barriers changed with the onset of COVID-19? 3.) What kind of resources do Latinx individuals think would improve their ability to access healthcare?

We are asking you to take part in this study because you **have experience either accessing or trying to access healthcare/ mental health care since the COVID-19 Pandemic. It is important to hear from you to understand how telehealth has either increased or decreased accessibility through your experiences. Furthermore, it is important to try and understand through your perspective/experiences on how healthcare providers can continue to improve access to healthcare.**

About **15–17** of subjects will take part in this research study at Boston University/via zoom.

How long will I take part in this research study?

We expect that you will be in this research study for **50–60 minutes**. During this time, we will ask you to make **1** study visits **Via zoom or a preferred private location of your choice.**

What will happen if I take part in this research study?

You will receive an email with the zoom link during an agreed upon a time convenient for you. You will then be asked a series of questions regarding access to health care via zoom which will be recorded. Interviews will take no longer than 60 minutes and you will only need to attend one zoom call. For any reason during the interview if you would like to withdraw from the study you may withdraw at any time.

If you agree to take part in this study, we will ask you to sign the consent form before we conduct any study procedures.

What are the risks of taking part in this research study?

Risks of Completing Tasks

You may get tired during the tasks. You can rest at any time.

Questionnaire/Survey Risks

You may feel emotional or upset when answering some of the questions. Tell the interviewer at any time if you want to take a break or stop the interview.

You may be uncomfortable with some of the questions and topics we will ask about. You do not have to answer any questions that make you feel uncomfortable.

Loss of Confidentiality

The main risk of allowing us to use and store your information for research is a potential loss of privacy. We will protect your privacy by labeling your information with a code and keeping the key to the code in a password-protected computer.

If future benefit: Others may benefit in the future from the information that is learned in this study.

Study Participation and Early Withdrawal

Taking part in this study is your choice. You are free not to take part or to withdraw at any time for any reason. No matter what you decide, there will be no penalty or loss of benefit to which you are entitled. If you decide to withdraw from this study, the information that you have already provided will be kept confidential.

Audio/Video Recording

Instead of in-person visits, we will be conducting some study visits remotely via an online video service called Zoom. We will be using Boston University's secure Zoom account. Zoom requires the use of a web browser but does not require any software download. For more information about Zoom security and privacy, please see the Boston University webpage on Zoom Meetings, or ask the research team.

Boston University cannot fully guarantee the privacy or security of any content sent electronically and Zoom recordings cannot be uploaded and stored 100% securely, though the researchers will do everything they can to protect your information.

We would like to audio/video record you during this study over Zoom. If you are **audio/video recorded** it **will** be possible to identify you. We will store these recordings on our computer and only approved study staff will have access to the recordings. We will label these recordings with a code instead of your name. The key to the code connects your name to your recording. The researcher will keep the key to the code in a **password-protected computer. These recordings will be stored no longer than 4 weeks. They will be transcribed and then removed completely.**

Do you agree to allow us to audio/video record you during this study?

______YES ______NO _______Participant Initials

Use of Your Study Information

<u>No</u> future use of collected identifiable samples/data/information, the following wording must be used:
Private information collected from you during this study will NOT be used for future research studies or shared with other researchers for future research, even if the information identifying you are removed from the sample and/or private information.

How Will You Keep My Study Records Confidential?

We will keep the records of this study confidential by **removing all identifiers from the data. I will create unique codes for each interview and once they are transcribed, I will have the recording removed from my computer.** I will make every effort to keep your records confidential. However, there are times when federal or state law requires the disclosure of your records.

The following people or groups may review your study records for purposes such as quality control or safety:

- The Researcher and any member of their research team
- The Institutional Review Board at Boston University. The Institutional Review Board is a group of people who review human research studies for safety and protection of people who take part in the studies.
- The sponsor or funding agency for this study
- Central University Offices

The study data will be stored **on a password protected computer.**

The results of this research study may be published or used for teaching. We will not include identifiable information on data that are used for these purposes.

Will I get paid for taking part in this research study?

- **For completing this study/interview I will be giving you a $100 Visa gift card for your time.**

What will it cost me to take part in this research study?

There are no costs to you for taking part in this research study.

Who do I ask if I have questions or concerns about this research study?

Please call us with any concerns or questions about the research, or any research-related problems:

- **Ronnie Blackwell [redacted] or at ronnieb@bu.edu.**
- **I can be contacted any time Monday through Friday from 9–5 if you have any concerns.**
- **If you cannot reach me, you can contact Dr. Howard at khoward@bu.edu.**

If you have questions about your rights as a research participant, or if you have any complaints or concerns and want to speak with someone independent of the research team, you may contact the Boston University Charles River Campus IRB at 617-358-6115. The IRB Office webpage has information where you can learn more about being a participant in research, and you can also complete a Participant Feedback Survey.

Statement of Consent

I have read the information in this consent form including risks and possible benefits. I have been given the chance to ask questions. My questions have been answered to my satisfaction, and I agree to participate in the study.

SIGNATURE

____
Name of Study Participant

______________________________ ________________
Signature of Study Participant Date

I have explained the research to the research participant and answered all their questions. I will give a copy of the signed consent form to the participant.

____
Name of Person Obtaining Consent

____ ____________________
Signature of Person Obtaining Consent Date

Appendix I.2

Informed Consent (Spanish)

Protocol Title: The Effects of COVID-19 on Existing Barriers to Healthcare Access for the Immigrant Latinx Community A Mixed Methods Study
Investigador Principal: Ronnie Blackwell
Descripción de la Población Estudiada: Inmigrantes latinos de primera generación que han intentado acceder a la atención médica desde que llegaron a Estados Unidos.
Version Date: 4/4/23

Resumen del Estudio

El propósito de este estudio es **investigar qué barreras existen para que los pacientes latinos accedan a la atención médica durante y después de la pandemia, así como comprender cómo la telesalud ha afectado positiva o negativamente al acceso a la atención médica para esta población.**

Los participantes que tomen parte en este estudio de investigación estarán en él entre **45 y 60 minutos**. Durante este tiempo, los sujetos se **conectarán a través de Zoom o en un lugar privado preferido elegido por los participantes una vez.**

Los participantes en este estudio **recibirán un enlace de Zoom por correo electrónico para una hora acordada que sea conveniente para el participante. La llamada no durará más de 60 minutos y se grabará para transcribirla. Se realizará una entrevista semiestructurada en la que se harán preguntas sobre el acceso a la atención médica y la salud mental. Una vez finalizada la entrevista y transcrito el diálogo, borraré las grabaciones.**

No hay **ningún** riesgo al participar en este estudio**. Participar en este estudio no entraña ningún riesgo y se protegerá la identidad de todos los participantes. Se eliminarán todos los factores identificativos, salvo el titulo laboral.**

Introducción

Por favor, lea atentamente este formulario. El propósito de este formulario es proporcionarle información importante sobre su participación en un estudio de investigación. Si tienes alguna pregunta sobre la investigación o cualquier parte de este formulario, por favor pregúntanos. Participar en este estudio de investigación depende de usted. Si decide participar en este estudio de investigación, le pediremos que firme este formulario. Le entregaremos una copia del formulario firmado.

Las personas a cargo de este estudio son **Ronnie Blackwell & Kimberly Howard.** Puede ponerse en contacto con **Ronnie Blackwell** en el numero [redacted] **o ronnieb@bu.edu**. **Kimberly Howard está disponible en khoward@bu.edu** Nos referiremos a esta persona como el "investigador" a lo largo de este formulario.

¿Qué debo saber sobre un estudio de investigación?

La participacion en la investigacion es voluntaria, lo que significa que es algo que se hace de manera voluntaria. Usted decide participar o no en el estudio. Si elige participar ahora, puede cambiar de opinión y dejar de participar más adelante. Si decides no participar, esa decisión no resultará en ninguna penalización o pérdida de beneficios a los que de otro modo tendría derecho.

¿Por qúe se hace este estudio?

Los objetivos de este estudio son responder a tres preguntas: 1.) ¿Cuáles son las barreras existentes para acceder tanto a la atención primaria como a la atención de salud mental para la comunidad Latinx después de COVID-19? 2.) ¿Cómo han cambiado estas barreras con el inicio de COVID-19? 3.) ¿Qué tipo de recursos creen las personas Latinx que mejorarían su capacidad de acceso a la atención médica?

Te estamos pidiendo que participes en este estudio porque **tienes experiencia accediendo o intentando acceder a la atención medica/ atención de salud mental desde el comienzo de la pandemia de COVID-19. Es importante que nos cuentes tu experiencia para entender cómo la telesalud ha aumentado o disminuido la accesibilidad. Además es importante tratar de entender a través de su perspectiva/ experiencias sobre cómo los proveedores de atención médica pueden seguir mejorando el acceso a la atención médica.**

Unos **15–17** sujetos participarán en este estudio de investigación en Boston University/vía zoom.

¿Por cuánto tiempo participaré en este estudio de investigación?

Esperamos que participe en este estudio de investigación durante **50–60 minutos**. Durante este tiempo, le pediremos que realice **1** visita de estudio **vía zoom o en un lugar privado preferido de su elección.**

¿Que sucederá si participo en este estudio de investigación?

Recibirá un correo electrónico con el enlace de Zoom en el momento acordado que más le convenga. Luego, se te hará una serie de preguntas sobre el acceso a la atención médica a través de Zoom, las cuales serán grabadas. Las entrevistas no durarán más de 60 minutos y solo tendrás que asistir a una llamada de Zoom. Si en algún momento durante la entrevista deseas retirarte del estudio, puede hacerlo en cualquier momento.

Si aceptas participar en este estudio, te pediremos que firmes el formulario de consentimiento antes de realizar cualquier procedimiento del estudio.

¿Cuáles son los riesgos de participar en este estudio de investigación?

Riesgos de Completar las Tareas

Puede que se canse durante las tareas. Puedes descansar en cualquier momento.

Riesgos del Cuestionario/Encuesta

Es posible que puedas sentirte emocional o molesto a responder a algunas de las preguntas. Si en algún momento deseas tomar un descanso o detener la entrevista, comunícaselo al entrevistador.

Es posible que algunas preguntas y temas te hagan sentir incómodo. No estás obligado a responder a ninguna pregunta que te haga sentir incómodo o que no quieras responder.

Pérdida de la Confidencialidad

El principal riesgo de permitirnos utilizar y almacenar su información para la investigación es una posible pérdida de privacidad. Protegeremos su privacidad mediante etiquetando su información con un código y guardando la clave del código en una computadora protegida por contraseña.

Si el beneficio futuro: Otras personas podrán beneficiarse en el futuro de la información obtenida en este estudio.

Participación en el Estudio y Retirada Anticipada

La participación en este estudio es voluntaria. Usted tiene la libertad de no participar o retirarse en cualquier momento por cualquier motivo. Sea cual sea su decisión, no habrá ninguna sanción o pérdida de beneficios a los que le corresponden. Si decide retirarse de este estudio, la información que nos haya facilitado se mantendrá confidencial.

Grabación de Audio/Vídeo

En lugar de visitas en persona, haremos algunas visitas de estudio a distancia a través de un servicio de vídeo en línea llamado Zoom. Usaremos la cuenta segura de Zoom de Boston University. Zoom requiere el uso de un navegador web, pero no requiere la descarga de ningún software. Para obtener más información sobre la seguridad y privacidad de Zoom, consulte la página web de Boston University sobre Zoom Meetings, o pregunte al equipo de investigación.

Boston University no puede garantizar totalmente la privacidad o seguridad de ningún contenido enviado electrónicamente y las grabaciones de Zoom no pueden cargarse y almacenarse de forma 100% segura, aunque los investigadores harán todo lo posible para proteger su información.

Nos gustaría grabarle en audio/vídeo durante este estudio a través de Zoom. Si se **graba su audio/vídeo será posible identificarle**. Guadaremos estas grabaciones en nuestra computadora y sólo el personal autorizado del estudio tendrá acceso a ellas. Etiquetaremos estas grabaciones con un código en lugar de su nombre. La clave del código conecta su nombre con su grabación. El investigador guardará la clave del código en una **computadora protegida por contraseña. Estas grabaciones no se conservarán más de 4 semanas. Se transcribirán y luego se eliminarán por completo.**

¿Está de acuerdo en permitirnos grabarle en audio/vídeo durante este estudio?

______SI ______NO _______ Iniciales del participante

Uso de la Información de su Estudio

Si no se utilizará en el futuro muestras/datos/información identificables recogidos, deberá utilizarse la siguiente redacción:
La información privada que se obtenga de usted durante este estudio NO se utilizará para futuros estudios de investigación ni se compartirá con otros investigadores para futuras investigaciones, incluso si los datos que le identifiquen se eliminen de la muestra y/o de la información privada.

¿Cómo mantendrán la confidencialidad de mis registros de estudio?

Mantendremos la confidencialidad de los registros de este estudio **eliminando todos los identificadores de los datos. Crearé códigos únicos para cada entrevista y, una vez transcritas, eliminaré la grabación de mi computadora.** Haré todo lo posible por mantener la confidencialidad de sus registros. Sin embargo, hay ocasiones en que las leyes federales o estatales exigen la divulgación de sus registros.

Las siguientes personas o grupos podrían revisar sus registros del estudio con fines de control de calidad o seguridad:

- El investigador y cualquier miembro de su equipo de investigación
- The Institutional Review Board con Boston University. The Institutional Review Board es un grupo de personas que revisan los estudios de investigación con seres humanos para garantizar la seguridad y protección de las personas que participan en ellos.
- El patrocinador o la agencia de financiación de este estudio
- Central University Offices

Los datos del estudio se almacenarán **en una computadora protegido con contraseña.**

Los resultados de este estudio de investigación podrán publicarse o utilizarse para la enseñanza. No incluiremos información identificable en los datos que se utilicen para estos fines.

¿Me pagarán por participar en este estudio de investigación?

- **Por completer este studio/entrevista, recibirás una tarjeta de regalo Visa de $100 como compensación por tu tiempo.**

¿Cuánto me costará participar en este estudio de investigación?

No habra ningún costo para ti por participar en este estudio de investigación.

¿A quién debo dirigirme si tengo preguntas o dudas sobre este estudio de investigación?

Llámenos si tiene alguna duda o pregunta sobre la investigación o cualquier problema relacionado con ella:

- **Ronnie Blackwell** [redacted] **o en ronnieb@bu.edu.**
- **Puede ponerse en contacto conmigo en cualquier momento de lunes a viernes de 9 a 5 si tiene alguna duda.**
- **Si no puede contactarme, puede dirigirse al Dr. Howard en khoward@bu.edu.**

Si tiene preguntas sobre sus derechos como participante en una investigación, o si tiene alguna queja o duda y desea hablar con alguien independiente del equipo de investigación, puede ponerse en contacto con Boston University Charles River Campus IRB en 617-358-6115. La página web de la Oficina de la IRB tiene información donde usted puede aprender más sobre ser un participante en la investigación, y también puede completar una Encuesta de Retroalimentación del Participante.

Declaración de Consentimiento

He leído la información contenida en este formulario de consentimiento, incluidos los riesgos y los posibles beneficios. Se me ha dado la oportunidad de hacer preguntas. Se ha respondido satisfactoriamente a mis preguntas y acepto participar en el estudio.

SIGNATURE

____
Nombre del Participante en el Estudio

______________________________________ ____________________
Firma del participante en el estudio Fecha

He explicado la investigación al participante y he respondido a todas sus preguntas. Entregaré al participante una copia del formulario de consentimiento firmado.

____
Nombre de la Persona que Obtiene el Consentimiento

____ ____________________
Firma de la Persona que Obtiene el Consentimiento Fecha

References

Abraído-Lanza, A. F., Dohrenwend, B. P., Ng-Mak, D. S., & Turner, J. B. (1999). The Latino mortality paradox: A test of the “salmon bias” and healthy migrant hypotheses. *American Journal of Public Health*, *89*(10), 1543–1548.

Access to Health Services | Healthy People 2020. (n.d.). Retrieved August 4, 2021, from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Acosta, A. M., Garg, S., Pham, H., Whitaker, M., Anglin, O., O’Halloran, A., Milucky, J., Patel, K., Taylor, C., Wortham, J., Chai, S. J., Kirley, P. D., Alden, N. B., Kawasaki, B., Meek, J., Yousey-Hindes, K., Anderson, E. J., Openo, K. P., Weigel, A., … Havers, F. P. (2021). Racial and Ethnic Disparities in Rates of COVID-19–Associated Hospitalization, Intensive Care Unit Admission, and In-Hospital Death in the United States From March 2020 to February 2021. *JAMA Network Open*, *4*(10), e2130479. https://doi.org/10.1001/jamanetworkopen.2021.30479

Ai, A. L., Pappas, C., & Simonsen, E. (2015). Risk and Protective Factors for Three Major Mental Health Problems Among Latino American Men Nationwide. *American Journal of Men’s Health, 9*(1), 64–75. https://doi.org/10.1177/1557988314528533

Albright, J. N., & Hurd, N. M. (2020). Marginalized Identities, Trump-Related Distress, and the Mental Health of Underrepresented College Students. *American Journal of Community Psychology*, *65*(3–4), 381–396. https://doi.org/10.1002/ajcp.12407

Alcántara, C., Casement, M. D., & Lewis-Fernández, R. (2013). Conditional risk for PTSD among Latinos: A systematic review of racial/ethnic differences and sociocultural explanations. *Clinical Psychology Review*, *33*(1), 107–119. https://doi.org/10.1016/j.cpr.2012.10.005

Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and Mental Health. *Current Epidemiology Reports*, *4*(2), 145–155. https://doi.org/10.1007/s40471-017-0111-2

AMN Healthcare (2022). Survey of physician appointment wait times and Medicare and Medicaid acceptance rates. https://ir.amnhealthcare.com/node/17201/pdf

Apesoa-Varano, E. C., & Hinton, L. (2013). The Promise of Mixed-Methods for Advancing Latino Health Research. *Journal of Cross-Cultural Gerontology*, *28*(3), 267–282. https://doi.org/10.1007/s10823-013-9209-2

Arbona, C., Olvera, N., Rodriguez, N., Hagan, J., Linares, A., & Wiesner, M. (2010). Acculturative Stress Among Documented and Undocumented Latino Immigrants in the United States. *Hispanic Journal of Behavioral Sciences*, *32*(3), 362–384. https://doi.org/10.1177/0739986310373210

Arriola, L. R., & Grossman, A. N. (2021). Ethnic Marginalization and (Non)Compliance in Public Health Emergencies. *The Journal of Politics*, *83*(3), 807–820. https://doi.org/10.1086/710784

Artiga, S., Orgera, K., & Damico, A. (2020). *Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018*. Issue Brief, Kaiser Family Foundation.

https://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-the-ACA-2010-2018.pdf

Attipoe-Dorcoo, S., Delgado, R., Gupta, A., Bennet, J., Oriol, N. E., & Jain, S. H. (2020). Mobile health clinic model in the COVID-19 pandemic: Lessons learned and opportunities for policy changes and innovation. *International Journal for Equity in Health*, *19*(1), 73. https://doi.org/10.1186/s12939-020-01175-7

Ayón, C., Marsiglia, F. F., & Bermudez-Parsai, M. (2010). Latino family mental health: Exploring the role of discrimination and familismo. *Journal of Community Psychology*, *38*(6), 742–756. https://doi.org/10.1002/jcop.20392

Barnett, M. L., Yee, H. F., Jr, Mehrotra, A., & Giboney, P. (2017). Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted and Decreased Wait Times To See Specialists. *Health Affairs*, *36*(3), 492–499. https://doi.org/10.1377/hlthaff.2016.1283

Behbahani, S., Smith, C. A., Carvalho, M., Warren, C. J., Gregory, M., & Silva, N. A. (2020). Vulnerable Immigrant Populations in the New York Metropolitan Area and COVID-19: Lessons Learned in the Epicenter of the Crisis. *Academic Medicine*, *95*(12), 1827–1830. https://doi.org/10.1097/ACM.0000000000003518

Berk, M. L., Schur, C. L., Chavez, L. R., & Frankel, M. (2000). Health care use among undocumented Latino immigrants. *Health Affairs*, *19*(4), 51–64. https://doi.org/10.1377/hlthaff.19.4.51

Best, A. L., Fletcher, F. E., Kadono, M., & Warren, R. C. (2021). Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19

Response: Implications for Ethical Public Health Practice. *Journal of Health Care for the Poor and Underserved*, *32*(1), 90–98. https://doi.org/10.1353/hpu.2021.0010

Bestsennyy, O., Gilbert, G., Harris, A., & Rost, J. (2021). Telehealth: a quarter-trillion-dollar post-COVID-19 reality. McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality

Bucay-Harari, L., Page, K. R., Krawczyk, N., Robles, Y. P., & Castillo-Salgado, C. (2020). Mental Health Needs of an Emerging Latino Community. *Journal of Behavioral Health Services and Research*. *47,* 388–398. https://doi.org/10.1007/s11414-020-09688-3

Buckingham, S. L., & Brodsky, A. E. (2021). Relative privilege, risk, and sense of community: Understanding Latinx immigrants' empowerment and resilience processes across the United States. *American Journal of Community Psychology*, *67*(3–4), 364–379.

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino Adults' Access to Mental Health Care: A Review of Epidemiological Studies. *Administration and Policy in Mental Health*, *33*(3), 316. https://doi.org/10.1007/S10488-006-0040-8

Cavazos-Rehg, P. A., Zayas, L. H., & Spitznagel, E. L. (2007). Legal status, emotional well-being and subjective health status of Latino immigrants. *Journal of the National Medical Association*, *99*(10), 1126–1131.

CDC. (2020, February 11). *Cases, Data, and Surveillance*. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 2050312118822927. https://doi.org/10.1177/2050312118822927

Ciotti, M., Ciccozzi, M., Terrinoni, A., Jiang, W.-C., Wang, C.-B., & Bernardini, S. (2020). The COVID-19 pandemic. *Critical Reviews in Clinical Laboratory Sciences*, *57*(6), 365–388.

Coffman, M. J., & Norton, C. K. (2010). Demands of immigration, health literacy, and depression in recent Latino immigrants. *Home Health Care Management and Practice*. https://doi.org/10.1177/1084822309347343

Connelly, L. M. (2009). Mixed methods studies. *Medsurg Nursing*, *18*(1), 31–33.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage Publications.

Cronin, R. M., Jerome, R. N., Mapes, B., Andrade, R., Johnston, R., Ayala, J., Schlundt, D., Bonnet, K., Kripalani, S., Goggins, K., Wallston, K. A., Couper, M. P., Ellitt, M. R., Harris, P., Begale, M., Munoz, F., Lopez-Class, M., Cella, D., Condon, D., … O'Donnell, C. (2019). Development of the Initial Surveys for the All of Us Research Program. *Epidemiology*, *30*(4), 597–608. https://doi.org/10.1097/EDE.0000000000001028

Damle, M., Wurtz, H., & Samari, G. (2022). Racism and health care: Experiences of Latinx/é immigrant women in NYC during COVID-19. *SSM – Qualitative Research in Health*, *2*, 100094. https://doi.org/10.1016/j.ssmqr.2022.100094

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services*, *67*(3), 265–274.

Dillon, F. R., De La Rosa, M., & Ibañez, G. E. (2013). Acculturative stress and diminishing family cohesion among recent Latino immigrants. *Journal of Immigrant and Minority Health*, *15*, 484–491.

Documet, P. I., Troyer, M. M., & Macia, L. (2019). Social Support, Health, and Health Care Access Among Latino Immigrant Men in an Emerging Community. *Health Education and Behavior*. *46*(1), 137–145. https://doi.org/10.1177/1090198118763870

Dudley, M. J. (n.d.). *Why care about undocumented immigrants? For one thing, they've become vital to key sectors of the US economy*. The Conversation. Retrieved September 10, 2022, from http://theconversation.com/why-care-about-undocumented-immigrants-for-one-thing-theyve-become-vital-to-key-sectors-of-the-us-economy-98790

Duffy, M. E. (1987). Methodological Triangulation: A Vehicle for Merging Quantitative and Qualitative Research Methods. *Image: The Journal of Nursing Scholarship*, *19*(3), 130–133. https://doi.org/10.1111/j.1547-5069.1987.tb00609.x

Escalera, C., Strassle, P. D., Quintero, S. M., Maldonado, A. I., Withrow, D., Alhomsi, A., Bonilla, J., Santana-Ufret, V., & Nápoles, A. M. (2022). Perceived general, mental, and physical health of Latinos in the United States following adoption of immigrant-inclusive state-level driver's license policies: A time-series analysis. *BMC Public Health*, *22*(1), 1609. https://doi.org/10.1186/s12889-022-14022-x

Escarce, J. J., & Kapur, K. (2006). Access to and quality of health care. In *Hispanics and the Future of America*. https://doi.org/10.17226/11539

Escobedo, L. E., Cervantes, L., & Havranek, E. (2023). Barriers in healthcare for Latinx patients with limited English proficiency—a narrative review. *Journal of General Internal Medicine*, *38*(5), 1264-1271.

Fleming, P. J., Lopez, W. D., Mesa, H., Rion, R., Rabinowitz, E., Bryce, R., & Doshi, M. (2019). A qualitative study on the impact of the 2016 US election on the health of immigrant families in Southeast Michigan. *BMC Public Health*. *19*, 947. https://doi.org/10.1186/s12889-019-7290-3

Funk, C., & Lopez, M. H. (2022, June 14). 1. A brief statistical portrait of U.S. Hispanics. *Pew Research Center Science & Society*. https://www.pewresearch.org/science/2022/06/14/a-brief-statistical-portrait-of-u-s-hispanics/

Galvan, T., Lill, S., & Garcini, L. M. (2021). Another Brick in the Wall: Healthcare Access Difficulties and Their Implications for Undocumented Latino/a Immigrants. *Journal of Immigrant and Minority Health*, *23*(5), 885–894. https://doi.org/10.1007/s10903-021-01187-7

Garcia, C., Garcia, M. A., & Ailshire, J. A. (2018). Sociocultural variability in the Latino population: Age patterns and differences in morbidity among older US adults.

Demographic Research, *38*, 1605–1618. https://doi.org/10.4054/DemRes.2018.38.52

Garcia, H. A., Finley, E. P., Ketchum, N., Jakupcak, M., Dassori, A., & Reyes, S. C. (2014). A Survey of Perceived Barriers and Attitudes Toward Mental Health Care Among OEF/OIF Veterans at VA Outpatient Mental Health Clinics. *Military Medicine*, *179*(3), 273–278. https://doi.org/10.7205/MILMED-D-13-00076

Garcini, L. M., Vázquez, A. L., Abraham, C., Abraham, C., Sarabu, V., & Cruz, P. L. (2024). Implications of undocumented status for Latinx families during the COVID-19 pandemic: A call to action. *Journal of Clinical Child & Adolescent Psychology*, *53*(1), 10-23.

Goldman, D. P., Smith, J. P., & Sood, N. (2005). Legal status and health insurance among immigrants. *Health Affairs*, *24*(6), 1640–1653.

González Burchard, E., Borrell, L. N., Choudhry, S., Naqvi, M., Tsai, H.-J., Rodriguez-Santana, J. R., Chapela, R., Rogers, S. D., Mei, R., Rodriguez-Cintron, W., Arena, J. F., Kittles, R., Perez-Stable, E. J., Ziv, E., & Risch, N. (2005). Latino Populations: A Unique Opportunity for the Study of Race, Genetics, and Social Environment in Epidemiological Research. *American Journal of Public Health*, *95*(12), 2161–2168. https://doi.org/10.2105/AJPH.2005.068668

Greenaway, C., Hargreaves, S., Barkati, S., Coyle, C. M., Gobbi, F., Veizis, A., & Douglas, P. (2020). COVID-19: Exposing and addressing health disparities among ethnic minorities and migrants. *Journal of Travel Medicine*, *27*(7), taaa113. https://doi.org/10.1093/jtm/taaa113

Guarnaccia, P. J., Martínez Pincay, I., Alegría, M., Shrout, P. E., Lewis-Fernández, R., & Canino, G. J. (2007). Assessing Diversity Among Latinos: Results From the NLAAS. *Hispanic Journal of Behavioral Sciences*, *29*(4), 510–534. https://doi.org/10.1177/0739986307308110

Gwynn, R. C. (2021). Health Inequity and the Unfair Impact of the COVID-19 Pandemic on Essential Workers. *American Journal of Public Health*, *111*(8), 1459–1461. https://doi.org/10.2105/AJPH.2021.306386

Halcomb, E. J., & Hickman, L. (2015). Mixed methods research. *Nursing Standard, 29*(32), 41–47. https://doi.org/10.7748/ns.29.32.41.e8858

Hallgren, K. A. (2012). Computing Inter-Rater Reliability for Observational Data: An Overview and Tutorial. *Tutorials in Quantitative Methods for Psychology*, *8*(1), 23–34.

Heyvaert, M., Maes, B., & Onghena, P. (2013). Mixed methods research synthesis: definition, framework, and potential. *Quality & Quantity*, *47*, 659–676.

Hipolito-Delgado, C. P. (2010). Exploring the Etiology of Ethnic Self-Hatred: Internalized Racism in Chicana/o and Latina/o College Students. *Journal of College Student Development*, *51*(3), 319–331. https://doi.org/10.1353/CSD.0.0133

Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services. (1993). *Access to Health Care in America* (M. Millman, Ed.). National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK235882/

Jazieh, A. R., & Kozlakidis, Z. (2020). Healthcare Transformation in the Post-Coronavirus Pandemic Era. *Frontiers in Medicine*, *7*, 429. https://doi.org/10.3389/fmed.2020.00429

Khandkar, S. H. (2009). Open coding. https://www.academia.edu/attachments/34014007/download_file?st=MTcxNjA2MjYxNiwyMDkuNi4xMTIuMjA3&s=swp-splash-paper-cover

Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, *45*(1), 104–110. https://doi.org/10.1016/j.jpsychires.2010.04.031

Kim, G., Worley, C. B., Allen, R. S., Vinson, L., Crowther, M. R., Parmelee, P., & Chiriboga, D. A. (2011). Vulnerability of older latino and asian immigrants with limited english proficiency. *Journal of the American Geriatrics Society*, *59*(7), 1246–1252. https://doi.org/10.1111/j.1532-5415.2011.03483.x

Kop, W. J. (2021). Biopsychosocial Processes of Health and Disease During the COVID-19 Pandemic. *Psychosomatic Medicine*, *83*(4), 304–308. https://doi.org/10.1097/PSY.0000000000000954

Kopasker, D., Montagna, C., & Bender, K. A. (2018). Economic insecurity: A socioeconomic determinant of mental health. *SSM – Population Health*, *6*, 184–194.

Krupenkin, M., Rothschild, D., Hill, S., & Yom-Tov, E. (2019). President Trump Stress Disorder: Partisanship, Ethnicity, and Expressive Reporting of Mental Distress After the 2016 Election. *SAGE Open*. *9*(1). https://doi.org/10.1177/2158244019830865

Lee, J., Hong, J., Zhou, Y., & Robles, G. (2020). The Relationships Between Loneliness, Social Support, and Resilience Among Latinx/é Immigrants in the United States. *Clinical Social Work Journal*, *48*(1), 99–109. https://doi.org/10.1007/s10615-019-00728-w

Lee, S. M., & Lee, D. (2021). Opportunities and challenges for contactless healthcare services in the post-COVID-19 Era. *Technological Forecasting and Social Change*, *167*, 120712. https://doi.org/10.1016/j.techfore.2021.120712

Mahtta, D., Daher, M., Lee, M. T., Sayani, S., Shishehbor, M., & Virani, S. S. (2021). Promise and Perils of Telehealth in the Current Era. *Current Cardiology Reports*, *23*(9), 115. https://doi.org/10.1007/s11886-021-01544-w

Marks, A., & García Coll, C. (2012). *The Immigrant Paradox in Children and Adolescents: Is Becoming American a Developmental Risk?* American Psychological Association. https://doi.org/10.1037/13094-000

Marshall, K. J., Urrutia-Rojas, X., Mas, F. S., & Coggin, C. (2005). Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women. *Health Care for Women International*, *26*(10), 916–936. https://doi.org/10.1080/07399330500301846

Martínez, M. E., Nodora, J. N., & Carvajal-Carmona, L. G. (2021). The dual pandemic of COVID-19 and systemic inequities in US Latino communities. *Cancer*, *127*(10), 1548–1550. https://doi.org/10.1002/cncr.33401

Martinez-Donate, A. P., Dsouza, N., Cuellar, S., Connor, G., Zumaeta-Castillo, C., Lazo-Elizondo, M., Yamasaki, Y., Perez, C., Carroll-Scott, A., Martinez, O., & Hassrick, E. M. (2022). Provider perceptions of availability, accessibility, and adequacy of health and behavioral services for Latino immigrants in Philadelphia: A qualitative study. *BMC Public Health*, *22*(1), 1645. https://doi.org/10.1186/s12889-022-14066-z

Massoud, M. F. (2022). The price of positionality: assessing the benefits and burdens of self-identification in research methods. *Journal of Law and Society*, *49*, S64–S86.

Mendoza, H., Masuda, A., & Swartout, K. M. (2015). Mental Health Stigma and Self-Concealment as Predictors of Help-Seeking Attitudes among Latina/o College Students in the United States. *International Journal for the Advancement of Counselling*, *37*(3), 207–222. https://doi.org/10.1007/s10447-015-9237-4

Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*. *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Miles, M. B., Huberman, A. M., & Saldana, J. (2018). *Qualitative Data Analysis: A Methods Sourcebook*. SAGE Publications.

Morales, L. S., Lara, M., Kington, R. S., Valdez, R. O., & Escarce, J. J. (2002). Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes. *Journal of Health Care for the Poor and Underserved*, *13*(4), 477.

Mulvaney-Day, N. E., Alegría, M., & Sribney, W. (2007). Social cohesion, social support, and health among Latinos in the United States. *Social Science & Medicine*, *64*(2), 477–495. https://doi.org/10.1016/J.SOCSCIMED.2006.08.030

NeJhaddadgar, N., Ziapour, A., Zakkipour, G., Abbas, J., Abolfathi, M., & Shabani, M. (2020). Effectiveness of telephone-based screening and triage during COVID-19 outbreak in the promoted primary healthcare system: A case study in Ardabil province, Iran. *Journal of Public Health/Zeitschrift für Gesundheitswissenschaften*. *30,* 1301–1306. https://doi.org/10.1007/s10389-020-01407-8

Noe-Bustamante, L., Krogstad, J. M., & Lopez, M. H. (2021, July 15). For U.S. Latinos, COVID-19 Has Taken a Personal and Financial Toll. *Pew Research Center.* https://www.pewresearch.org/race-ethnicity/2021/07/15/for-u-s-latinos-covid-19-has-taken-a-personal-and-financial-toll/

Noyola, N., Moreno, O., & Cardemil, E. V. (2020). Religious coping and nativity status among Mexican-origin Latinxs: A mixed-methods study. *Journal of Latinx Psychology*, *8*(3), 238.

Ortlipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Report*, *13*(4), 695–705. https://doi.org/10.46743/2160-3715/2008.1579

Passel, J. S., & Cohn, D. (2008, October 2). Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow. *Pew Research Center's Hispanic Trends Project*. https://www.pewresearch.org/hispanic/2008/10/02/trends-in-unauthorized-immigration/

Perreira, K. M., Gotman, N., Isasi, C. R., Arguelles, W., Castañeda, S. F., Daviglus, M. L., Giachello, A. L., Gonzalez, P., Penedo, F. J., Salgado, H., & Wassertheil-Smoller, S. (2015). Mental Health and Exposure to the United States: Key Correlates from the Hispanic Community Health Study of Latinos. *The Journal of Nervous and Mental Disease*, *203*(9), 670–678. https://doi.org/10.1097/NMD.0000000000000350

Podewils, L. J., Burket, T. L., Mettenbrink, C., Steiner, A., Seidel, A., Scott, K., Cervantes, L., & Hasnain-Wynia, R. (2020). Disproportionate Incidence of COVID-19 Infection, Hospitalizations, and Deaths Among Persons Identifying as Hispanic or Latino—Denver, Colorado March–October 2020. *MMWR: Morbidity and Mortality Weekly Report*, *69*(48), 1812–1816. https://doi.org/10.15585/mmwr.mm6948a3

Polit, D. F., & Beck, C. T. (2010). *Essentials of nursing research: Appraising evidence for nursing practice*. Lippincott Williams & Wilkins.

Raymond-Flesch, M., Siemons, R., Pourat, N., Jacobs, K., & Brindis, C. D. (2014). "There Is No Help Out There and If There Is, It's Really Hard to Find": A Qualitative Study of the Health Concerns and Health Care Access of Latino

"DREAMers." *Journal of Adolescent Health*, *55*(3), 323–328. https://doi.org/10.1016/j.jadohealth.2014.05.012

Raffaelli, M., & Wiley, A. R. (2013). Challenges and strengths of immigrant Latino families in the rural Midwest. *Journal of Family Issues*, *34*(3), 347–372.

Regnault, A., Willgoss, T., Barbic, S., & On behalf of the International Society for Quality of Life Research (ISOQOL) Mixed Methods Special Interest Group (SIG). (2018). Towards the use of mixed methods inquiry as best practice in health outcomes research. *Journal of Patient-Reported Outcomes*, *2*(1), 19. https://doi.org/10.1186/s41687-018-0043-8

Riley, A. R., Chen, Y.-H., Matthay, E. C., Glymour, M. M., Torres, J. M., Fernandez, A., & Bibbins-Domingo, K. (2021). Excess mortality among Latino people in California during the COVID-19 pandemic. *SSM – Population Health*, *15*, 100860. https://doi.org/10.1016/j.ssmph.2021.100860

Rivers, P. A., & Patino, F. G. (2006). Barriers to health care access for Latino immigrants in the USA. *International Journal of Social Economics*, *33*(3), 207–220. https://doi.org/10.1108/03068290610646234

Rodríguez, E. M., & Smith, L. (2020). Provider Perspectives on Stressors, Support, and Access to Mental Health Care for Latinx/é Youth. *Qualitative Health Research*, *30*(4), 547–559. https://doi.org/10.1177/1049732319857695

Rodriguez-Alcalá, M. E., Qin, H., & Jeanetta, S. (2019). The Role of Acculturation and Social Capital in Access to Health Care: A Meta-study on Hispanics in the US.

Journal of Community Health, *44*(6), 1224–1252. https://doi.org/10.1007/s10900-019-00692-z

Saeed, S. A., & Masters, R. M. (2021). Disparities in health care and the digital divide. *Current Psychiatry Reports*, *23*, 61. https://doi.org/10.1007/s11920-021-01274-4

Salinas, Cristobal, Jr. 2020. “The Complexity of the ‘x’ in Latinx/é: How Latinx/é/a/o Students Relate to, Identify with, and Understand the Term Latinx/é.” *Journal of Hispanic Higher Education*, Special Issue, 19 (2): 149–168. doi:10.1177/1538192719900382.

Sangalang, C. C., Becerra, D., Mitchell, F. M., Lechuga-Peña, S., Lopez, K., & Kim, I. (2019). Trauma, post-migration stress, and mental health: A comparative analysis of refugees and immigrants in the United States. *Journal of Immigrant and Minority Health*, *21*, 909–919.

Santos, S. J., Bohon, L. M., & Sánchez-Sosa, J. J. (1998). Childhood family relationships, marital and work conflict, and mental health distress in Mexican immigrants. *Journal of Community Psychology*. *26*(5), 491–508 https://doi.org/10.1002/(sici)1520-6629(199809)26:5<491::aid-jcop7>3.0.co;2-u

Shaver, J. (2022). The State of Telehealth Before and After the COVID-19 Pandemic. *Primary Care*, *49*(4), 517–530. https://doi.org/10.1016/j.pop.2022.04.002

Stafford, A. M., Tanna, A., Bueno, K. M., Nagy, G. A., Felsman, I. C., de Marchi, S., & Gonzalez-Guarda, R. (2023). Documentation Status and Self-Rated Physical Health Among Latinx Young Adult Immigrants: the Mediating Roles of

Immigration and Healthcare Stress. *Journal of Racial and Ethnic Health Disparities*, *10*(2), 761–774.

Szaflarski, M., & Bauldry, S. (2019). The effects of perceived discrimination on immigrant and refugee physical and mental health. *Advances in Medical Sociology, 19*, 173–204. https://doi.org/10.1108/S1057-629020190000019009

Talevi, D., Socci, V., Carai, M., Carnaghi, G., Faleri, S., Trebbi, E., di Bernardo, A., Capelli, F., & Pacitti, F. (2020). Mental health outcomes of the CoViD-19 pandemic. *Rivista di Psichiatria*, *55*(3), 137–144. https://doi.org/10.1708/3382.33569

The “All of Us” Research Program. (2019). *The New England Journal of Medicine*, *381*(7), 668–676. https://doi.org/10.1056/NEJMsr1809937

The Lancet. (2020). The plight of essential workers during the COVID-19 pandemic. *Lancet*, *395*(10237), 1587. https://doi.org/10.1016/S0140-6736(20)31200-9

Thomas, D. (2006). A General Inductive Approach for Qualitative Data Analysis. *The American Journal of Evaluation*, *27*(2), 247–256 . https://journals.sagepub.com/doi/abs/10.1177/1098214005283748

Tikhonov, A. A., Espinosa, A., Huynh, Q.-L., & Anglin, D. M. (2019). Bicultural identity harmony and American identity are associated with positive mental health in U.S. racial and ethnic minority immigrants. *Cultural Diversity and Ethnic Minority Psychology*, *25*, 494–504. https://doi.org/10.1037/cdp0000268

Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of*

Midwifery & Women's Health, *47*(2), 80–96. https://doi.org/10.1016/S1526-9523(02)00218-0

Valentín-Cortés, M., Benavides, Q., Bryce, R., Rabinowitz, E., Rion, R., Lopez, W. D., & Fleming, P. J. (2020). Application of the Minority Stress Theory: Understanding the Mental Health of Undocumented Latinx/é Immigrants. *American Journal of Community Psychology, 66*(3–4), 325–336. https://doi.org/10.1002/ajcp.12455

Vargas Bustamante, A., Fang, H., Garza, J., Carter-Pokras, O., Wallace, S. P., Rizzo, J. A., & Ortega, A. N. (2012). Variations in healthcare access and utilization among Mexican immigrants: The role of documentation status. *Journal of Immigrant and Minority Health, 14,* 146–155. https://doi.org/10.1007/s10903-010-9406-9

Verea, M., & Verea, M. (2018). Anti-Immigrant and Anti-Mexican Attitudes And Policies during the First 18 Months Of the Trump Administration. *Norteamérica*, *13*(2), 197–226. https://doi.org/10.22201/CISAN.24487228E.2018.2.335

Verile, M. G., Ertl, M. M., Dillon, F. R., & De La Rosa, M. (2019). Acculturative stress among Latina young adult immigrants: The mediating role of receiving community context. *Translational Issues in Psychological Science*, *5*(1), 91.

Walker, D., & Myrick, F. (2006). Grounded Theory: An Exploration of Process and Procedure. *Qualitative Health Research*, *16*(4), 547–559. https://doi.org/10.1177/1049732305285972

Wang, K., Chen, X. S., Dong, Y., Sanabria Véaz, K. G., & Gu, D. (2024). Bridging the Access Gap: A Decade of Narrowing the Digital Divide for Hispanic Older

Adults in the United States. *Journal of Aging and Health*. https://doi.org/10.1177/08982643241238789

Wiley, S., Lawrence, D., Jessica Figueroa, & Percontino, R. (2013). Rejection-(dis)identification and ethnic political engagement among first-generation latino immigrants to the united states. *Cultural Diversity and Ethnic Minority Psychology, 19*(3), 310–319. https://doi.org/10.1037/a0031093

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93*(2), 185–187. https://doi.org/10.2105/AJPH.93.2.200

World Health Organization. (2020). *Advice on the use of masks in the context of COVID-19: Interim guidance, 6 April 2020*. World Health Organization. https://iris.who.int/handle/10665/331693

Yamanis, T. J., del, R.-G. A. M., Rapoport, L., Norton, C., Little, C., Linhales, B. S., & Ornelas, I. J. (2021). Understanding Fear of Deportation and Its Impact on Healthcare Access among Immigrant Latinx/é Men Who Have Sex with Men. In A. J. LeBlanc & B. L. Perry (Eds.), *Sexual and Gender Minority Health* (Vol. 21, pp. 103–131). Emerald Publishing Limited. https://doi.org/10.1108/S1057-629020210000021010

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