# Immigration as a Social and Structural Determinant of Health

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**Key Points**

- Immigration and especially undocumented status can create barriers to health for immigrant populations. Barriers should be viewed through a structural lens and framework, as opposed to being viewed as purely behavioral or cultural issues.
- Undocumented immigrants' disadvantaged health status and barriers to care increase the likelihood that the ED will be their most likely touch point in the healthcare system.
- The ED visit represents a potent opportunity to address acute and upstream causes of poor health in immigrant populations.
- Healthcare systems can be optimized to provide immigration-informed care. This can be done through knowledge of local access barriers and development of referral systems to help address health related and other structural barriers immigrants can face (e.g., access to care through insurance or primary care programs, legal aid resources, sanctuary status of health settings).

## Foundations

### Background

In the year 2018, approximately 44 million people, or 13.7% of the entire US population, were thought to be foreign born, the highest proportion since 1910 [1]. Among US children, 19.6 million were foreign born or had at least one

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parent who was foreign born [2]. Far from being homogenous, the US immigrant community is diverse in culture, history, and beliefs. Legal classification of immigrant groups has significant bearing on their social stability, access to health resources, and consequently, health [3]. The US Census Bureau divides foreign-born US residents into four primary categories: naturalized US citizens (those who have attained US citizenship), lawful permanent residents (LPR) ("green card holders"), humanitarian migrants (refugees and asylees), and unauthorized migrants ("undocumented"). It is important to recognize that terms "illegal immigrants" and "illegal aliens" are sometimes used to refer to undocumented persons. The use of illegal implies that the illegality is inherent to the person rather than an externally applied legal categorization that is malleable over time. This phrase risks dehumanizing the individual and making professional obligations to the patient and the right to health subservient to politicized categories. These terms have been shown to engender negative attitudes towards these patients and thus we discourage use of these terms by providers [4].

Almost half of foreign-born US residents are naturalized citizens [5]. As citizens, this population faces no immigration-based exclusion from healthcare or social services, though they may still face stigma and prejudice that hinders health care access [6]. Another 30% of foreign-born US residents are LPRs, with most being eligible for naturalization over time. LPRs are generally not eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage unless they have maintained their LPR status for at least 5 years. Twenty-three percent of LPRs are uninsured compared to 8% of US citizens [3].

A humanitarian immigrant (refugee and asylee) is a "person(s) who is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion" [7]. Humanitarian immigrants are eligible for LPR status after 1 year and naturalization after 5 years. While refugees apply for status outside of the US, asylees apply for status either within the US or at a port of entry. In 2017, 146,003 refugees and asylees adjusted their status to lawful permanent residents in the US, of whom 120,356 (82%) were refugees and the remainder, 25,647 (18%), were asylees, making up a very small percentage of all foreign-born persons living in the US [8]. Immigrants who are granted humanitarian status are generally eligible for Medicaid, CHIP, and other public benefits.

Undocumented US residents refer to residents who lack legal standing in the US and are at risk for deportation. More than 11.3 million undocumented people currently reside throughout the US [9, 10]. Among this population, 47% are women, and approximately 9% are minors. The majority of undocumented individuals are from Mexico (56%), followed by Central America (15%) and Asia (14%) [11]. Although children make up a small proportion of the entire undocumented US population, four million US citizen children have at least one undocumented parent [7].

## Evidence Basis

It is important for emergency medicine practitioners to recognize that immigration is a social determinant of health in its own right, in addition to being highly correlated with other social determinants. A large body of research highlights distinct behavioral and cultural characteristics of minority and immigrant subcommunities in influencing lifestyle practices and perceptions of health, healthcare, and illness [12, 13]. Such findings have led to an emphasis on cross-cultural understanding of individual patients in an attempt to decrease health inequities of marginalized populations [12]. In regards to immigration, this simplistic view of cultural competence overlooks the structural forces and structural violence that drive migration, impart physical and mental trauma, limit access to healthcare and services, and constrain healthy behavior [12, 14]. Therefore, structural competence—the ability to discern forces that influence health outcomes at levels above individual interaction—is imperative to emergency practitioners' understanding and promotion of health among immigrant communities [13]. Structural competency consists of: (1) recognizing the sociopolitical structures that shape clinical interactions; (2) developing a language of structure outside of the medical lens; (3) rearticulating "cultural" formulations in structural terms; (4) observing and imagining structural interventions; and (5) developing structural humility [12]. This process includes, but is not limited to, recognition of domestic policies that promote displacement and migration of foreign populations, including an analysis of historical and contemporary US military and neoliberal economic policies that undermine sovereignty (i.e., those policies that serve to destabilize foreign governments to extract and export wealth and natural resources). Relevant examples to the US context include US interventions in Central American conflicts at the end of the twentieth century and free trade policies such as the North American Free Trade Agreement (NAFTA) and the Dominican Republic-Central America Free Trade Agreement (CAFTA-DR) which have displaced millions of individuals from Mexico and Central America, and drive migration to the US [15, 16]. Research from a structural framework has focused mostly on immigration status affected by limited access to healthcare and health-protective resources, agnostic to these larger forces at the root of US migration [13].

### Limited Access to Healthcare

Rates of emergency department (ED) utilization are lower for noncitizens than for citizens; annual ED use rates are 12.2% vs. 15.4% and 19.3%, respectively, for undocumented individuals, naturalized citizens and US-born citizens [17]. Despite that, undocumented individuals remain uniquely dependent on the ED for care due to insurance barriers to outpatient care [18, 19]. Undocumented populations, including children, are explicitly excluded from expansion of eligibility for Medicaid and Medicare coverage under the Patient Protection and Affordable Care Act (PPACA) [20]. Participants in the Deferred Action for Childhood Arrivals (DACA) are similarly excluded from eligibility in most states [21]. More than 45% of non-elderly undocumented immigrants are uninsured [3]. As the overall percentage of

uninsured Americans decreases, the percentage of the uninsured population that is undocumented is predicted to increase to 25% [3, 17]. Though children of undocumented immigrants are eligible for services through CHIP, research has shown these children have both significantly fewer medical appointments and ED visits compared to children of US citizens [22, 23].

### Limited Access to Health Protective Resources

The undocumented immigrant is the most vulnerable when compared to documented immigrants, facing compounding layers of structural barriers that ultimately have negative impacts on health [24]. Multiple social, economic, and political factors framed by local or national policies affect immigrant health. Undocumented immigrants have fewer employment opportunities and are susceptible to extortion and workplace abuse as a result of working in the informal economy, which is exacerbated by a reluctance to report crimes to authorities due to fears of immigration enforcement [25]. They additionally have less access to educational opportunities and the social safety net, which includes assistance with food, wages, housing, health insurance, and healthcare systems in general [26]. Overall, undocumented persons have fewer opportunities for upward mobility compared to documented persons, leading to feelings of reduced agency and empowerment [18, 26, 27].

## Emergency Department and Beyond

Immigration status is both a structural and a behavioral barrier that permeates and disadvantages the immigrant globally by exacerbating all other social risks [13]. There are significant barriers to care before an immigrant becomes an ED patient. The ED visit represents a limited window of opportunity to direct patients to appropriate care and resources.

### Bedside

Emergency provider understanding and awareness is the linchpin in the care of the immigrant patient. Knowledge of the patient's risks, as well as structural competency, language competency, and the wherewithal to deliver care in a compassionate way reinforce patient-centeredness. Emergency providers can establish and reinforce the sanctuary state of the hospital and healthcare setting in the patient encounter. Sanctuary status of health care settings designates a safe space for care, with policies and a culture reducing cooperation with immigration enforcement [28]. Emergency physicians should realize that there might be a lack of trust in the healthcare setting. Undocumented immigrants cite a fear of discovery and deportation even in use of the ED, which worsened after the rhetoric and immigration policies following the 2016 US presidential election [29, 30]. Patients need to feel that their provider is concerned with their health and safety regardless of background, country

of origin, or immigration status [31]. Asking basic questions regarding insurance status and empanelment in primary care can be helpful. Specific follow-up care questions can also be useful surrogates for asking about documentation status, which requires the practitioner to develop local knowledge of the population (e.g., an undocumented person in California could be someone born outside of the country who is enrolled in limited scope Medicaid). Depending on state and local policies, there may be populations that are at high likelihood of being undocumented, and thus the ED visit presents an opportunity to offer both primary care enrollment resources together with immigration resources [32].

In addition, providers should recognize that while the medical record is protected by HIPAA, there are limitations to these protections. Notation of the patient's undocumented status in the medical record could imperil patients if accessed by immigration agencies, and also subject patients to stigma. Recognizing this risk, providers must be thoughtful about the purpose of including citizenship status in medical records, if it is to be included at all [31]. Unlike other social determinants of health where documenting or using ICD-10 codes can help determine the scope of the issue, immigration status is more delicate and nuanced. Proxies using insurance status and knowledge of local populations as discussed above need to be developed and validated based on local infrastructure and resources.

Specifically, providers should recognize that undocumented populations are particularly vulnerable to labor and sex trafficking in addition to other abuses. It is estimated that the majority (67%) of labor trafficking victims and a large (17%) percentage of sex trafficking victims are non-US citizens [33]. Their tenuous legal status creates barriers to leaving a dangerous social and work dynamic. Similarly, in nontrafficked undocumented patients, lack of legal status risks abuse including but not limited to domestic violence, wage theft, and unsafe labor conditions [25]. ED providers must maintain a high degree of suspicion regarding exploitation. It's essential to promote confidentiality by separating the patient from employers or domestic partners when obtaining a history [34]. Patients should be advised regarding their rights and offered referrals to appropriate local support services. Providers should be aware that undocumented victims of trafficking, domestic violence, torture, and other crimes may be eligible for adjustment to legal citizenship, which may support escape from exploitative conditions. While the complexity of immigration status adjustment falls beyond the scope of ED practice, providers should make referrals to legal partners, and emergency departments can establish medical–legal partnerships to improve identification of eligible cases [35].

Apart from the clinical setting, emergency providers can also be involved in advocacy for refugee and asylum seekers by performing forensic evaluations in conjunction with immigration attorneys to substantiate legal cases such as asylum claims. Medical asylum clinics can be an important site of medical–legal partnerships, where physicians can actively contribute to an asylum seeker's legal case. Working within the infrastructure of a local asylum clinic, an emergency provider can obtain training from organizations such as Physicians for Human Rights and can volunteer to perform these evaluations.

## Hospital/Healthcare System

At the hospital level, immigration-informed care starts with effective communication, which means providing adequate resources for those patients who have limited English proficiency (LEP) [36]. Despite demonstrating LEP in the clinical setting, immigrants are often treated in English or another language inadequately [37]. It is up to hospital systems to understand their demographics and provide appropriate resources for their patient populations (i.e., ensuring languages spoken are available from interpreter services). Intertwined with, and dependent on LEP, is health literacy [38]. Inadequate measures to accommodate LEP and reduced health literacy impede a hospital's ability to provide effective treatment to immigrant populations.

The hospital system must also mitigate barriers to immigrant patients entering the health care setting by creating a supportive and welcoming environment for this population. It is important to understand that the culture of fear has been layered on top of a baseline vulnerability, as demonstrated in a study in 2013 which showed that one in every eight undocumented patients reported fear of discovery and subsequent deportation during an ED visit [29]. Patients who are most vulnerable may be accessing the healthcare system as their only touch-point to any social or governmental services due to this culture of fear. The unique opportunity to deliver resources to an undocumented person or asylum seeker is rare and requires a cohesive system that is capable of addressing the needs of this special population without introducing stigma or reinforcing fear.

Overall, undocumented patients are more likely to be unfamiliar with the complicated US health system and to experience difficulty in navigating care. Patient navigator interventions have been successful in improving outcomes and overcoming this barrier [39]. Additionally, there is minimal literature documenting outcomes of efforts to reduce fear in healthcare settings, but there are multiple case examples of best practices. Making hospitals "sanctuary sites" may improve use of healthcare and decrease fear among immigrant populations [28, 40]. New York City has pioneered methods of communicating with immigrant communities, with signs declaring "You are safe here" and "We care about your health not your documentation status" in healthcare settings, as well as publishing an open letter to immigrants explaining the importance of healthcare and ensuring their safety from immigration enforcement in health settings [41]. New York City also offers free or low-cost health coverage to all residents regardless of ability to pay or documentation status [41]. Some health systems have also issued statements noting that they will not cooperate with Immigration and Customs Enforcement (ICE), and others have prepared trainings to help providers respond to protect patients if ICE officers attempt to use health facilities for enforcement activities [28]. Patient-centered programs like these can be developed in conjunction with community immigrant advocacy organizations that can hone the messaging, and aid with receptivity among patients.

Emergency department and healthcare systems can develop an immigration-informed social referral pathway to intervene upon the structural barriers that these patients face. This can be done through medical–legal partnerships or in

conjunction with local legal and community advocates [32, 42]. A sensitive and discreet screening process for undocumented status and other structural barriers should be combined with effective referrals to community-based immigrant rights organizations, immigration legal advocacy and other forms of community-based accompaniment and care navigation. This type of referral system should not be dependent upon the emergency provider alone but upon the emergency department system of care, including social workers, case managers, community health workers, and financial services.

The ED at Los Angeles County + USC Medical Center uses this model to offer undocumented patients immigration legal services [32]. The patient who remains uninsured, as in "residually uninsured" after expansion of the Affordable Care Act, represents a patient with a high likelihood of being undocumented. This categorization is used as a proxy for undocumented status, and enables providers to focus on referral to a co-located community resource center for insurance and primary care enrollment, as is standard practice in this ED. Patients are met by structurally and linguistically competent staff at the co-located resource center, where they are presented with options for insurance enrollment. If they are only eligible for the county level primary care access plan (a program for undocumented persons), they are offered immigration legal services referral. Similar programs are necessary for EDs to address upstream factors of disease and ultimately practice more immigration-informed care, but they start with research of the local immigrant access infrastructure in order to discreetly direct and refer undocumented patients to needed resources.

## Societal Level

At this time, the rights and vulnerabilities of immigrant populations in the US are closely tied to their documentation status [43]. The various levels of documentation from undocumented immigrant to naturalized US citizen have corresponding levels of opportunity within our society. While federal policies largely define the scope of public benefits available to immigrant populations, state and regional institutions can mediate the impact on their constituents. In the case of healthcare, the Affordable Care Act largely excludes health insurance access to undocumented populations [20]. States and local municipalities sometimes find ways to fund health care for this population (i.e., emergency and hospital-based care for acute health events can still be covered by Emergency Medicaid in some instances) [44]. Structural barriers to health insurance, preventative care, and routine care promotes use of hospital and emergency services for catastrophic care [26, 27]. This is exemplified in undocumented hemodialysis dependent patients. Those living in municipalities that only provided emergency hemodialysis suffered a 14-fold increase in mortality compared to those living in a municipality that funded standard regular hemodialysis [45]. This highlights not only the health impact of constraining services to immigrant populations but also the possibility of state and regional bodies in mediating the impact.

Federal anti-immigrant political rhetoric has been tied to a perceived lack of safety amongst both documented and undocumented ED patients [30]. This sense of societal prejudice and insecurity permeates communities and has been linked to increased anxiety and depression, and higher mortality in both documented and undocumented Latinx immigrant populations [6, 46]. Increased ICE enforcement and presence in the news also portends detrimental mental and physical health outcomes among undocumented immigrants [47–51]. Fear and perceptions of discrimination undermine trust in social institutions such as health care, social services, and law enforcement, leaving immigrant populations vulnerable to both crime and poor health outcomes [30, 49].

The impact of anti-immigrant political rhetoric on health seeking behavior has been well documented. In 1994, California passed Proposition 187 which barred undocumented immigrants from using nonemergency services. In response, Latinx populations responded by seeking fewer low acuity and preventative mental health care visits, but increasing amounts of high acuity visits [52, 53]. In Arizona, Senate Bill 1070 increased leniency for traffic stops by law enforcement for immigration purposes. The passage of the bill was associated with decreased prenatal and well-child visits, and interval reductions in birth weights in local Latinx populations [54, 55]. In Georgia, the passage of House Bill 87 which granted local law enforcement the authority to enforce immigration law resulted in a fewer number of Latinx pediatric ED visits, but increased visit acuity and hospitalization rates [56]. These studies exemplify the risk of anti-immigrant rhetoric and legislation in exacerbating inequities in care by deterring care seeking behavior. Consequently sociopolitical conditions may drive patients to defer preventative and routine care until disease progression demands higher acuity ED care [57].

Minimal healthcare utilization as a result of structural barriers and behavioral de-incentivization through anti-immigrant rhetoric have recently been exacerbated by the February 2020 expansion of the *public charge* rule, which introduces immigration enforcement consequences for use of health-related services [58]. The proposed rule creates immigration consequences for use of foundational health assistance programs including: housing assistance such as housing support (Section 8) vouchers, cash assistance programs, food stamps, and long-term care facility use through payment programs including Medicaid [59]. These changes are likely to discourage patients from seeking safety net resources that are both high value from a health standpoint and necessary for ensuring a baseline level of subsistence, especially among needy families and children [60–62]. Not only undocumented immigrants, but mixed documentation status families are likely to be discouraged from using resources because of the fear of enforcement against family members [23, 62]. This includes patients who are citizens or legal permanent residents, who may reduce their own use of vital and high value services in an effort to indemnify their less documented family members against immigration enforcement [62]. Public charge compounds an already difficult pattern of access for these patients, underscoring the importance for ED providers to make the most of the emergency department presentations.

Of special consideration especially in recent times is the population of refugees and asylees. This group has experienced a high rate of violence and trauma in their

home countries, which has significant effects on mental and physical wellbeing [63, 64]. While processes exist to provide some protection and access to services once their cases are approved, the system is currently overwhelmed with a backlog of cases and more frequent denial of status, compounded by increasing impediments to approval. Witnessing or experiencing violence is more common now in migrants who seek safety in the US than in migrants presenting in previous years [65]. Emergency providers should recognize that this special vulnerability to victimization and violence does not belong only to those officially recognized as refugees and asylees, but to a large percentage of foreign-born persons in the US.

Our role as emergency providers begins with using an equity lens to approach each patient as deserving of care and resources and not respond to external hierarchies of deservedness in our society [66]. Educational resources can then be used to inform ourselves about immigrant health and how current policies may affect those barriers [55]. It is important for immigrants and undocumented populations themselves to be included in informing health practices and policy. This may include the creation of a hospital community advisory board, appointment of immigrants to leadership positions, partnership with local health advocacy organizations, and using community-based participatory research methods to study ongoing care [67]. Grounded in these relationships, medical providers can intervene upon barriers, improve messaging, and create welcoming health-centered language to reassure patients about our therapeutic alliance [68, 69]. Efforts to improve the health of these populations without the involvement of immigrant community voices will not only perform poorly but also violate the equity premise in which the effort is rooted [70]. Relationships between community-based organizations and healthcare providers can provide local-, state-, and national-level opportunities for policy advocacy and activism, as well as training future healthcare providers [71].

## Recommendations for Emergency Medicine Practice

### Basic

- Create a welcoming and supportive environment for immigrants that extends from the bedside throughout the hospital. Include adding signage and messaging throughout the hospital campus that assures equitable treatment and confidentiality.
- Ensure language justice and appropriate translation services.
- Understand your local context: who are the immigrant populations at risk, what are their health care utilization patterns and what are the specific barriers to health they face, including health insurance access barriers? This will allow individualized responses to structural barriers relevant to the local immigration context
- Connect with local immigrant advocacy groups that can inform the ED and provide patient perspective to move care upstream for these patients. Ideally, this connection would provide the foundation for a larger community partnered

relationship, but at minimum, it can be a vital source of information about how to tailor care in the ED to immigrant patients' needs.
- Recognize that certain undocumented patients may be eligible for legal status change due to their presenting trauma and warrant referral to legal service providers.

## Intermediate

- Advocate for healthcare settings to be free of anti-immigrant enforcement and anything else that might discourage health utilization. Lobby local health municipalities to make healthcare settings sanctuary sites [40].
- Create referral pathways to remove barriers to healthcare access. Determine which community support organizations serve immigrant populations and create direct conduits from the ED to those places of care.
- Develop relationships with federally qualified health centers or analogous clinics that are hubs for the care of undocumented patients and streamline referrals to them [72].
- Advocate for your municipality and hospital system to provide specialized pathways of care coverage for undocumented immigrant patients, and to have transparent insurance or fee systems to support immigrants' use of needed health care. Arguments can be made to the county level that preventative and primary care access can be cost saving over time. In counties or states without coverage programs for certain immigrant groups, hospitals may have to set up their own systems of charity care [73].
- Advocate for adoption of a patient advisory board model where patients can provide feedback on hospital decisions and advise implementation of programming across the hospital. Lobby hospital administration to have undocumented or immigrant community representation.
- Ensure that your ED and hospital administrators are aware of the expansion of the public charge rule and its implications for patients' access to care. Advocate that frontline staff who may interact with services subject to public charge such as patient financial services, registration and social work personnel are aware of the expanded rule and can avoid imperiling patients' immigration status. For example, social work staff need to know that if they offer Section 8 housing assistance to a patient, they should explain the public charge risk if the patient is undocumented.

## Advanced

- Build a system of screening and referral of patients to medicolegal partnerships from the ED [74]. Use the knowledge of barriers and local environment to target resources to immigrant patients in a culturally appropriate and unintimidating way. The LA County + USC medical legal partnership is one such example.

- Seek or provide training for individual physicians in forensic medical evaluations through organizations like Physicians for Human Rights or Healthright International and work with lawyers to substantiate asylum legal cases.
  - Form an asylum clinic with other trained physicians to receive referrals from local lawyers to perform forensic asylum evaluations [75].
  - Develop systems of detention advocacy for asylum seekers and other detainees, which can be analogous to asylum clinics but focused on identifying and advocating for those who require release from detention on health-related grounds.
- Organize as healthcare providers and advocates that immigration be treated as a social determinant of health and that we should be concerned about access within this population based on our duty to advocate for population and public health [76]. Organize healthcare providers to engage with domestic policies that drive migration and imperil migrants (i.e., military interventions, neoliberal trade policies, and border militarization).
- Push national organizations and advocacy groups to support expansion of health insurance to undocumented immigrant populations and denounce anti-immigrant rhetoric and legislation such as public charge [44]. Create spaces and positions of power for immigrant communities to inform health practices and policy.
- Develop community-based participatory research in conjunction with relevant community-based organizations to evaluate how effectively community conduits and care management programs improve patient outcomes, reduce ED recidivism, and encourage high value care.

## Teaching Case

### Clinical Case

A 38-year-old female presents to the ED after a six-foot fall from a ladder. She could not ambulate at the scene. Because she is distraught when providers attempt to examine her and will not communicate what happened or where she is most hurt, she receives CT scans of her head, c-spine, thorax, abdomen, and pelvis. She is signed out to you as the oncoming doctor pending the radiology reading of her CT scans. You enter the room to find a patient with a vacant stare. You attempt to engage her and she screams, "¡No me toca!" Her sister is at bedside and with the help of the interpreter you ask her about the patient and what could be going on.

She reveals the patient's backstory. She is originally from El Salvador where a predominant gang was extorting her. They came every week asking for a higher amount, until she was unable to make enough money to pay the fee. She feared for her life and in an attempt to escape their extortion and threats, she paid a coyote (smuggler) to smuggle her and her children into the US. Midway through the journey, the coyote sold her to a drug cartel that held her in captivity for 10 months. She was repeatedly sexually and physically assaulted while her family in the US collected enough money to pay a ransom. She was then freed and brought to Los Angeles. Her sister describes how she hasn't been the same since this experience and she has significant residual mental health issues, including intermittent episodes

where she seems to go blank like in today's presentation that resemble flashbacks. These episodes are increasingly affecting the patient's ability to function and especially to parent, so other family members often watch her children. The family has been trying to convince her to seek medical help and especially mental health care, but she is too afraid of deportation and the thought of returning to the nightmare she escaped.

She works cleaning houses to help support her family. Today's fall happened at work. She was asked by her employer to clean the windows on the outside of the house. Despite pleading that she didn't know how to use a ladder, the boss insisted. She complied for fear of losing her job, as work has been hard for her to find due to her lack of documentation.

The patient's CT scans are read as negative. After time, reassurance, and anxiolytic medications, the patient is able to engage in conversation and returns to her baseline mentation. After offering her several community resources, you are able to have the social worker connect her with a local federally qualified clinic that specializes in care for this population and with a local immigrant rights organization. Through these organizations, she receives treatment of her psychiatric disease with medication and therapy. She is also connected to immigration legal services where, with their help, she submits a trafficking visa application to acquire legal status.

**Teaching Points**

1. Immigration is an important and often under-recognized social determinant of health.
2. Undocumented patients are largely excluded from public services, including, but not limited to, health insurance.
3. The ED has become a primary touch-point for this population, as a social and health care safety net.
4. In certain cases, undocumented individuals may be eligible for asylum or other pathways to legal permanent residence and naturalization if connected to appropriate legal partners.

**Discussion Questions**

1. In this scenario, what are the barriers to health and health care encountered by the patient? What are some barriers in your ED and health system when taking care of the immigrant population?
2. Please compare a cultural competence and structural competence lens for reviewing this case. Do the resulting interventions differ?
3. Blueprint what an emergency department and health system might look like to best meet the needs of this patient. What avenues may be available in your ED, health system, and local community for collaborative work to help the undocumented immigrant population?

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