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SDOH and Immigration Status

Offering Advocacy and Adhering to Ethical Practice Across the Care Continuum

Michelle Baker, BS, RN, CRRN, CCM, Vivian Campagna, DNP, RN, CMGT-BC, CCM, ICE-CCP, and Ellen Mitchell, MA, RN, CCM

ABSTRACT

Purpose: Social determinants of health (SDOH), the environmental, economic, and social factors that influence people's health outcomes, are widely recognized across health and human services. In addition, there are other factors that can exacerbate SDOH; among them is immigration status. Its influence is so profound that it has been suggested that immigration be considered an SDOH in and of itself (National Academies of Sciences, Engineering, and Medicine, 2018). Across the continuum, case managers need to be aware of the immigration status of their clients (the individuals for whom they advocate and provide services). This is particularly important when addressing the care needs and discharge plans for clients in acute care, community-based health, and workers' compensation. With workers' compensation, when an individual is undocumented and severely injured, immigration status directly impacts the services they may receive under state mandates. Moreover, such limitations can present ethical dilemmas for case managers, including what happens to workers if they are returned to their home countries.

Primary Practice Settings: SDOH and immigration status can impact individuals in acute care, subacute care, community-based care, and workers' compensation.

Implications for Case Management Practice: SDOH and immigration status highlight the disparities that exist within health and human services. Although equity is a core value of case management practice, the case manager's ability to provide equal access to care and resources can be severely limited because of the individual's immigration status. At all times, case managers must practice within their licensure and certifications. By recognizing that immigration status should be an SDOH, case management professionals and health and human services organizations can elevate the discussion of how to care for individuals with catastrophic injuries and illnesses who are undocumented.

Key Words: *acute care, case management, case management process, discharge planning, guardianship, immigration, medical repatriation, SDOH, social determinants of health, workers' compensation*

As advocates in care settings across health and human services, case management professionals must be cognizant of the impact of social determinants of health (SDOH), defined as the economic, environmental, and social conditions in which people are born, work, live, develop, and age (Campagna et al., 2022). Beyond the widely recognized SDOH, such as poverty, lack of education and literary skills, and substandard living conditions, there are also broader forces and systems that impact people's daily lives and health; among them is immigration status. Immigrants who struggle with English language skills and employment opportunities, particularly those who are undocumented, face challenges that further compound the economic, social, and environmental influences on their health and well-being. The negative impact of immigration status can be so profound that researchers have suggested it can also be considered an SDOH (National Academies of Sciences, Engineering, and Medicine, 2018).

Conflict and war, persecution, economic upheaval, natural disasters, and climate change can lead to displacement of people who are forced to leave their home countries and migrate elsewhere. Such upheavals are adding to a rise in international migration, which grew to 281 million in 2020, for a total of 3.6% of the global population living outside the countries in which they were born, according to the United Nations' International Organization for Migration, as cited in Natarajan et al. (2022). Such statistics provide a compelling picture of global migration trends that show no signs of abating.

Address correspondence to Vivian Campagna, DNP, RN, CMGT-BC, CCM, ICE-CCP, c/o Commission for Case Manager Certification, 1120 Rt. 73, Ste 200, Mount Laurel, NJ 08054 (ccmchq@ccmcertification.org).

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Immigration is a political issue. In the United States, federal government policies have a direct effect on immigration, such as the number of people allowed to emigrate to the United States, as well as border enforcement and deportation practices. Commentary on such policies is beyond the scope and intention of this article. However, case managers need to be cognizant of immigration trends and debates over immigration-related issues because of the impact on some members of the populations they serve. More specifically, and central to the argument of this article, case managers in every care setting need to take immigration status into consideration just as they would any SDOH. This is particularly important when advocating for individuals in care settings such as emergency departments/acute care, community-based health, and workers' compensation. In these care settings, immigration status often has a direct impact on care provision and discharge planning, especially for people who are undocumented.

Challenges for the Undocumented

Metchnikoff et al. (2018) described the challenges faced by many who are undocumented, uninsured, and unable to obtain the care they need, including substandard living conditions, occupational hazards, little access to health care, scarce social and financial supports, fears of deportation, and potential discrimination. Against this stark backdrop of daily life for many undocumented individuals and their families, case managers who advocate for them may find themselves in ethical dilemmas. They can be caught between ethical principles such as beneficence, which compels them to act in the best interest of the client, and the reality that immigrant status is a barrier to accessing care. Examples include the inability to place in a subacute facility an individual who needs to be discharged from a hospital because that patient lacks a payer source, or an undocumented worker whose benefits under workers' compensation are restricted by state law and cannot receive the vocational support they need after suffering a severe injury.

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For case managers who come from helping professions such as nursing and social work, restrictions on the services they can extend to people in need of them can be frustrating and upsetting. Furthermore, certain practices in the health care industry, including medical repatriation by a hospital, can put case managers in a legal gray area. Although there are no easy or obvious answers to these dilemmas, case managers do need to be aware of the practices of their organizations and what they can and cannot do under their licensure or certification, as well as in accordance with the law.

Immigrant Status and Workers' Compensation

Case managers who specialize in workers' compensation often have experience advocating for recent immigrants, including undocumented workers, when they become injured on the job. Workers' compensation is state mandated, and statutes vary from state to state. Regarding undocumented workers, most state courts have ruled that they are eligible for some workers' compensation benefits such as payment of their medical expenses, provided that the employer is covered by workers' compensation (Ceniceros, 2014). However, even when undocumented workers are eligible for workers' compensation benefits, they may be reluctant to report a work-related injury. A U.S. Department of Labor (2016) study found that undocumented workers were unlikely to file a claim, even in instances of work-related injuries that resulted in amputations, and linked such reluctance to fear of recrimination or threat of deportation. As a result, undocumented workers may not seek treatment until there is a complication, such as an infection, which often results in them seeking care at a hospital emergency department (a scenario that is discussed later in this article).

Limitations on their workers' compensation benefits and reluctance to file a claim compound the risks for recent immigrants and those who are undocumented. These individuals are often employed in physically demanding and sometimes dangerous occupations that put them at risk of severe or catastrophic injury. Among these occupations, agricultural jobs pose several hazards, such as accidents involving heavy equipment, exposure to pesticides and other chemicals, and falls from ladders. According to the Center for Migration Studies (Rosenbloom, 2022), 86% of workers in the U.S. agricultural sector are foreign-born and 45% of workers in agriculture are undocumented. The Center has estimated the number of undocumented immigrants working in

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agriculture in the United States at 283,000, accounting for 4% of the total undocumented workforce in the United States (Rosenbloom, 2022). A National Occupational Research Agenda (NORA) study determined immigrant farmworkers to be a vulnerable population, because of limited English proficiency, low levels of education and job training, and often being undocumented (NORA, 2018). Other occupations frequently held by undocumented workers include construction, as both laborers and carpenters, which also poses higher than average risks for occupational injuries (Hall & Greenman, 2015). When these workers suffer catastrophic injuries, state laws will determine what they are eligible for in terms of workers' compensation benefits, making it imperative that case managers who work with them be well versed in state statutes, particularly when the injured worker is undocumented.

Case Study: 21-Year-Old With TBI

Consider the case of a 21-year-old man from Central America who was an undocumented laborer working construction. He suffered a traumatic brain injury (TBI) and other severe injuries during a fall while on the job. Because of the severity of his case, the workers' compensation insurer assigned a case manager to advocate for him and manage his care, including a discharge plan from acute care to rehabilitation and then back into the community. His case, however, presented several complications, particularly for discharge planning. Based on his capacity at the time, the TBI made it impossible for the man to make informed decisions for himself. In addition, he did not have any family or other support system members in the United States who could act as a proxy on his behalf. His closest associates were several other men who shared the small apartment where he lived, but none were related to him.

After extensive outreach, the case manager was able to contact a family member in Central America who agreed to come to the United States on a temporary visa to care for the man postdischarge from the hospital until he was well enough to be transported back to his home country, which was the desire of the man and his family. The level of care the man would receive in his home country was questionable, given his chronic need for follow-up to keep from losing the progress he had made; however, the case manager's ability to advocate for him was limited by his immigration status. Once he left the United States, all workers' compensation benefits ceased and no follow-up by the case manager was possible.

As this example shows, a case manager may be able to help obtain emergency visas for a family member (e.g., a parent or spouse) to come to the United States for a short period of time to care for the injured worker. This process, however, is difficult and the arrangement is temporary as the visa will not allow for a permanent stay. In such instances, the injured worker usually returns to their country of origin, if possible. These transfers can be very difficult to coordinate when the individual has been severely or catastrophically injured, and medical resources could be limited in the home country. Nonetheless, with few options and being away from their family and community, the injured worker often chooses to go home. The case manager must abide by the person's desires and goals. Other individuals may choose to stay in the United States in a long-term living situation with assistance, alone without family or resources, if they are in a jurisdiction that supports such care. It is crucial that the case manager engage as many community resources as possible with the injured worker to assist with financial, psychosocial, and spiritual needs.

Support for Injured, Undocumented Workers

Another key question for the case manager to consider is how much workers' compensation insurers will assist within jurisdictional guidelines. In the case of a catastrophically, in the case of a catastrophically injured individual, a workers' compensation insurer may be willing to pay for some services to avoid continuing costly hospitalization. For example, if an injured worker lives in an apartment or other housing that is inaccessible (e.g., with several flights of stairs), the insurer may agree to provide temporary housing to allow that individual to be safely discharged from inpatient treatment and receive rehabilitation and physical therapy on an outpatient basis. To facilitate this transition, the case manager may have to find creative solutions, such as an extended-stay hotel or other accessible housing.

There may be other ways for the case manager to access support and services for the person in the community. For example, the injured worker may request outreach to a particular church or spiritual community, which the case manager can help facilitate to provide emotional support. There may also be community groups that offer legal assistance to help with the individual's immigration status, or there may be volunteer groups that can help the individual with their English language difficulties.

The most difficult cases, however, are often those in which there is no legitimate workers' compensation coverage, even though the worker was told there was, or the employer is so small that a major injury would bankrupt the company and coverage would cease. This sad situation happens all too often, and in those instances, case managers usually try to do what they can, though interventions and services will be limited.

As this discussion shows immigration status is a direct determinant of the care, treatment, and other resources an injured worker is entitled to receive under state law. This adds further support for viewing immigration status as an SDOH to ensure its inclusion in discussions around health equity.

The Acute Care Conundrum

Case managers who specialize in acute care also face difficult challenges because of the immigration status of the person who is hospitalized. When individuals are undocumented, they are ineligible for Medicaid or Medicare and cannot buy insurance through marketplaces established under the Affordable Care Act. However, Medicaid may pay for treatment of emergency medical conditions for persons who do not qualify due to immigration status, provided that the person meets the state's income and residency requirements (Centers for Medicare & Medicaid Services [CMS], (n.d.-b). Regardless of their immigration status or ability to pay, the Emergency Medical Treatment and Labor Act (EMTALA) requires that individuals who go to a Medicare-participating hospital with a dedicated emergency department must be treated (CMS, n.d.-a). However, when a serious injury or illness is involved, these cases can become highly problematic for the hospital and the care team, including the hospital-based case manager.

Case Study: Undocumented and Working "Off the Books"

A man worked in a bodega, a neighborhood grocery store in a Spanish-speaking neighborhood of New York City, where a piece of equipment fell from a high shelf and hit him on the head. Knocked unconscious, he was taken to a hospital where he was diagnosed with a TBI. When the man's wife arrived at the hospital along with a family friend, they spoke to the emergency department staff through a translator, repeating what the bodega owner had said: "The man will take care of it."

The hospital case manager and the social worker asked clarifying questions, trying to discern who "the man" was and eventually learned this referred to "the government." But that was not what happened with this man. Although the accident involved a workplace injury, he was an undocumented worker who performed "undocumented work," meaning he was paid in cash and was never on the books. Therefore, he was not covered by workers' compensation. Although the hospital must treat him, the legal obligation to provide care stopped at acute care.

What happens next to undocumented and uninsured individuals is a gray area for hospitals. Because hospitals cannot refuse care, these individuals may end up being hospitalized for an extended period, even years. Consider a 75-year-old Liberian immigrant who suffered from dementia. Although her caregivers would have preferred for her to be transferred to a skilled nursing facility, her immigration status (she had first been considered a refugee from violence in her home country but was not granted asylum) made her ineligible to receive long-term care in Massachusetts where she lived. As of the publication date of the news article describing the woman's case, she had been in an acute care hospital for 3 years (Jolicoeur & Mullins, 2021). Such cases pose a conundrum: How to provide care to someone who should be discharged safely, but there is no place to which they can be transitioned for the next level of care. As hospitalization continues, the financial burden on the hospital compounds, without reimbursement.

Pursuing Guardianship

There are few options available to hospitals; among them is guardianship, a legally complicated procedure whereby the hospital applies to have a legal guardian appointed by the court for the patient. When a guardianship is approved and a guardian appointed, that guardian then has the legal authority to make decisions on behalf of the individual, such as transferring them to subacute or long-term care. In such instances, a hospital may work with the guardian and arrange to pay for care in a nursing home because the per diem at a subacute facility is far less than the cost of care and lost revenue in an acute setting.

Two associate general counsels for Boston Medical Center (BMC) Health System wrote of their hospital system's policies for pursuing guardianship for

patients lacking a support system, including people who are homeless and/or recent immigrants. After implementing a new policy and procedures, the attorneys wrote, the average length of stay for individuals needing guardianship decreased by 75%, from 150 to 39 days. This compared with a hospital-wide average length of stay of 5 days. They wrote, “In extreme cases, some patients without guardians have stayed at BMC for more than a year after they were ready for discharge” (Langlois & Yacovone, 2019, p. 2).

Medical Repatriation

Another option is to pursue repatriation. This is often viewed as a controversial practice and can pose an ethical dilemma for case managers and others on the care team. Only the federal government has the authority to deport someone to their country of origin. However, hospitals can pursue medical repatriation on the grounds that the individual has no other care options in the United States. For the hospital, this issue is a matter of economics: They cannot afford to have someone occupy a hospital bed indefinitely.

An often-quoted 2008 *New York Times* article described the medical deportation of a Guatemalan man who was repatriated by the hospital that treated him. After the man sustained very serious injuries in a car crash, a Florida hospital had kept him as a patient for several years, at a cost of $1.5 million. Although highly critical of the practice of medical deportation, the article did summarize the difficulty hospitals face in such cases:

> Many American hospitals are taking it upon themselves to repatriate seriously injured or ill immigrants because they cannot find nursing homes willing to accept them without insurance. Medicaid does not cover long-term care for illegal immigrants, or for newly arrived legal immigrants, creating a quandary for hospitals, which are obligated by federal regulation to arrange post-hospital care for patients who need it. (Sontag, 2008, p. 2)

Without a rehabilitation center willing to take the Guatemalan man as a patient, he was medically repatriated back to his country. Once back in Guatemala, however, his family told reporters that the man received no rehabilitative care, despite the fact he has a TBI (Sontag, 2008).

Not all medical repatriations result in poor outcomes. Writing for *National Public Radio*, Dr. John Henning Schumann (2016), who practices in Tulsa, OK, described his experience caring for a man in his 50s who suffered paralysis in half his body following a stroke. He could not live on his own or care for himself, even after weeks of intensive therapy. The ideal plan, Schumann said, would have been to arrange discharge from the hospital to a rehabilitation facility. However, the man was an immigrant who had entered the United States illegally and he did not have insurance. Without a payment source, no other facility would take the man as a patient, and his immigration status precluded an outside charity to cover his costs of care. The hospital decided to pursue repatriation to Mexico for the man to receive rehabilitation, at a cost of $50,000 for medical air transport. Schumann stated that, from the hospital’s point of view, transferring the man to Mexico would stop “the indefinite, uncompensated costs of continued hospitalization,” while freeing up a hospital bed, presumably for an insured patient (Schumann, 2016, p. 3).

The patient consented to the transfer, and his family in Mexico also agreed to the plan, and after the transfer was completed, the man arrived at a rehabilitation hospital not far from his hometown in Mexico (Schumann, 2016). A takeaway from this example is that consent is key to the appropriateness of repatriation and acknowledges patient autonomy, as long as the patient understands the choices offered.

Hospitals continue to face the decision of what to do for an undocumented individual who has been a patient for an extended period of time and needs to be discharged to another setting, but no alternatives can be found because of the person’s immigration status. It is beyond the scope of this article to weigh in on the legal arguments surrounding medical repatriation, which sometimes result in lawsuits (as in the case of the Guatemalan man). However, it must be acknowledged that case managers could find themselves enmeshed in the repatriation process, such as identifying care resources in the home country and helping to arrange the transfer. This can put case managers into a difficult situation ethically: sending individuals back to their country of origin without any assurance that they will receive the necessary care.

A takeaway from this example is that consent is key to the appropriateness of repatriation and acknowledges patient autonomy, as long as the patient understands the choices offered.

As with so many issues surrounding immigration and other SDOH factors, there is no easy solution. The health care system is trying to manage the unmanageable amid the reality of financial burdens that can spiral into millions of dollars per patient. It is not for us, the authors of this article, to impose our personal views into medical and legal gray areas. However, it is a reminder for all case managers of the difficulty of navigating ethical issues amid the complexity of health and human services today.

Ethics and Health Equity

Issues such as SDOH and immigration status highlight the disparities that exist within health and human services. At issue is the concept of equity, which has implications far beyond equal access to resources such as equality in receiving treatment once they enter a hospital. As Quick et al. (2023) observed, "Equity, however, looks at how—and if—a person can get to the door of the hospital. Financial, environmental, mobility, and other barriers can stand in the way, preventing access" (p. 7). Immigration status, particularly when viewed as an SDOH, is often a significant barrier.

Equity is a core value of case management practice. As the Code of Professional Conduct for Case Managers (Code) from the Commission for Case Manager Certification (CCMC, 2023) states, "In pursuit of health equity, priorities include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health, and facilitating safe care transitions" (p. 3). In addition, the overarching principle of advocacy calls on case managers to practice at the highest of professional standards to promote equity, particularly among vulnerable and underserved individuals. This can be summed up in the first two principles of case management, as articulated in the Code: "Board-certified case managers will place the public interest above their own at all times" and "will respect the rights and inherent dignity of all their clients" (CCMC, 2023, p. 2).

When the client is undocumented and uninsured, however, the case manager's ability to promote equity and provide equal access to care can be severely limited. This type of ethical dilemma is hard for any case manager to reconcile. Support can be found from the ethics committee within the organization (e.g., the hospital) for which the case manager works and/or from case managers, such as a supervisor, who have experience with these situations. In addition, guidance can be found within the Code, itself, and another of the principles of practice: to "obey all laws and regulations" (CCMC, 2023, p. 2). Although it may offer little consolation emotionally during a difficult case, the truth is case managers *must* practice within the bounds of their licensure and certifications.

Greater awareness of the issue, however, can also lead to action. By recognizing that immigration status should be considered an SDOH, case management professionals and health and human services organizations can elevate the discussion of how to care for individuals with catastrophic injuries and illnesses who are undocumented. This is particularly important amid the ongoing political debates around immigration and frequent challenges to state workers' compensation laws that provide reimbursement for expenses to treat undocumented workers. By keeping the focus on immigration status as an SDOH, we can broaden the health equity discussion to include more of the populations served by case managers across the care continuum.

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Michelle Baker, BS, RN, CRRN, CCM, is a commissioner and a former chair of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists with its CCM and CDMS credentials. She is also Director, Clinical Network Operations, for Paradigm, where she manages workers' compensation catastrophic nurse case managers.

Vivian Campagna, DNP, RN, CMGT-BC, CCM, ICE-CCP, is the Chief Industry Relations Officer of the CCMC. With more than 30 years of case management experience, Vivian spent much of her professional career in acute care case management, before joining the Commission.

Ellen Mitchell, MA, RN, CCM, is the Director for Industry Relations for the CCMC. She has more than 25 years of experience in the field of hospital case management and holds a master's degree in acute care nursing.

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