

# A Collaborative Report on the Aging Undocumented Population of Illinois



## **Rush University Medical Center**

Rush Center for Excellence in Aging

Department of Social Work & Community Health

Center for Community Health Equity

Department of Preventive Medicine

Rush Alzheimer's Disease Center

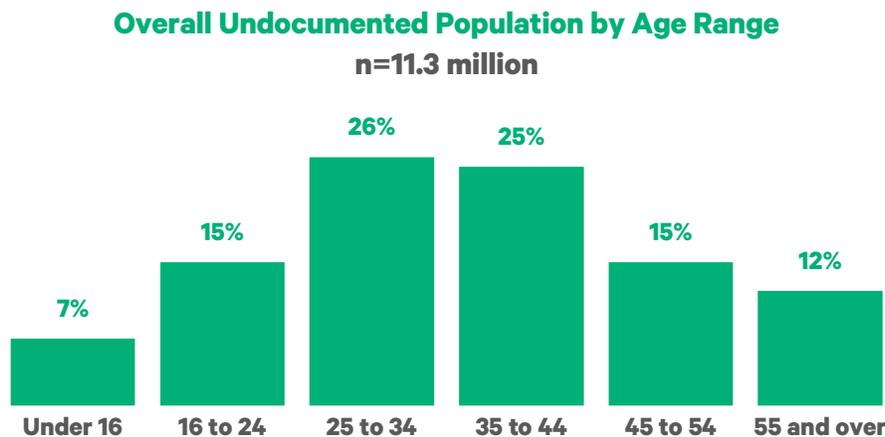
**Rob Paral & Associates**

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# Introduction

A study from the U.S. Census Bureau predicts that the population of individuals over the age of 65 will grow substantially by 2030 and will more than double by 2050 (Ortman, Velkoff, & Hogan, 2014). This report made waves throughout the aging network<sup>1</sup> and became a catalyst for change and awareness. Meanwhile, figures from the Migration Policy Institute demonstrate many of 11 million undocumented individuals living in the United States fall within similar age stratifications as the general population mentioned in the 2014 U.S. Census Report (Migration Policy Institute, 2018).



Source: Migration Policy Institute (2012-16 American Community Survey and the 2008 Survey of Income and Program Participation)

Existing calculations from reputable sources, such as the Migration Policy Institute, as seen above, currently group all undocumented immigrants age 50 and older together in their estimates of the current population. However, in the field of health care and aging, we know the aging experience varies widely between age brackets, as well as by social determinants of health. Those of us who work with the immigrant community, and particularly those of us with undocumented loved ones, know the reality already— **the undocumented population is aging.**

Undocumented individuals face pervasive and structural barriers due to their immigration status that block them from the services older adults depend on to successfully age in place. Meanwhile, Illinois has among the highest populations of U.S. undocumented individuals (400,000+). The movement of the population into senior years has substantial implications for public systems of health, health care and social services throughout the state.

**This report explores how the undocumented population in Illinois will continue to grow by 2030, as well as discuss in depth the implications of that data.**

The Rush Department of Social Work & Community Health, the Rush Center for Excellence in Aging, the Rush Alzheimer’s Disease Center and the Center for Community Health Equity decided to collaborate on a project to better understand the current undocumented older adult population and estimate its expected growth over the next

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<sup>1</sup> The “aging network” refers to the network of organizations and agencies that serve, advocate for, and study older adults and caregivers of older adults.



Ananias Ocampo, 76, pushes his cart along 18th Street to Paulina Street to sell ice cream in Chicago's Pilsen neighborhood on Sept. 25, 2020. Ocampo has arthritis, diabetes and osteoarthritis. (Zbigniew Bzdak / Chicago Tribune)

decade. These aforementioned partners at Rush University Medical Center worked with Rob Paral & Associates to find these estimates, and subsequently convened a collaborative of individuals with both personal experience, as well as professional experience working with the undocumented community, older adults, and/or their intersections.

As the U.S. population ages, and the older adult population diversifies ethnically, racially, linguistically and economically, this will also include the aging of the undocumented community. This report strives to take into account the aging of the undocumented community, specifically when we discuss the future of aging and health care services.

**This report includes the first estimate of Illinois' current undocumented older adult population, as well as calculations of how the population will continue to grow.**

## About This Report

The demographic portion of the report was completed by Rob Paral of Rob Paral & Associates, and the Rush team convened a cross-sector collaborative to advise the group throughout the stages of the project, as well as to interpret and discuss the implications of an aging undocumented community. The collaborative included community and organizational leaders from the sectors of senior and social service organizations, community-based organizations, immigrant services, advocacy and community organizing, health care, public health, disability studies and advocates, academic research, professional associations, health care providers and their intersections. The collaborative included members with both personal and professional experience related to these fields. The list of collaborative members who participated that wished to share their information is listed in Appendix IV.

This collaborative met across the span of four meetings, including two structured focus groups, to discuss the implications of an aging undocumented population, as well as to inform what data would be necessary to comprehensively understand the impact. The transcripts from these meetings was analyzed and organized using the Social Ecological model framework (Bronfenbrenner, 1979).

This report will also be structured using a socioecological model framework to guide our discussion of the implications of an aging undocumented community, focusing first on individual experiences then moving to interpersonal, community, organizational and policy levels. A visual representation of this framework as it applies to our discussion is included in Figure 1.

While this framework works well to organize our discussion, it is important to recognize how every issue discussed has some impact on all levels of this model; therefore, we discuss specific examples throughout the report. In order to cut down on repetition, some of these examples that could fall in multiple sections will only be present in one section.

The report is intentionally worded in a way that centers the unique experience and humanity of the undocumented community, avoiding stigmatizing language and uplifting the dignity of undocumented older adults as they face vast challenges currently and in the future. The undocumented community, including undocumented older adults, is resilient in the face of immense structural barriers and disinvestment, and continue to make immense contributions to their communities. The report authors and the collaborative members seek to highlight the strength, resilience and contributions of undocumented older adults to our communities and the State of Illinois.

Figure 1



Staff from community-based organizations The Resurrection Project and Erie Neighborhood House attend a training to facilitate evidence-based chronic disease self-management workshops for older adults (Nov 2019, Photo Courtesy of AgeOptions & Rush)

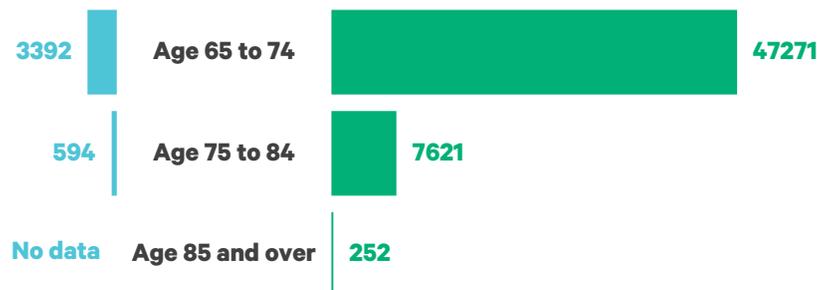


# Undocumented Older Adult Population Growth by 2030

The population of undocumented adults 65 years of age and older in Illinois will increase more than twelve-fold by 2030 (1,283% increase). The total of undocumented individuals age 65 and above will increase from 3,986 to 55,154. As seen below in Figure 2, stratified by age bracket, each bracket will increase drastically. As the undocumented population ages, each age bracket will have unique needs and experiences in health care and social services.

Undocumented Older Adult Population in Illinois  
2017 vs 2030

Figure 2

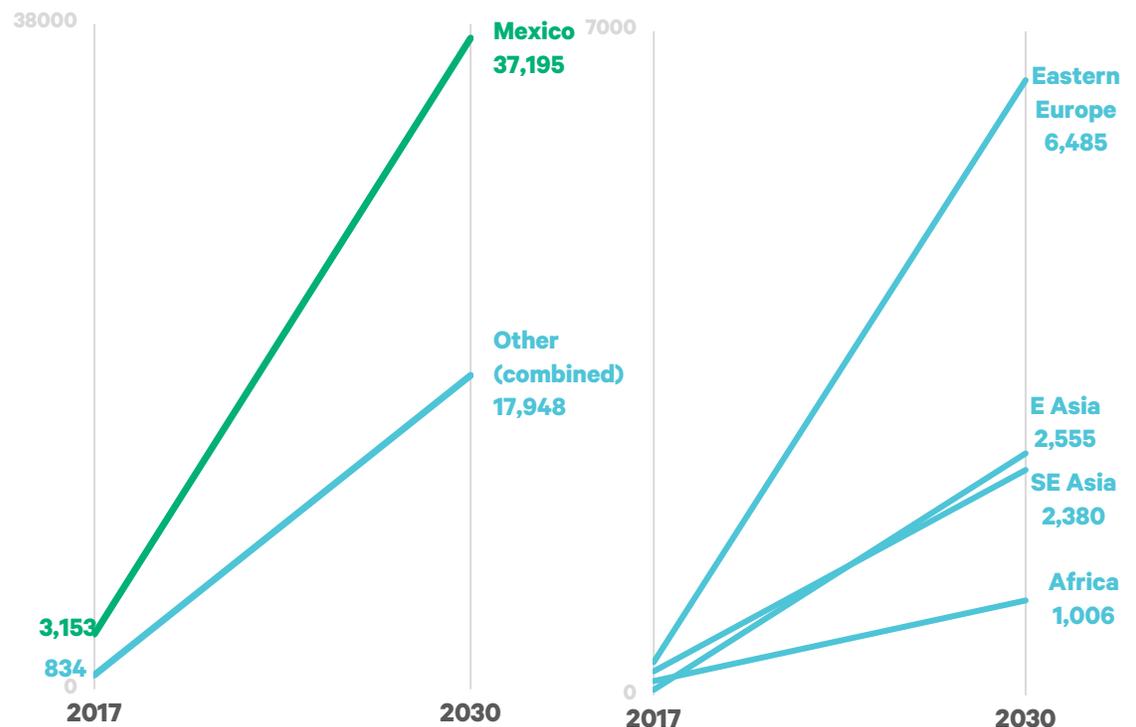


As presented in the data in Figures 3 and 4, Mexican immigrants comprise the largest share of both the current and future undocumented older adult populations. In fact, the total of undocumented older adults whose country of origin is Mexico comprises a larger percentage of the undocumented older adult population than all other countries of origin combined, as demonstrated in Figure 3. All countries of origin with available data are visible in the table of Figure 3, which displays regions of origin other than Mexico for additional visual comparison. More details can be found in the Appendix.

This knowledge certainly will inform our understanding of the cultural implications of the aging undocumented population and the nuanced undocumented older adult experience.

However, it is also important to point out that undocumented older adults, similarly to the overarching undocumented population, is extremely diverse in terms of race, ethnicity, socioeconomic status and other social determinant of health factors.

Figure 3: Comparison of Undocumented Older Adult Population Growth by Country/Geographic Region of Origin



# Executive Summary



Participants enjoy art activities in an event organized by La BROCHA Chicago  
(Photo Courtesy of Dr. Judith Rocha)

Undocumented older adults, as a result of irregular immigration status, face pervasive barriers to health and wellness that impede their ability to age well in their homes and in their communities. As a result of their status, they are also blocked from health care services typically provided to older adults.

The undocumented population in Illinois is aging, and a large population of undocumented individuals will be moving into their senior years by 2030. This report strives to raise awareness about this population and discuss the implications of an aging undocumented population.

The first part of this two-part project is demographic data created by Rob Paral & Associates to estimate the current undocumented older adult population in Illinois and their characteristics, as well predictive analytics to anticipate the growth of that population. For the second part of this project, the researchers convened a collaborative of individuals with professional and personal experience for four meetings, two to inform the demographic portion of the report, and two for focus groups to discuss the multilevel implications of this population growth.

## The following overarching themes and recommendations were drawn from the qualitative data from the Collaborative:



### **The current patchwork of resources will not be enough in 2030**

Because undocumented older adults are blocked from accessing many of the services that older adults depend on for healthy aging and aging in place, health care providers and health care supportive staff such as social workers, nurses, occupational and physical therapists, and other care managers must come up with creative and innovative solutions to provide care for their patients. This includes depending on informal resources, placing heavy burdens on family caregivers and relying on charity care or philanthropic organizations. The current practice of creating a patchwork of formal and informal resources unique to each undocumented older adult patient will not be sustainable as the population continues to grow.



### **Caregiver burden and family care**

The data has implications for caregiving as well. Many assume that since immigrant communities are very family-oriented and only 8% of undocumented adults 55 and older live alone, that their families will be able to provide for them. However, this places an extreme caregiving burden on these families, and we cannot assume that every individual will have these resources. Even so, without structural change and access to many programs, family caregiving, regardless of quality, will not be enough. The aging of the undocumented community should be approached with family systems in mind.



### **The current health care and social service systems are not prepared**

Many of the services older adults depend on to age well in their homes and their communities are either totally inaccessible or extremely difficult to navigate for the undocumented population. Undocumented older adults will require enhanced social care, especially if there are no structural solutions that provide coverage and access to these individuals.



### **Social and economic cost**

While families and communities will bear the immense social cost to disparities and inequities in care and access, health care organizations will likely bear an immense financial burden in health care expenditures, charity care and financial assistance, emergency department visits, hospitalizations and readmissions.



### **Undocumented older adults are valued members of our communities and society**

Undocumented older adults deserve to age with dignity and respect, with access to the services they need to do so. Undocumented older adults are integral parts of our families, our communities and our society. Undocumented older adults' voices should be included and centered in any decision regarding policy, research or reform to ensure they are not continually left out of reform and to design programs with our most vulnerable seniors in mind.



### **Need for cultural sensitivity and awareness training**

As the population of older adults continues to diversify and the undocumented population continues to grow, health care and social service organizations must expand their competencies and awareness around undocumented individuals. Meanwhile, community-based organizations, multipurpose social service organizations, federally qualified health centers (FQHCs) and free/charitable clinics must expand their competencies to work with older adults.



# Individual Characteristics and Experiences

## Undocumented individuals face barriers in accessing health care, and particularly preventive health care

Many services that older adults depend on require a Social Security number to confirm access, presenting a primary barrier for undocumented older adults. Meanwhile, even some resources that do not require a Social Security number may still have additional barriers that prevent undocumented and potentially other older adults from accessing them, including English-only or online-only forms, limited hours and locations, or requiring formal documentation of income. Many individuals may have family members or loved ones who can assist them in navigating the few resources available to them; however, there is no guarantee that all older adults will have this support, and furthermore no guarantee their loved ones will be able to navigate these systems either.

While many older adults know they will be able to depend on Medicare to cover their medical expenses and grant them access to quality medical care, and that they may be able to retire with a pension and Social Security, undocumented individuals know this is not an option for them. Further, when they attempt to access existing services they need to stay healthy and age well, older undocumented adults often face the harsh realization that these services are inaccessible, more challenging to navigate or far more expensive than they had imagined.

For example, many programs that provide access to undocumented immigrants can be difficult to navigate, such as hospital or medical center financial assistance or hardship programs, as the documentation required may be excessive or require additional steps to attain, may be only in English or may be limited in scope or capacity.

Many free services available to older adults, particularly those at the city and state level, are currently not accessible to undocumented individuals. For example, transportation services such as PACE require a Social Security number, and **home health services, home-based mental health services and homemaker services through the Community Care Program all have immigration status requirements either directly or indirectly by requiring public insurance.** In Illinois, there are many home-based psychotherapy services particularly created for older adults and people with disabilities; however, many of these services are inaccessible for the uninsured and undocumented.

## Undocumented older adults are forced to stay in the workforce

**Because undocumented individuals are unable to attain retirement benefits or public health insurance benefits, this leads to undocumented individuals remaining in the workforce longer, particularly in more highly physically demanding jobs like construction, the service industry and caregiving work.** While some of

Advanced practice nurse Barbara Shaw, DNP, APN, FNP-C assists a patient with his medication management at Heartland Health Center in Chicago on Feb 22, 2018 (Antonio Perez/Chicago Tribune)



these jobs may provide health insurance for undocumented employees, for many undocumented workers, the only benefit of work is the pay. The physical demands of these jobs, in addition to the fact that undocumented people work until later ages and with fewer rights and protections, creates a worrisome risk for occupational injury.

Additionally, according to a study by New American Economy, undocumented workers pay taxes and contributed \$13 billion to Social Security funds and \$3 billion to Medicare in 2016 (Roberts, 2019).

Unfortunately, under the current system, these workers will never benefit from these contributions. Those who are unable to work and may not have family to support them, or may not have supportive family networks, may fall through the cracks and have difficulty finding enough food to eat, paying for their housing and are at an extremely high risk for social isolation. Additionally, as undocumented adults are working longer, there is an increased risk of occupational hazards, while the protections and resources for those who experience occupational injuries are typically not accessible for this population. Those who work in informal and unregulated workplaces, such as construction workers, domestic workers, street vendors and restaurants may not benefit from occupational workplace regulations that protect their well-being or could support them or their financial well-being in case of an accident.



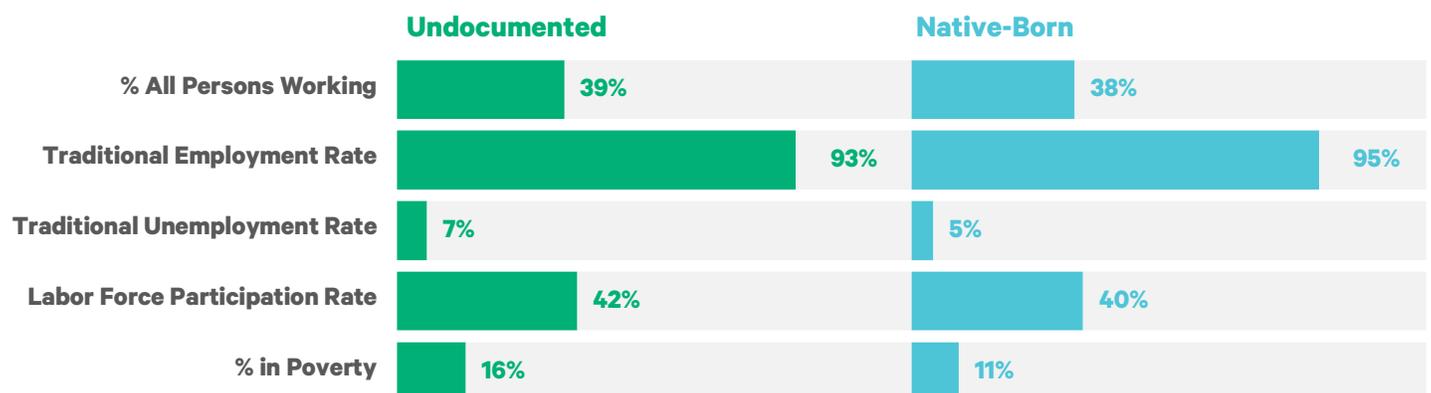
Two members of the West Town Senior Center Dance during a celebration of Mexican Independence Day (Photo Courtesy of Chicago Department of Public Health)

According to the data from Rob Paral & Associates, older undocumented residents have participation and employment rates that are comparable to the older native-born population. The “percent of all persons working” calculation seen in Figure 6 shows how likely an older person is to be employed regardless of whether he or she is “in the labor force.” About 39% of all older undocumented persons are working compared to 38% of older native-born persons. Traditional employment and unemployment rates such as those reported by the news media describe the share of persons who either do or do not have a job as a percent of the population that is working or that is seeking employment (i.e., the “labor force”). By this measure, the undocumented are slightly more likely than the older native-born population to be unemployed, at 7% compared to 5% for the native born.

The fact that undocumented persons are more likely to be working but have a higher unemployment rate is reflected in their labor force participation rate of 42%, compared to 40% of the native-born. Of all groups in the table below, the undocumented have the second highest rate of labor force participation.

**Despite their similar labor force characteristics, the undocumented are more likely to be in poverty than the average older native-born person. About 16% of older undocumented persons are unemployed compared to 11% of all older native-born Illinoisans.**

Figure 4: Undocumented Illinois Residents 55 and older compared to Native Born Groups (2017)



## Housing

Collaborative members identified housing as an issue for undocumented older adults. While anecdotally, collaborative members identified that numerous undocumented individuals strive to own property, and many may be homeowners, obtaining and maintaining stable housing is unrealistic for many. Of those who are homeowners or live in stable housing, factors such as gentrification place them at risk. As any community ages, housing accessibility, as well as informed and varied choices, are critical to insuring older adults age with dignity.



**Obviously the cost of housing is a really important component for folks feeling like they can or can't age in place in the way that they'd want to and not feeling forced into a living situation that's not what they'd choose.**

Unfortunately, many undocumented individuals who do not have family are at risk of housing instability. One of our collaborative members who works closely with the limited-English-speaking population states that many homeless individuals congregate in public libraries, and many of them are undocumented. Some older immigrants become socially isolated, and once they lose their limited housing options by being evicted due to the inability to pay for rent or mortgage, they end up living on the streets. And unfortunately, they are then faced with having to navigate services for the housing insecure with limited English-speaking ability.

For more information and statistics on multigenerational housing and social isolation, view the “Social Networks and Families” section of this report.

## The Health Consequences of the Chilling Effect

Additionally, the current political climate, federal policies and increased immigration enforcement have created an environment in which immigrants and minorities of a variety of backgrounds — not only those who are undocumented — may be fearful of pursuing the few resources or benefits for which they qualify. This has created a dilemma that will further exacerbate health disparities as these trends continue. Fear, coupled with lack of access, may cause undocumented individuals to delay seeking care until their conditions become more serious or complicated, resulting in hospitalizations. The trend of immigrant individuals and families avoiding care and services out of fear of immigration enforcement has been coined by researchers and community activists as the “chilling effect” of federal policies such as public charge, increased enforcement and threats to DACA, as well as anti-immigrant political rhetoric (Kaiser Family Foundation, 2018; Manatt Health, 2018; Haley et al, 2019).

The barriers created by having multiple medical issues and chronic health conditions, cognitive or neurological issues and physical disabilities are more difficult to circumvent without access to services older adults typically use to ease those difficulties. This includes assistive devices, technical and mobility aids, and other important services necessary for effective rehabilitation.

**Without preventive care, medical comorbidities, such as chronic conditions, can become exacerbated, and have more drastic consequences on individual health.** For example, uncontrolled diabetes can eventually lead to blindness or amputations, and lack of preventive oral health measures can lead to oral health emergencies requiring extractions. Individuals living with Alzheimer's dementia that require neurological specialty care receive a formal diagnosis, treatment and follow-up; however, this specialty care is extremely expensive, inaccessible or nearly impossible to navigate for undocumented individuals.

Undocumented individuals depend heavily on care provided out of (FQHCs) or free and charitable clinics. While this may be great for accessing preventive care, some specialty care, and, in some instances, medications, these resources often do not cover comprehensive or acute care. Another option for undocumented individuals are health systems with accessible charity care or financial assistance policies; however, these may be challenging to navigate and vary from health system to health system.

## Legal Implications

For the majority of undocumented individuals, there is no pathway to regularization of status under the current immigration system, no matter what resources they might be able to access. Navigating the naturalization process is not easy nor cheap. Costs include biometric and filing fees as well as legal fees. Some agencies provide assistance to help cover legal costs, and without this assistance, the cost of paying a lawyer, as well as other legal costs, quickly add up. These high fees simply are not possible for undocumented older adults who may have limited savings. The process of helping undocumented folks obtain legal status can be arduous, and sometimes culminates with few results. If pathways were created for undocumented individuals to regularize their status from the interior, then many individuals would certainly take advantage of that opportunity.

## Older adults may fall through the cracks in the immigration system

The immigration system and the pathway to citizenship is complicated and, more importantly, unavailable to the majority of undocumented people residing in the United States. As older adults move locations, experience cognitive decline or lose aspects of their independence due to declining health, they may also experience difficulty in maintaining their authorized immigration status through a green card or visa. While we are unsure if this may be a common issue and further work is needed to understand this phenomenon, our collaborative was adamant about its inclusion. There are numerous concrete and hypothetical reasons for why an older adult or their family may fall behind in renewal of immigration status. For example, those in long-term care facilities who have been hospitalized for long terms or those who have changed their addresses may all miss immigration renewal paperwork sent via mail. For immigrant older adults experiencing dementia, they may also miss deadlines or may incorrectly file renewal paperwork. Additionally, younger family members may have a lack of understanding of the implications of undocumented immigration status on health care access, and although extremely unlikely, may not prioritize renewal paperwork for their loved one.



**Clients went without knowledge and education about certain legal procedures, which were not necessarily complex.**

**But, because no one was asking questions and people were just doing whatever they felt was ok, clients ended up basically not necessarily being helped effectively.**

## Potential Solutions



### Advocacy and Creating Welcoming Environments

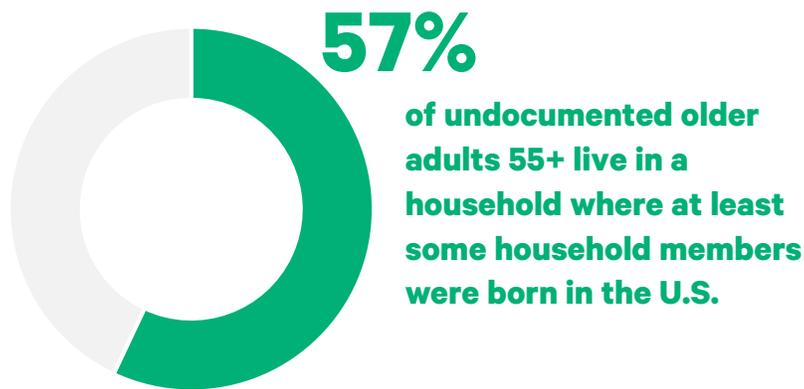
Undocumented older adults will individually benefit immensely from reforms in interpersonal, organizational and policy areas. While structural change is necessary to create an environment in which undocumented people can age well, accommodating our society to be more age-friendly will also benefit elderly undocumented individuals. Organizations and individuals should consider, when expanding their competencies with older adults, to center the experiences of undocumented older adults. And all organizations, particularly health care organizations, should be continually working toward efforts to make their institutions more welcoming to undocumented individuals.

# Social Networks and Families

In the next level of the socioecological framework—interpersonal—we consider relationships and how interactions with others can be both barriers and facilitators for undocumented older adults. In particular, the interactions with families and household members, social networks, and healthcare providers.

**Families can be a great source of support, but this support should not be assumed to be universal.**

Undocumented older adults are generally more likely to live in multi-generational households compared to native-born older adults, as demonstrated in Figure 5. According to these estimates, only 8% of undocumented older adults age 55+ live alone, while approximately 70% live in multi-generational households.



Living alone is one of the leading factors contributing to loneliness and social isolation, which has drastic health consequences for older adults (CDC, 2020). At least on the surface, the low rates of living alone could be protective for this population overall; however, as our collaborative reinforced, simply living with others in the same household does not necessarily mean that older adults will be less lonely, isolated, or

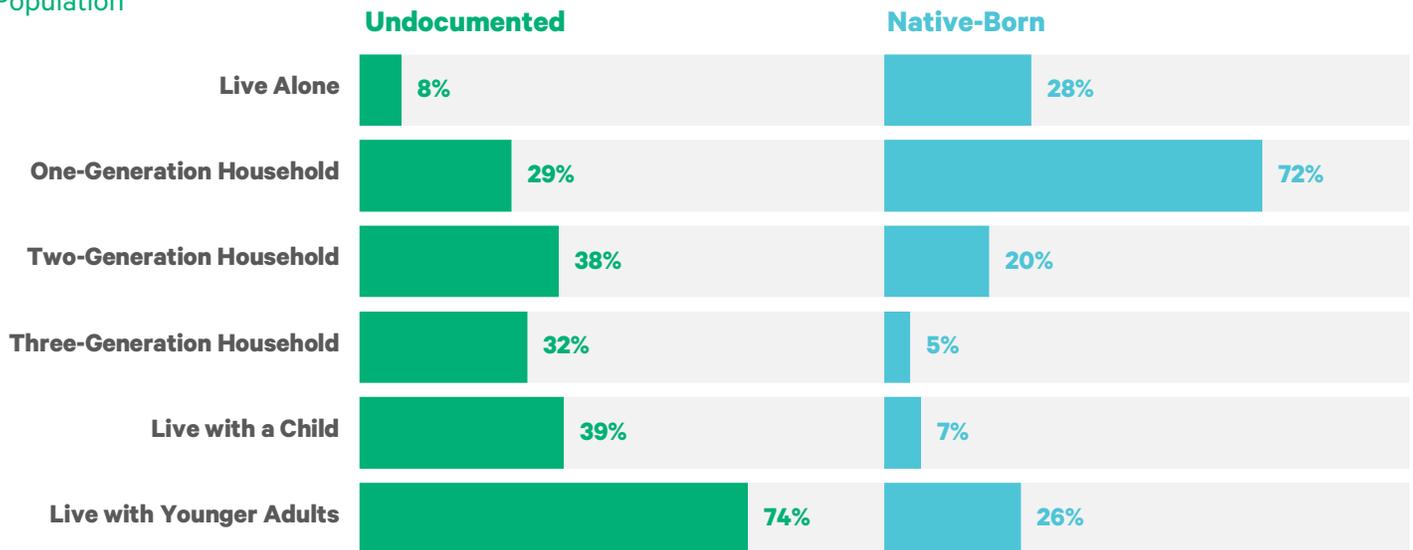
receive sufficient social support. In many instances, all household members of undocumented older adults are foreign born, though mixed-status families — where some members have legal status or were even born in the United States — are also quite common.

Often, it is the children in mixed-status households who have legal status. The American Immigration Council has reported that in Illinois, one in every 10 children under the age of 18 living in the state are U.S. citizens living with at least one undocumented family member, equating to 292,127 children in total (American Immigration Council, 2020). These children — or other household members with legal status — may qualify for resources and benefits that the undocumented older adult or other undocumented household members do not. Unfortunately, we were unable to find existing data in literature regarding the immigration status of adult children caregivers of undocumented older adults; however, Rob Paral's report found that **74% of undocumented older adults 55 and older live with younger adults, as opposed to 26% of the native born population.**

Older adults exercise at the North Center Senior Satellite Center in Chicago, IL (Photo Courtesy of Chicago Department of Public Health)



Figure 5: Housing Arrangements of Illinois Undocumented Older Adults 55 and up, Compared to Native Born Population



Many individuals choose to live in intergenerational households due to both cultural norms and structural factors such as housing affordability and availability, socioeconomic status, etc. This desire to be close to family, childcare, and cost-splitting can contribute to a variety of benefits for all in the household. Still, although living in multi-generational households can be a great asset in terms of support for the older adult from a health and social standpoint, familial relationships can be complicated, and providers should not assume that family can care for an older adult.

Understanding the family unit not only means knowing who is part of an older adult’s family, but also knowing whether the older adult truly has support from these family members. In addition to being more likely to live in a multigenerational household, most undocumented older adults live in households where someone is employed —

approximately 85% — higher than rates of native-born adults in this same age group (see Table 2). However, this high level of employment does not equate to lower poverty levels as 19% of older undocumented older adults and 13% of households have at least one member who is unemployed. Over 60% of children in mixed-status families are low income and live in families that earn less than \$38,000 (Satinsky, 2020). They often struggle to get by even with more workers on average per household (1.75) compared to native-born families (1.23) (Satinsky, 2020).

Even if other family members are employed, household resources may still be quite stretched, and younger family members may be struggling with similar situations as an older adult in terms of legal status, limited resources and/or limited English proficiency. Approximately 27% of

undocumented older adults live in a household where all members have limited English proficiency. Older adults may continue working longer than they normally would in order to continue provide for the household, contributing to increased stress. Undocumented older adults report that language, cost, limited literacy level and documentation are barriers to access health care services. Older adults also report stress about their inability to contribute to the household income if their health declines to a point at which they could no longer work, worrying about placing a burden on family members to assist with health care costs (Ayon, Ramos Santiago, & López Torres, 2020).

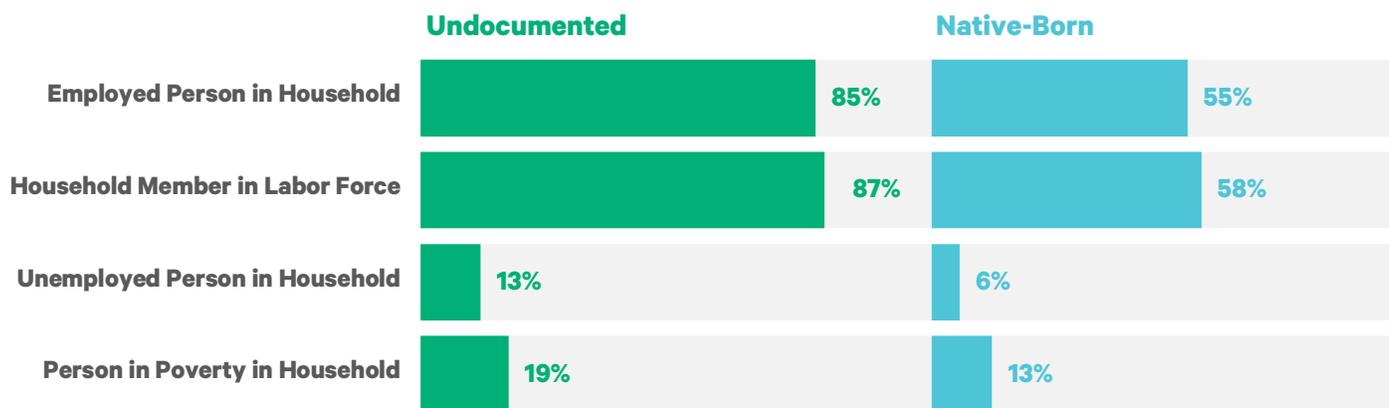
Navigating systems in the United States, which may be far different from the family's country of origin, can add an additional layer of complexity for a family in terms of obtaining health care and accessing other needed services.



**A lot of family structures are actually defined by external factors like economics, health systems, and what’s available around them because they just have no other choice.**

Data from Rob Paral & Associates in Figure 6 highlights the striking difference of undocumented vs. native-born individuals in terms of how their households are engaged with work. Eighty-five percent of older undocumented Illinoisans are in a household where someone works compared to 55% of the older native-born population. Older undocumented individuals are also significantly more likely to have someone in their household in the labor force (i.e., employed or actively looking for work). About 19% of older undocumented persons are in households where a person is in poverty. This is higher than native born households overall (13%) though not as high as the rate at which older African Americans live with someone in poverty (26%).

Figure 6: Employment and Unemployment Rates of Undocumented Older Adults 55+ compared to native-born older adults



**1 in 4**    

**undocumented older adults report having no English speakers in their home.**

### Caregiving needs for undocumented older adults

Like with the general aging population in the United States, the “sandwich generation,” adults who have responsibilities for raising their own children while also caring for their aging parents — is facing increasing stress with caregiving demands. Caregiving for an older adult with complex health needs is often a large responsibility for families, and when the older adult is undocumented, these responsibilities can be compounded. Caregivers may be undocumented themselves, may have limited English proficiency and may be unfamiliar with how to navigate the health care system, aging services, long-term care, etc. Caregiving resources, programs and aid that are available for older adults generally require a Social Security number for enrollment or benefit eligibility, leaving out undocumented older adults. Even when these resources exist, they are often limited in terms of scope (e.g., limited to people with a specific condition) or even the number of people who can use them. Inability to access needed resources can put large strain on families and caregivers.

Meanwhile, undocumented individuals who may be caring for others are completely inaccessible for respite care<sup>2</sup> based on immigration status. Additionally, those family caregivers may not be able to access state-funded paid

<sup>2</sup> Respite care refers to a short-term break for caregivers. A professional supervises a care recipient so that the caregiver can have time on their own.



Staff members cheer as Claudio Velez, better known as Chicago’s “Tamale Guy,” was discharged from Rush University Medical Center on Thursday, October 1, 2020 after a month-long bout with COVID-19.

From the older adult’s perspective, shifting from being a caregiver or income provider to then needing caregiving can be a major shift in household relationships and family dynamics. Older adults who may be used to working and helping to provide for their family may be unable to work due to changes in health status. As stated by a focus group participant,



**...when the undocumented adult requires medical services and care, it’s a dramatic shift at times for the entire family unit. The older adult may have to rely on their family and children more than they’ve ever needed to, which ultimately causes the shift in the relationship from the caregiver responsibility.**

Caring for family members with Alzheimer’s Disease and dementia can become particularly complicated for households with undocumented older adults. Misconceptions around these diseases can contribute to early symptoms being overlooked.



**For instance, with dementia, even today a person who may live with family and experiences the symptoms associated with dementia will begin to withdraw and isolate themselves from their families before understanding or seeking treatment until the condition has progressed and someone takes notice. This puts a strain on not just the emotional well-being of the individual, but also their care partners.**

### **Loneliness and social isolation: Risk factors and impact on health**

Loneliness — defined as “the feeling [of] being alone, regardless of the amount of social contact,” and social isolation — “lack of social connectedness” — among older adults are major risk factors for adverse health outcomes, including premature mortality, dementia risk, cardiovascular disease, higher health care usage and depression (National Academies of Science, Engineering, and Medicine, 2020; CDC, 2020).

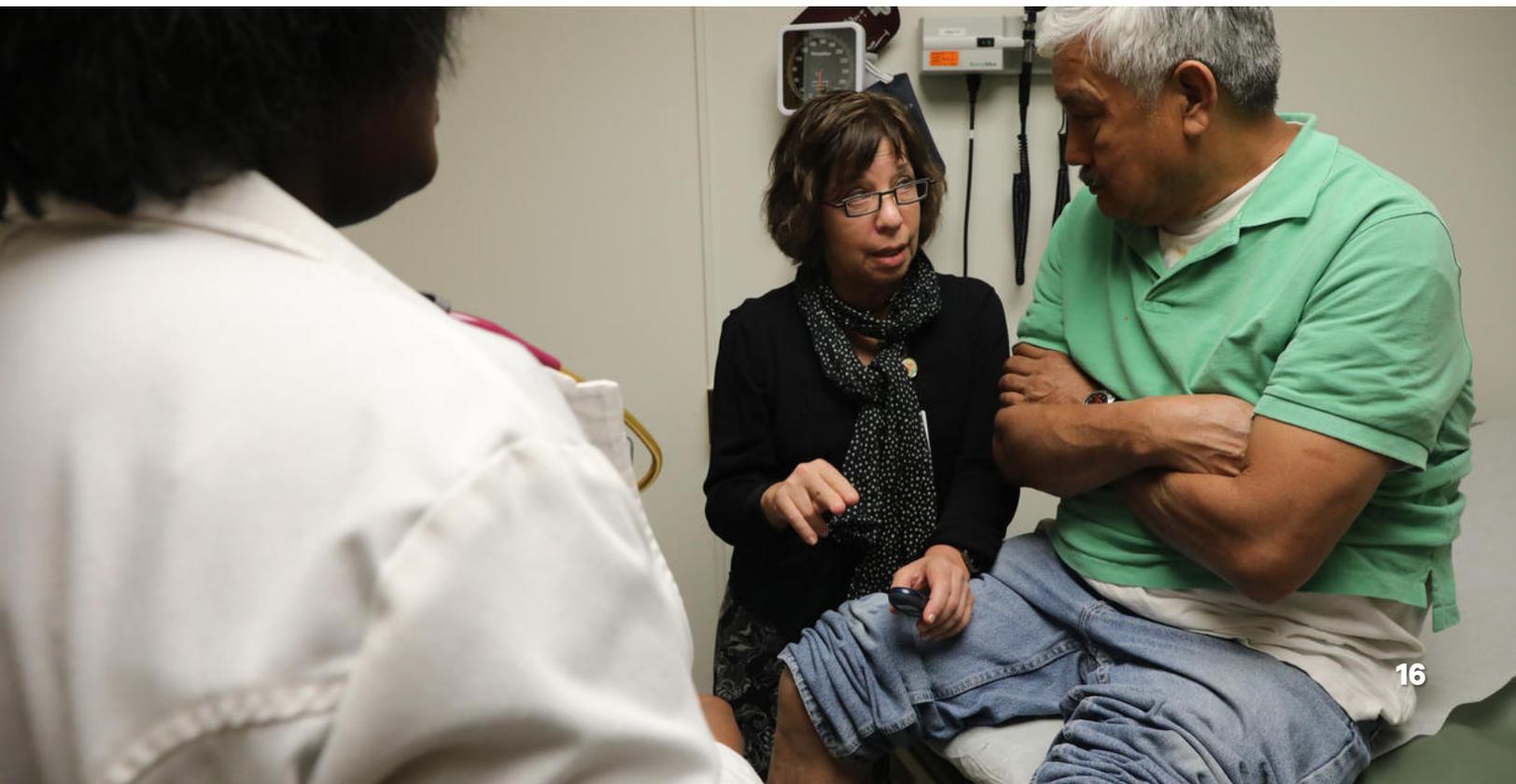
Though this report's estimates indicate that undocumented older adults live alone at substantially lower rates than native-born older adults, undocumented and immigrant older adults can face unique challenges that contribute to loneliness and social isolation. A recent report from the National Academies of Science, Engineering, and Medicine highlighted that immigrants are more likely to experience loneliness and social isolation compared to native born older adults (Ramos et al., 2015; Shelton et al., 2011; Steele et al., 2018; Viruell-Fuentes et al., 2013).

Immigrants face numerous stressors when deciding to start a new life in the United States, the biggest one being communication barriers. The need to learn a new language while also learning to navigate new systems and environments can not only be challenging but also isolating. Furthermore, hesitation to start conversations or ask for directions and fear of deportation are just some of the behaviors that could contribute to social isolation.

Language barriers may also inhibit older adults from participating in community programs and events, accessing programs and services, and socializing in settings such as faith organizations or senior centers. This also varies greatly due to geography, which is discussed further in the "Communities, Culture and Geography" section of this report. Further, the understandable fear that many undocumented immigrants face in relation to their immigration status — including fears of deportation — can further contribute to isolation. Retracting from society can lead to depression and take a toll on one's mental, physical and cognitive health. When one feels out of place or vulnerable, or experiences being outcast or discriminated against, it can be difficult to reach out for help. Even though immigrants may have resided for years, or even decades, in a new location, they may still not have established a local social network due to cultural, linguistic or other access barriers.

Because undocumented older adults are predominantly Latinx, many may assume that undocumented older adults are less likely to experience social isolation and loneliness. A central theme through this report reinforces that undocumented older adults cannot always depend on family to provide all the necessary support older adults need to age well. There must be structural solutions. Many immigrant older adults' children do not have the ability to stay home and care for them, in addition to the fact that many immigrants leave their established social networks when they move to a new country.

Advanced practice nurse Barbara Shaw, DNP, APN, FNP-C assists a patient with diabetes with an injured foot at Heartland Health Center in Chicago on Feb 22, 2018 (Antonio Perez/Chicago Tribune)





## Potential Solutions



**Understanding an older adult's full family or household unit, or lack thereof, can be beneficial for adequately serving or caring for that older adult.** Ensuring that family members who qualify for resources can get them can alleviate stress for the whole family or household unit. We also cannot assume that all older adults have familial support or can access the services or care plans we initially recommend for them.



**Promote socialization and engagement.** As we discuss methods that allow us to create a safety net for the aging undocumented population, as advocates, we can also advocate for ways to keep all older adults, particularly older adults from immigrant communities, engaged and active. Therefore, the community can support their social and emotional well-being. For example, many older adults may choose group living facilities such as retirement communities or independent living facilities for the opportunity to socialize more. These are services from which undocumented older adults are currently denied, cost-prohibitive or underutilized.



**Screen for loneliness and isolation in all patients.** It has been recommended that health care providers screen for loneliness and social isolation among their older patients, and this may be particularly relevant for older adults who have language barriers and are not living in communities that are reflective of their cultural norms. Stated by one focus group participant, "In terms of social isolation, folks may not be living near a lot of other older adults who share language or culture, and so that has to impact how we approach our work as well, to see the important role that we as providers have as being that connection to people who are isolated." Even if an older adult has their basic needs met, being socially engaged is crucial for quality of life.

# The Role of Health Care Providers



**There are so many creative solutions that we as professionals have to find, but there are no structural solutions for those who fall through the cracks and may not have an advocate.**

## **Health care providers must find creative solutions to ethically care for their undocumented patients**

Given the estimation of population growth of undocumented older adults cited in this report, health care providers will soon encounter undocumented older adults as patients at higher rates. Unfortunately, due to not qualifying for Medicare and many other benefit programs and resources, providing adequate health care for these patients will bring unique challenges for providers.

Social workers, care managers and patient navigators may not be able to rely on the usual resources they use to help patients due to eligibility being tied to having a Social Security number. The lack of resources for undocumented older adults makes it frustrating for providers who simply want to provide quality care to their patients and clients. The providers for these patients must go the extra mile in order to get these patients the care and resources they need, and those options may be scarce, informal or unreliable. Providers and caregivers often find themselves seeking creative solutions and spending more time finding or trying to find resources that do not exclude undocumented older adults — piecing together resources from multiple sources both formal and informal, negotiating, and depending on family members and volunteers.

Let's consider patients discharged from inpatient stays at a hospital, for example. Many of these patients require home health, homemaker services or even skilled nursing. In Illinois, uninsured undocumented individuals do not qualify for any of these services; therefore, an inpatient care manager or discharge planner must take this into consideration when planning a safe and ethical discharge. Social workers and nurse care managers in the collaborative shared their experience of reaching out to local churches to find volunteers to take the place of homemaker services, finding a volunteer nurse from a nearby church willing to do wound care or even teaching family caregivers how to run an IV for antibiotics.

These efforts are usually cautiously carried out, while trying to avoid "outing" or disclosing a patient's immigration status. The *AMA Journal of Ethics* states that "to minimize the patients' risks and fears, immigration status should be avoided when it comes to [undocumented] patients' charts" (Kuczewski, Mejias-Beck, & Blair, 2019). This helps to establish and honor the rapport and trust built between patient and provider. Some health care providers have come



**As social workers, we are going to be pulled into a lot of care coordination and assistance related to our undocumented older adults, as well as their families. That might be a strain for us because we're indirectly treating two or more patients, and those patients who could potentially have really high needs.**



up with keywords to signify that this patient or client is of higher need, does not qualify or is “uninsurable” to get around this issue.

The stress of having to create creative solutions for discharge planning, care management or care provision, as well as the frustration of having to navigate blocked access will inevitably lead to frustration and hopelessness, and potentially burnout and vicarious trauma.

### **As the older adult population diversifies, the need for language access will also increase**

Overall, the U.S. population of older adults is becoming more and more diverse, and practices and programs based upon societal norms for non-Hispanic white and/or English-speaking older adults may not be appropriate. Lack of resources and appropriate practices can contribute to burnout and distress among providers and staff.

According to a survey published by the Center for Medicare and Medicaid Services (CMS), 41% of providers surveyed indicated that they heavily rely on their co-workers to act as interpreters to bridge the gap between patient-provider care (Center for Medicare & Medicaid Services, 2013). However, under current U.S. law and policy, qualified interpreters are required for all health care interactions if providers themselves are not sufficiently competent in the patients' language (Basu, Costa, & Jain, 2017).

### **Potential Solutions**



**Combat inequities in language access.** Facilities and organizations can support their staff by providing qualified interpreter services, as well as ensuring that resources available for diverse older adults are well known in their organization. Taking these steps is not only important for caring for undocumented older adults but can improve care for all patients. Interpreters should be readily available, and providers can receive training on how to effectively work with interpreters.



**Expand competencies through training, education, sensitivity training, and culture change.** Health care providers also must prepare to expand their competencies in working with older adults, particularly older adults from diverse backgrounds. A study performed by Rush University Medical Center found that 35% of health care providers in emergency medicine, family medicine, pediatrics and internal medicine do not know what benefits undocumented immigrants may qualify for (Palomares et al., 2020). As the population continues to grow and age, health care providers will need to receive training in sensitivity and competency to more provide more effective care to those who are undocumented. Additionally, providers and organizations who have experience working with

immigrant populations, should seek out training and programs that cater to the older adults within the communities they serve.



**Decrease burnout.** As will be discussed in the policy section, structural and policy solutions that allow undocumented older adults to be integrated into aging programs and services will be necessary to decrease provider stress and burnout. As the health care workforce prepares to serve the growing undocumented older adult population in Illinois, structural solutions such as Medicaid reform, immigration reform or public access programs will allow for undocumented older adults to receive ethical care without requiring care managers and other providers to struggle to find creative solutions.



**Increase collaboration and resource sharing.** Health care organizations, and in particularly care managers could work more collaboratively with community-based organizations and other social service organizations that contribute to the patchwork of resources available to undocumented individuals. Providers can advocate for these types of collaborations and study pilot programs that measure their effectiveness. More of these types of partnerships will be discussed in the “Health Care Organizations and Care Management” section.

A patient at Community Health Care Clinic in Normal, IL has her vitals taken. Photo courtesy of Illinois Association of Free and Charitable Clinics



# Communities, Culture and Geography

## Cultural differences across various communities

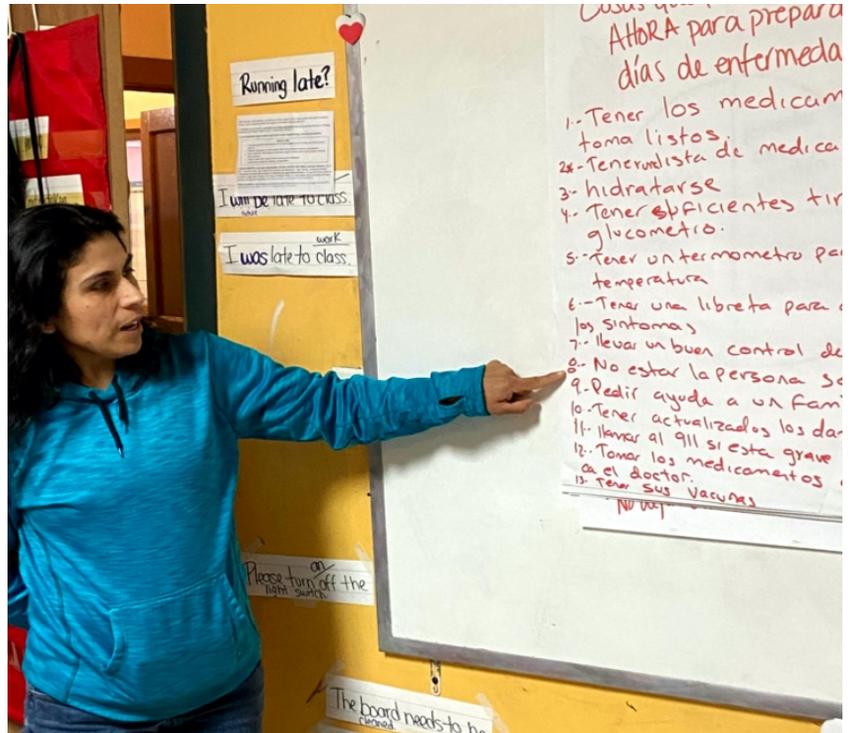
Though undocumented older adults come from a variety of cultural and social backgrounds, the majority of undocumented older adults in Illinois (and in the United States) are Latinx. In general, cultural family dynamics play crucial roles in financial matters, health care and other types of decision-making in Latinx culture, as well as the cultures of many immigrant communities. The importance of family is of major value in traditional Latinx culture and taking care of others in the family is typically considered a cultural norm. According to the collaborative, those who are able to work in gainful employment may split their income amongst the whole family in order to care for their needs. This can put a major burden on the individual and their source of income. In addition to these financial strains, the unique and dynamic caregiver experience for these families is complex and compounded by the effects of inequity and blocked access to insurance and services.

As noted in Figure 3 on page 5, the aging undocumented community in Illinois is ethnically diverse, and therefore carries cultural differences and needs that require accommodation. Ethnic groups may have similar experiences based upon shared culture, language or

country of origin; however, they also may have very different experiences based on individual circumstances, but also using an intersectional lens, may have vastly different experiences in reference to varied socioeconomic status, religion, immigration status, education, gender and gender identity, sexual orientation, etc.

In terms of living situations and transportation barriers, one participant spoke about experiences within the Southeast Asian community, referencing how older undocumented adults often live with their children and grandchildren all in the same home. Many older adults in this community tend to depend on their adult children for transportation, which causes a strain because they are also working and caregiving for their own children. This can cause a feeling of isolation by the older adults. Some of these older undocumented adults might not live near other older adults of their same background or that speak the same language. This is extremely isolating, and we must see the important role that health care providers, social services and community-based organizations can play in being a bridge to those individuals who are isolated. A collaborative member shared that some of their older adult clients express wanting to move to their native country where they are connected to the community and share the same language. The prevalence of these issues vary greatly from community to community and are largely related to race, geography and accessibility.

A staff member from Universidad Popular attends a training to facilitate Tomando Control de su Salud workshops. (March 2020, Rush)



## Importance of shared language and culture

The prevalence of limited or lack of English proficiency across immigrant communities in Illinois has been widely documented. Yet, many institutions do not accommodate the plethora of languages spoken by Illinois' diverse immigrant community.

Relevant public messages, health information and media advisories continue to be primarily disseminated in English, which creates a serious gap in knowledge and information to non-English speaking communities. In the case of falls, a crucial issue in late adulthood, commercial for products such as Life-Alert and information about key fall prevention strategies are widely circulated in the media. However, a collaborative member stated that when sharing this information in a Spanish-language fall prevention education group, this was new information to them. One individual even referred to the Life Alert “I’ve fallen and I can’t get up” commercial and stated their confusion with “Why is that white lady on the ground?” They didn’t understand the meaning of the commercial. This highlights a major problem in properly disseminating crucial information to this population.

## Cultural perceptions and norms of health and mental health care

Our collaborative members expressed concern regarding stigma and hesitancy to pursue health and mental health care services. While stigma is an important theme to be mindful of while discussing social or health care service provision, it is important to recognize that stigma is perpetuated by structural inequities and pervasive barriers to care experienced by marginalized communities. Additionally, stigma, while often associated as a primary deterrent to access of services, is secondary to the structural barriers that minority communities experience in accessing these services. The topic of stigma is often used to place blame on marginalized communities for not “wanting” to pursue needed services, such as health care, preventive health care or mental health.

The Center for Community Wellness at Saint Anthony Hospital in Chicago collaborated with 22 community-based organizations and completed a three-year study and Mental Health Needs Assessment (MHNA) of the Little Village, Brighton Park and neighboring communities with similar demographics; low-income, predominantly Mexican-immigrant communities with a large undocumented population. The MHNA found that only 29.5% of residents within the Little Village neighborhood who desired mental health treatment were able to access it. “Findings indicate a desire to seek counseling services with 58% in 2014 and 56% in 2015 reporting positively. In both years depressive symptoms were the highest reported reason. When it came to selecting from a list of 10 barriers to accessing services, cost (55% 2014, 33% 2015) and lack of health insurance (39% 2014, 22% 2015) were the two highest reported barriers while “not thinking it would help” (9% 2014, 6% 2015) and stigma (7% 2014, 5% 2015) were the lowest rated” (Collaborative for Community Wellness, 2018).



A patient at Rush University Medical Center in Chicago, IL meets with a Spanish Interpreter.



Photo courtesy of the National Council on Aging

The concepts, opinions and beliefs of health care vary greatly based on individual experience and can be heavily influenced by country of origin. In many countries, preventive medicine is nonexistent due to a lack of institutional infrastructure. Additionally, due to lack of resources, access and adequate outreach by health systems, many undocumented immigrants have not experienced going into clinics or hospitals before; therefore, many can be intimidated by the process. The U.S. health care system also is vastly different and has far more challenging bureaucracy to navigate than many health systems in their country of origin (Carroll, 2020; Papanicolas, Woskie, & Jha, 2018). Having to navigate these new systems is complex and intimidating for the general population, and is even more intimidating for those who do not speak English.

Cultural competency and cultural sensitivity, as well as awareness of caregiver and family dynamics are critical in understanding mental health in these diverse communities. Reaching out to caregivers to understand and recognize early symptoms can help them get services and care for the patient. However, training providers to understand this cultural stigmatization of mental health and the importance of making big decisions as a family in this culture can help them identify cognitive issues earlier and more effectively facilitate these difficult “goals of care” conversations so critical to health care.

“  
It’s not enough to only access such services; it’s important to see if aging immigrants can participate and engage in meaningful ways.”

### Geography and transportation

In urban and rural areas alike, transportation consistently is a major barrier for older undocumented individuals. Lack of physical mobility for this population compounded with lack of access to transportation services such as their own vehicles, public transportation or special transportation services creates barriers for individuals to meet with legal specialists to physically go through the naturalization process, as well as get to important appointments, both legal and medical. Furthermore, in urban settings where the community may be more dense, it might be easier for individuals to walk to the grocery store a few blocks away—this is more challenging for someone living in the suburban areas where their grocery store is not within walking distance. Also, there may not be as many facilities or organizations for undocumented individuals in the suburban areas as there are in the urban areas, meaning those that live in the suburban areas need to travel into the city center to access these organizations. This may take hours

due to city traffic, take up a significant portion of their day, and they might not be able to make that trip by themselves, implicating another family member might need to accompany them. Furthermore, these trips may be expensive, particularly if a taxi or other ride-sharing service is needed. Older adults often have multiple medical appointments, meaning more trips and thus higher costs.

## Cultural competency and geriatric preparedness

Community organizations and community-based services are largely unprepared to deal with this intersection of aging undocumented individuals. Organizations that cater to the aging population overwhelmingly lack linguistic and cultural adaptations for their programming and approaches. Senior centers are a resource available to all older adults regardless of immigration status, providing communal space, meals and activities for all. However, many senior centers' programming and nutrition programs lack cultural adaptation and may not have any Spanish-speaking staff, volunteers or instructors. This disparity applies to many community-based organizations and services, such as public libraries, shelters, housing programs and social service programs. Cultural and linguistic competency at community-based organizations can be the essential difference in whether an older adult is successfully connected to a resource. Many helpful services for support and health education are not available or are available far less often in languages other than English, such as support groups, dementia care, palliative and hospice care or chronic condition management. This speaks to the related demand for health care professionals from diverse communities, and particularly those with training and motivation to treat disinvested communities.

Meanwhile, services that cater to immigrants are not always prepared to work with older adults, many having misconceptions of the services older adults depend on, or may lack a deep understanding of aging, such as chronic conditions, medication management, mobility issues, depression and social isolation.



**When I went to meet with our alderman and ask for support for our programs in the community, he responded 'We don't have a lot of older adults here.'**

**I said, 'Little Village has a really big undocumented population. And yes, they're not old right now, but in 5-10 years, they will be.'**

A collaborative member that works frequently with individuals experiencing homelessness stated that many organizations that serve the homeless may not be accustomed to working with undocumented individuals nor older adults. While many of these organizations are currently becoming more competent working with older individuals, through working more collaboratively with hospitals, collaborating for health screenings and even clinics, these organizations may be unprepared to work with older individuals of varying immigration statuses. Free and charitable clinics are now starting to see an increase in older patients and are therefore expanding their competencies to address these patients. Many of these clinics are already working heavily with the immigrant population and

therefore could be considered leaders as other health care institutions move to serve this population.

## Potential Solutions for Communities and Community-Based Organizations



**Trust in Community Based Organizations.** Community-based organizations and advocacy organizations are an immense resource for communities, particularly immigrant and ethnically diverse communities. Community-based organizations often know their communities best and are extremely important partners in community health interventions. However, these organizations work within limited capacity and funding. In order for them to continue to serve the communities, they must be empowered to do so with funding, institutional support, partnership and training.



**Address pervasive barriers to care.** For many organizations, disparities in care or service delivery may derive from a lack of competency or awareness. However, it's more likely that these organizations may experience more pervasive barriers such as policy restrictions that forbid them from providing certain services to those without legal immigration status. In this situation, community-based organizations are at a crossroads — struggling to serve their community members while needing to adhere to regulations. Some of these organizations may have trouble finding creative solutions for individuals as the population continues to grow or as rules and regulations tighten. As structural solutions are created that allow community-based organizations and social service agencies to incorporate undocumented individuals into their service models, many of these access issues will be alleviated.



**Support capacity building efforts and training.** Many organizational shortcomings can be attributed to limited capacity or lack of awareness, not simply an intentional choice to not adequately serve undocumented older adults. We also must keep in mind how this change in demographic will affect how organizations serve vulnerable seniors, such as Adult Protective Services (APS). APS will need to adjust how they operate working with older adults with varied immigration statuses. For example, many APS workers focus on connecting older adults to services and protections; however, many of the most utilized resources may not be available to the undocumented. Additionally, in situations where families may lack the resources to provide safe and appropriate care and supervision for older adults, social workers and other health care workers would typically submit an APS report. In these situations, APS reports result with a potential solution or resources provided; however, they may avoid doing so out of fear of risking legal trouble for the family and the family still not having access to resources. Therefore, organizations that protect older adults against elder abuse and neglect must also consider competencies in working with undocumented communities as this population continues to age.



**Include the undocumented community in program development and evaluation.** As the undocumented older adult population in Illinois increases, community organizations should seek the input of the undocumented community, particularly those who are aging to identify concerns and gaps, as well as to identify strengths and inform potential solutions. Incorporating the voices of undocumented older adults and their caregivers will be essential for establishing organizational and operational policies, but also as advocacy organizations recommend policy interventions on state and federal levels.



Photo courtesy of Chicago Department of Public Health

# Health Care Organizations and Care Management

## Leaving undocumented older adults out of reform will put additional strain on services older adults depend on to cover gaps in care and coverage.

Many individuals believe that when they retire and can access Medicare, they will have access to all the health care and services they need. Unfortunately, even U.S. citizens who access Medicare and Social Security often find that the coverage is not sufficient, and they seek out additional social services to cover the gaps. Programs for the uninsured and underinsured are already strapped for funding but also are challenging for individuals to access and to navigate.

As the undocumented population ages, if they do not have access to insurance and other options, they will inevitably seek out these services that are currently designed for the underinsured and uninsured. An example of an organization that provides this service could be donation banks for durable medical equipment (DME), free and charitable clinics, FQHCs or food pantries.

## Organizations may experience an increase in demand but will struggle to provide services under current payment and reimbursement models.

**Some services, such as dementia care, homemaker services or home health, require a Social Security number or public health insurance, and therefore are inaccessible by undocumented individuals.** Meanwhile, other services are inaccessible due to lack of language adaptation or lack of outreach or promotion to immigrant communities. If older adults in this community are unable to access the services they need, it will have a monumental impact on their families and communities.

Health care organizations may have financial assistance programs or “charity care” programs that provide services to the poor, uninsured and underinsured. This can be a great way for undocumented individuals to access care and avoid burdensome medical bills; however, these resources are limited and inconsistent from institution to institution.

A patient at Community Health Care Clinic in Normal, IL receives information during her intake. Photo courtesy of Illinois Association of Free and Charitable Clinics





For example, in October 2019, Cook County Health’s CEO sent out a letter to other hospitals in the area imploring for them to see more patients through their charity care programs. The CEO anticipated that in 2020 Cook County Health would need to budget \$409 million for charity care — more than double the budget six years prior. In fact, although there are more than 70 hospitals within Cook County, **“the County health system’s two hospitals provide more than half of all the charity care in the county”** (Schorsh, 2018; Schorsh, 2019).

Additionally, coverage provided under various charity care programs is not consistent from institution to institution. Without equitable and accessible financial assistance programs that serve undocumented immigrants in preventive measures, health care institutions may face far increased numbers of emergency department admissions and preventable hospitalizations of uninsurable individuals. Undocumented individuals may seek health care through the emergency department once their symptoms become unmanageable or out of pure frustration of attempting to access care through other routes to no avail.

### **Preventive and post-acute care**

Although many institutions may be able to currently serve the undocumented population, and particularly undocumented older adults through charity care programs, FQHCs, free and charitable clinics, and other accessible social service agencies, this unfortunately does not ensure access to care for home services, follow-up services or preventive care. Primary care, although a crucial part of maintaining health, is not enough for comprehensive care and wellness.

**Example 1** Patients who receive a dementia diagnosis from primary care physician will then have to pursue care from a neurologist, purchase expensive medications, and may eventually need the help of professional caregivers or home health aides.

**Example 2** When patients prepare for discharge from a hospital, they are given a care plan and may often be referred to a skilled nursing facility to prevent further complications, hospital readmissions, or worsening of symptoms.

**These services are currently totally or virtually inaccessible to undocumented older adults due to structural barriers.**

Often, once discharged, if there is no follow-up care, a patient's health can worsen quickly and without warning. If a patient is not able to discharge from the hospital to a rehab center or skilled nursing facility because of their lack of insurance and the inability of these institutions to accept undocumented patients, then **there is an increased risk of more acute hospitalizations, as well as a much higher risk for unsafe or unethical discharges.** In order to avoid this predicament, many care teams choose to delay or totally avoid discharging their undocumented patients, sometimes with a patient's length of stay spanning from weeks to years in an inpatient bed.

### **Considerations for charity care and financial assistance programs**

Charity care, as well, is a limited resource — not only because the resources within the health care institutions are finite, but also because many health care institutions determine eligibility for charity care based on household income. This becomes more complex in multigenerational and/or mixed-status households, where younger generations may have higher income due to ability to work, entrepreneurship or may have legal permission to work. This, however, does not mean they are able to fully provide for their older adult family members. Additionally, it is beneficial both to the patient and their families, but also saves a health care institution money to treat diseases preventively before complications arise. **As health care institutions move more toward addressing social determinants of health and increase a focus on preventive care and chronic care management, we must be certain that the undocumented community does not fall through the cracks.**

### **Aging undocumented population will greatly impact organizations**

As discussed earlier, **organizations or services that currently serve the underinsured and uninsured population will certainly face challenges as that demand and patient population increases.** This is not only larger health care institutions, but also palliative care, dialysis centers and hospice care.

Currently, care managers and other health care professionals struggle to help undocumented older adults navigate the complexity of accessible resources and loopholes; and each case is unique. **Health care workers are forced to find creative solutions to connect patients to care** using loopholes, negotiating with organizations or even gaining access to certain programs by identifying qualified noncitizens or U.S. citizens in the household.

Using certain family members as access points, depending on informal community organizations and church volunteer programs to provide wraparound care, and other creative solutions will not be sufficient to sustain long term for a growing population. Overall, as organizations struggle to navigate care and find solutions for their undocumented older adult patients among the limited resources available, there will become an increased need for more structural solutions. Without structural solutions, the frequency of older adults requiring these services will increase.



**We must acknowledge how we address social determinants of health such as insurance, transportation, primary care, food and housing, can all be heavily impacted by immigration status.**

Organizations such as FQHCs and free and charitable clinics may be able to currently provide quality wraparound care for undocumented individuals; however, they would not be able to provide such services if the demand increases twelvefold, as the data shows. Additionally, many undocumented or uninsurable individuals who are not connected to a medical home may use emergency rooms as their source of primary care or may admit themselves to emergency rooms for medical emergencies that could have been mitigated with other care and services (Samra et al, 2019; Pourat et al, 2014; Ortega et al, 2018; Flavin et al, 2018).

## Potential Solutions



**Advocate for health care reform.** As undocumented individuals age and require services, medications and other necessities, it will not only put a strain on organizations but will also create a significant social cost for families and communities. Health care institutions may bear the cost of these inequities in terms of bad debt, charity care and other expenses, and lower access to preventive care and equitable care has shown to result in more extensive health care expenditures for both patients and the health care institutions. Therefore, **advocating for reform and equitable health care access for the undocumented is certainly within the best interests of health care organizations.** Organizations and our policymakers must create ways for the undocumented community members to access these services so they can age well, access preventive care and manage chronic conditions to avoid complications.



**Employ and support social care workers.** Organizations and particularly health care organizations can address disparities and increase preventive care and chronic care management adherence through the employment of social care workers such as social workers and community health workers (Enard & Ganelin, 2013; National Academies of Sciences, Engineering, and Medicine, 2019).



**Expand charity care, financial assistance, and more public support of FQHCs and charitable clinics.** Health care institutions, foundations, public and governmental programs, and other structural figures could increase their support for institutional charity care programs, as well as support capacity building efforts and reimbursement for FQHCs and free and charitable clinics. Currently, some FQHCs and free and charitable clinics are partnering with larger health care institutions and managed care organizations to provide more comprehensive care for their patients, while also creating collaborative agreements, while other health care institutions are adapting their financial assistance programs to be more equitable and accessible.



**Invest in “geriatrizing” the FQHC workforce.** There could also be additional resources invested into FQHCs and free and charitable clinics to train their staff in geriatrics, in order to prepare the workforce for the aging uninsurable and undocumented population. This can be done with supporting and expanding efforts like Geriatric Workforce Enhancement Programs (GWEPs), like those at the [Rush Center for Excellence in Aging, the University of Chicago](#), and [the University of Illinois at Chicago](#), among [others](#) throughout the state and country.



**Create networks of collaboration and resource sharing.** In the meantime, institutions may also work collaboratively to coordinate their care, advocate for equitable access and structural solutions, and share known resources and navigational knowledge. This will greatly aide care management of undocumented older adults as they navigate the current patchwork of resources available to them. The current system is difficult to navigate, and undocumented immigrants are fearful of burdensome bills from hospitals and other health care institutions. Organizations could collaborate with community organizations to help immigrants, particularly those that are aging, to navigate health care as it currently is. While some organizations and passionate workers have created patchwork solutions to address disparities and provide care, organizations will need more structural change in order to be sustainable as the population continues to grow.

# Policy Implications

## A looming ethical and public health crisis

Current national, state and local public policy infrastructure is not prepared for the expected growth of the aging undocumented population. **The public policy barriers that currently block undocumented immigrants from accessing aging services will inevitably lead to a public health crisis.** Without access to health care coverage, there will be a steep increase in the progression of diseases and mental health issues, while will create a burden on family systems as well as both the health care workforce and the overall workforce, and will increase health care expenditures for health care systems, the safety net and taxpayers.

In the United States, older adults express challenges in accessing coverage, care and comprehensive services. This is especially true for the undocumented population. The Personal Responsibility and Opportunity Act removed several populations from public benefits and created immigration status requirements, leaving those who do not qualify with far fewer resources. Furthermore, the way that federal funding is allocated to public health services consistently excludes undocumented older adults. For example, if a social service agency receives federal funding, often that federal funding and its reporting requirements mandate that the funded services do not serve undocumented immigrants.

As called to our attention by a collaborative member, for example, much of the funding reserved for aging populations such as organizations related to Alzheimer's disease and dementia, are not accessible to people of all statuses. Additionally, some legal aid agencies that assist older adults navigate health-harming legal needs such as public benefits, advance directives, housing and utilities, and others are not accessible by those who are undocumented.

The services that are available to those who are undocumented may become overloaded as well, such as safety net organizations for basic needs such as food, clothes, etc. While there is not currently enough funding or resources in these services to successfully serve the existing population experiencing poverty, a stark increase in demand could overwhelm these systems.

### Lack of access to socialized programming

Essentially, **all undocumented immigrants are ineligible for several services that require a Social Security number to access.** These services include Medicaid, Medicare, Social Security, retirement, disability and SNAP, and may, in some cases include blocked or severely limited access DME, homecare, adult day care, transportation services, mental health services and others.

For many of these services, individuals would be forced to pay exorbitant out-of-pocket self-pay rates or depend on charity care, if available. These individuals are not able to access insurance without a Social Security number and qualifying immigration status. Without health insurance, this population experiences major barriers to accessing basic health care needs including mental health, preventive care or long-term care, as well as dental and vision care. Furthermore, with insurance, there are built-in services, including transportation,



**Excluding undocumented immigrants from public health insurance plans such as Medicare, Medicaid, and the Affordable Care Act marketplace has a reverberating effect that not only damages individuals, families, and communities, but also hurts healthcare institutions and creates a strain on the entire healthcare system.**



Older adults exercise at the North Center Senior Satellite Center in Chicago, IL (Photo Courtesy of Chicago Department of Public Health)

mental health services or crisis line services. Without insurance, this population is also locked out of these resources as well. Furthermore, being ineligible for these services automatically makes them ineligible for other services such as personal assistance or homemaker services, nutritional programs, and several other services that provide basic needs assistance to older adults and people with disabilities. Additionally, retirement, social security, and labor and workforce development programs also exclude undocumented individuals.

### Public policy facilitators

Though there are substantial barriers based on current policies, undocumented older adults are able to access care and services through the various patchwork of resources aforementioned in the “Health Care Organizations and Care Management” section. Many foundations and organizations have worked to cover the gaps in care and services for undocumented individuals. For example, patients may be able to access more services if they suffer from a particular medical condition, such as HIV or kidney disease. Care managers have also had experience in helping others in the household access benefits that they qualify for, ultimately lowering burden on the household.

Charity care programs, independently funded foundations, FQHCs, and free and charitable clinics are available. However, many in the community may not know about these resources, and a provider must “go the extra mile” to connect their patient with enough programs to provide comprehensive care. Though it is fortunate that programs exist, they often must be pieced together in order to meet a patient’s needs, and navigating these systems and resources can be a time-consuming process for a provider or caregiver. If a provider cannot go the extra mile or is not knowledgeable of these different piecemeal resources available specifically for these types of populations, the patient does not get the care that they need. **Every patient does not have an advocate willing to go to this extent that is also knowledgeable about the resources.**

As FQHCs, free and charitable clinics, and nonprofit and safety net hospitals provide care to those in poverty and the uninsurable, they could be subsidized and supported by policies and public funding. For example, Healthy San Francisco and other health care access programs for undocumented populations across the country can serve as models for potential temporary financial assistance to this population. Though it may be difficult to change public policy through federal legislature means, there is much that can be done on a state level to open up health care access to undocumented individuals or to subsidize the aforementioned organizations that actively serve this population.

## Improvements and interventions at the policy level

In order to create a network of systems that can support the aging undocumented population and avoid a major public health crisis in the United States, the collaborative recommended certain policy changes. Advocacy is needed at all levels to prepare our systems for the aging of the undocumented community. **By improving our infrastructure to better work with undocumented older adults, we will subsequently improve systems of care for undocumented immigrants overall, all older adults, and all patients.**



### Coalitions and centralized databases

Under the current system, tapping into existing and established coalitions in Illinois who serve undocumented patients, a centralized directory or database for resources and services available to undocumented individuals would be of great help to care managers and other providers. This resource, although frequently changing and expanding, would ease burden on providers struggling to navigate patchwork resources, helping them to more systemically create a personalized care plan for each undocumented patient. Furthermore, a coalition of health care providers and social service institutions that serve the undocumented could work to create and build a system through which undocumented patients can access medical care and social services. This type of coordination and action would help create access to at least a portion of the aging undocumented population.



### Support and increased capacity building of existing programs

Ultimately, if the organizations that currently serve the undocumented community must continue to meet increased demands over time, Illinois and federal governments must fund these programs' expansion and capacity-building efforts. In lieu of undocumented older adults gaining access to public health insurance options, if these government structures fail to support these programs, they will inevitably face a public health crisis. These organizations, who are able to service undocumented older adults through financial assistance and charity care programs, are already working with little resources and are moving toward reducing their charity care spending. These programs should rather expand, and the government must help fund these expansions, as well as create more explicit public policy that regulates financial assistance programs. This way, all charity care and financial assistance programs would be more uniform, and this can ease confusion and frustration from the community. Buy-in from elected leaders will be key to these types of changes. There are several coalitions working on health care expansion; however, the creation of a public task force for this population will help address various needs and continually speak up to ensure this population is not overlooked.



### Expand the public safety net

Given the anticipated increase of both the uninsured population overall and the undocumented older adult population, organizations will need more structural and sustainable solutions to allow them to effectively and competently serve these communities. As we will discuss in policy implications, states and the federal government could more heavily subsidize programming and health care services provided to the uninsurable. Public safety net programs should also reimburse health care institutions for providing comprehensive care for undocumented older adults, including both preventive and acute care or should create insurance programs that will allow equity in accessibility of these services.



### Legislative changes

Legislative-level changes will require considerably more time and effort but will have lasting impacts on breaking down public policy barriers for the aging undocumented population, allowing them to access more resources and receive the care that they need. These types of larger scale, public policy reforms include immigration reform, universal health insurance, minimum wage reform and workers' rights, using state and city taxes to pay for charity care programs and subsidize FQHCs and free and charitable clinics, repealing or amending the Personal Responsibility and Opportunity Act, and allocation of funds or improving the reimbursement system for hospitals that serve mainly undocumented populations.

Even if federal social programs are funded or expanded, without immigration reform, this population is still going to live with the fear of deportation and continue to be excluded from resources and services.



### Universal health coverage and/or accessible single-payor health care system

Universal health care that is accessible to the undocumented would allow this population to have access to health insurance, which subsequently would open several doors to additional services older adults require to age well. Illinois could potentially model a health plan after California's Medi-Cal program, which does not exclude non-citizens. In the state of California, both immigrant and native-born individuals may apply for health insurance through Covered California to determine eligibility for a health plan through Medi-Cal or Covered California. Those who are not lawfully present in the United States have the option to apply for health coverage through Covered California and may be covered through Medi-Cal up to the age of 19 or even for pregnancy coverage. Various counties in California also offer other health insurance types outside of the Covered California program, regardless of immigration statuses. Illinois already has a version of this coverage through having expanded Medicaid coverage to youth up to the age of 19 through All Kids. Illinois could also regulate Managed Care Organizations (MCOs) and private insurers to be more inclusive and equitable, as well, by creating regulations or offering incentives.



### Minimum wage, workers' rights, and domestic workers' rights

Advocating for reform of minimum wage, workers' rights and possible caregiving benefits will help alleviate some of the stress that the caregivers of these older undocumented patients feel. The inequities experienced by these families affect more than just this specific population. For years these populations have not been able to access caregiving benefits for themselves or for their family members. There have been few coalitions built between domestic workers and older adults with disabilities in need of care; however, this must be expanded and further advocated for. Recognition and protection for domestic workers, farm workers and other undocumented workers must be essential in ensuring the undocumented population can age well.

Photo courtesy of the Shriver Center on Poverty Law



# Discussing Complex Multilevel Interactions

While this report uses a socioecological framework to organize our discussion about the implications of an aging undocumented community, it is important to mention that all of these issues have an impact on all levels of the ecological model.

Locking certain older adults out of larger systems like Social Security and Medicare creates a domino effect that not only affects the individuals who cannot qualify for these programs, but directly impacts their caregivers and other family members, health care workers, communities, community-based organizations and health care organizations.

Not having access to Medicare and Medicaid blocks access to home health, homemaker services, skilled nursing care, rehab and so many other necessary services that older adults depend on to age successfully in their homes and communities.

Often movements or efforts to expand access may alienate some of the most vulnerable populations — for example, immigration reform that does not include the elderly or Medicare reform that doesn't expand access to immigrants. Food access, housing and homelessness, workers' rights, mental health, social isolation and loneliness, and any other social issue must be approached from an intersectional lens that recognizes both aging and immigration status. As health care and social service professionals, we cannot ignore the direct effect that immigration status has on the social determinants of health, particularly regarding aging.

In 2018, the National Academies of Science, Engineering, and Medicine released a report highlighting numerous ways in which immigration status is extensively linked to health outcomes as a social determinant of health (National Academies of Science, Engineering, and Medicine, 2018). Patients not having adequate access to preventive care, safe and ethical discharges from the hospital, home supports, hospice and palliative care, and many other aspects of the health care industry will harm not only those individuals, but will inevitably reverberate through society.



**Some people won't be able to work due to caretaking, which reduces income and increases stress among the families taking care of their parents. So I think that this can cause a real big strain on the whole system.**





**The growth of the undocumented population without adequate accommodations to our healthcare policies will result in more people living at the edge, in need of resources and using the ER as a plan.**

These issues are particularly salient when we look at family systems and caregiving. Families living in multigenerational households on limited incomes, when some members of those families have virtually no access to resources, will put a strain on the entire family. We do not want a future in which adults must choose between feeding their families or providing medications for their aging parents.

As we continue to serve and learn more about the aging of the undocumented community, it is incredibly important for activists, researchers, providers and others to continually center the voices of undocumented individuals and particularly undocumented older adults. It is important for us to look at these issues with a socioecological mindset — acknowledging that all issues have an effect on multiple levels.

Left: a participant in a community activity organized by La BROCHA; Right: Socorro Rocha (Photos courtesy of Judith Rocha, PhD, LCSW and La BROCHA)



# Appendix

## Appendix I: Current Issues for Consideration

### Public Charge

The Public Charge rule refers to a policy under U.S. immigration law, dating back to 1882, that allows the federal government, in particular the Department of Homeland Security (DHS) to implement a test that “can deny someone a green card or visa if it believes that person is ‘likely to become a public charge,’ that is, likely to rely on government support for that person’s livelihood” or to rely on public support for their basic needs (ICIRR, 2020). The use of benefits counts regardless of the amount received or used. The policy rather looks at the length of time any of these benefits were used and flags those who used any of the benefits for more than 12 months in the aggregate within any 36-month period (i.e., a recipient of two benefits for one month would count as two months in aggregate) (Protecting Immigrant Families, 2020). As of February 2020, the expanded definition and the totality of circumstances that the federal government are now considering as part of this test have gone into effect.

Since February 2017, there have been efforts to broaden who may be considered a public charge by including more public benefits and standards for the public charge test. These changes have worsened the anxiety and fear amongst immigrant communities of all immigration statuses, often referred to as the chilling effect. Health care providers have seen hesitancy in insurance enrollment and public benefits use, fear in accessing health care, and overall misinformation and worry about public charge.

Given that the information on the Public Charge rule, its current validity, as well as recommendations, are often changing, recommendations for Public Charge have been omitted from this report. For the most up-to-date information, please visit [www.protectingimmigrantfamilies.org](http://www.protectingimmigrantfamilies.org) (national) or for the state of Illinois, please visit [www.protectingimmigrantfamiliesillinois.org](http://www.protectingimmigrantfamiliesillinois.org).

### Illinois Medicaid Expansion

In May 2020, after long advocacy campaigns from various organizations throughout Illinois and countless discussions with the Illinois Department of Healthcare and Family Services (HFS) and the state legislature, Illinois passed an expanded budget for Fiscal Year 2021 that would include expanded Medicaid coverage for any adult over the age of 65 who falls below 100% of the Federal Poverty Level (FPL) regardless of immigration status. While this expansion in coverage is incremental, the impact will be monumental.

This expanded Medicaid program is different than traditional Medicaid in Illinois, which approves individuals, and in particular seniors, who are at 138% FPL. Additionally, the expanded Medicaid coverage will initially not cover long-term skilled nursing care, services in developmental disability, mental health facilities and funeral or burial expenses. Enrollment in this insurance plan does not count toward Public Charge considerations.

As noted in an article in the *Chicago Tribune*, many undocumented older adults will immediately benefit from this expanded program. To read an article by Laura Rodríguez-Presa to hear the stories of those directly impacted by this program, [click here](#).

As of December 1, 2020, this coverage has gone into effect. For more information and updates about health care coverage for immigrants in Illinois, as well as guidance for how to apply to this expanded Medicaid program, visit the Healthy Illinois Campaign website at [www.healthyillinoiscampaign.org](http://www.healthyillinoiscampaign.org).

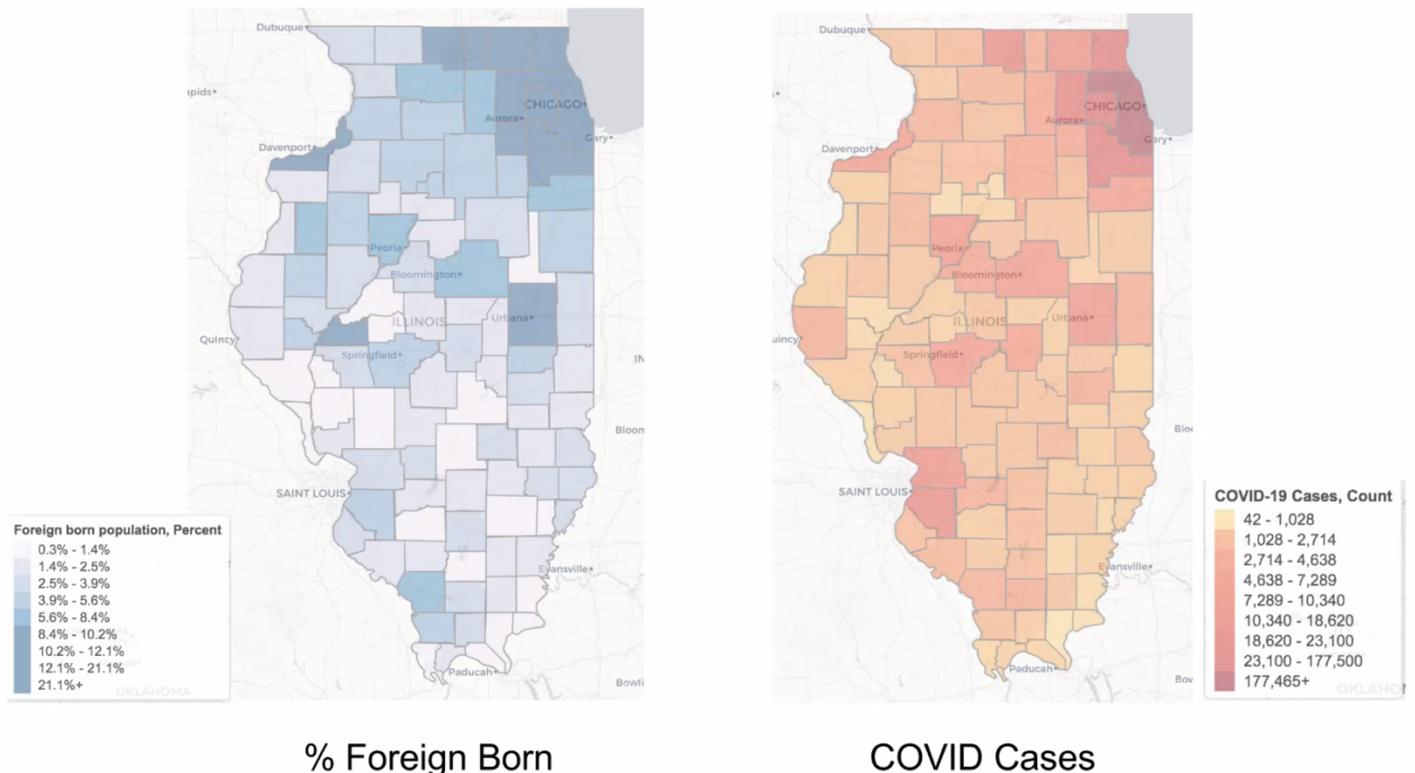
## COVID-19

In the state of Illinois, testing and treatment for COVID-19 are provided at no cost to the patient regardless of immigration status or ability to pay. While some for-profit companies are charging uninsured individuals for tests, locations where testing and care are provided for free regardless of insurance or ability to pay can be found on the Illinois Department of Public Health Website at [www.dph.illinois.gov/covid19](http://www.dph.illinois.gov/covid19) or each county's department of public health website. It is important to note that these tests, as well as any care provided for COVID-19 patients does not count toward the aforementioned considerations for Public Charge.

Throughout the COVID-19 pandemic, Black and Latinx communities have been disproportionately affected by the virus and its socioeconomic consequences. "Inequities in the social determinants of health, such as poverty and health care access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks" (CDC, 2020). "Those most vulnerable include the elderly, those with disabilities, those who are experiencing a series of health disparities such as diabetes Type 2, asthma, high blood pressure and other cardiovascular conditions. Other challenges experienced by Latino communities include a series of barriers to health and medical care due to lack of health insurance, the lack of English proficiency, combined with institutional racism and social discrimination, particularly against immigrants and the undocumented" (Illinois Unidos, 2020).

While there is no data to show specifically how immigrants are being affected by the COVID-19 pandemic, in a symposium presentation from the University of Chicago's Center for Chronic Disease Research & Policy. Dr. Aresha Martinez-Cardoso shared the maps depicted in Figure 6. Comparing these two maps, we see that the areas in Illinois with higher populations of foreign-born residents correlates strongly with the map documenting the confirmed cases of COVID-19. While this is not causative data, the correlation has an implication for how the immigrant community may also be disproportionately affected by COVID-19, as data from the CDC and numerous other sources show how social determinants of health greatly contribute to COVID-19 infections.

Figure 6: A heat map of Illinois that displays the percentage of foreign-born residents (left) compares similarly to a heat map of COVID-19 cases (right)



Through working with the immigrant community, collaborative members and advocates have stated that immigrant individuals have expressed extreme fear in accessing COVID testing and care, out of fear of immigration enforcement, fear of large bills from health systems and fear of the Public Charge rule. Additionally, our collaborative members have stated, from talking with families and immigrant communities, that many of our immigrant older adults live in multigenerational households (also supported by our data from Rob Paral & Associates). This living situation makes it hard for older adults to physically distance. Additionally, as essential workers are disproportionately Black and Latinx, as well as from immigrant communities, many who reside in the same home as immigrant older adults may be essential workers who are exposed to COVID-19 more frequently.

## Appendix II: Further Research for Further Advocacy

If more academic research and needs assessments can be made, these types of reports and information can hopefully lead to further advocacy at all different levels of government to lead to further legislative change. Collaborative members continuously suggested more qualitative research studies be performed to hear the experiences of undocumented older adults directly, as well as the need for researchers to continue monitoring geographical and racial/ethnic data on a local and community level. They stated that the data in this report was not sufficient to fully understand the needs of the immigrant older adult community. Additionally, centering the experiences of older adults in the formation of any solutions in their care and wellness is central to creating age-friendly health systems and age-friendly communities.

### **Additional research and efforts suggested include:**

- The inclusion of immigration status and language access in hospitals' community health needs assessments and community health improvement plans
- Qualitative studies of the lived experiences of undocumented older adults through which undocumented older adults are involved in the formation and are subjects of the study
- Studies on the intersections of disability, sexual orientation, ethnicity and language access among undocumented older adults
- An additional demographic study with more detail and further projections of the expected growth of the undocumented older adult community
- Considerations for undocumented individuals and immigrant individuals of all statuses into research and best-practices regarding Age-Friendly Health Systems and Age-Friendly Communities
- Additional focus on disability access within the undocumented community

## Appendix III: Methods

The demographic data for this report was analyzed and compiled by Rob Paral of Rob Paral & Associates. The data sources for this project principally include:

- American Community Survey for 2013-2017 in aggregate and microdata form, available from the U.S. Census Bureau, and year 2000 data from the decennial census of that period. This information reports on the demographic, social and economic characteristics of the population, including foreign-born and noncitizen U.S. residents. This is public-use information available at no charge from the federal government.
- Summary-level, aggregate data tabulations of undocumented immigrants in Illinois. This information was provided by the Center for Migration Studies New York and is generated by CMSNY from their proprietary data sets. The data is in aggregate form and no individual-level data are provided to this project.

Detailed information on undocumented immigrants is available from the Center for Migration Studies of New York, where researcher Robert Warren has developed a method of attributing a likely immigration status to individual census records. The CMSNY data permits us to look at specific characteristics of undocumented populations such as their age. CMSNY provided Rob Paral & Associates with the estimated counts of undocumented immigrants by age and country of origin who reside in Illinois.

As you read this report, keep in mind that the figures are estimates, and that by definition, there is no perfect method for determining the exact population of undocumented immigrants with no margin of error. However, Rob Paral cross-references data that is available through these aforementioned data sources to determine individuals and households that are “likely” to be undocumented, which is the current standard in the field. The characteristics of undocumented immigrants are estimated using proxy populations that are assigned weights based on their representation among all older undocumented immigrants. This method was pioneered by The Urban Institute, is used by Rob Paral & Associates, and has been vetted and is as accurate as possible, and is similar to methods used by other demographers attempting to estimate the undocumented immigrant population. Additionally, the fact that households and individuals cannot be precisely identified is indeed a reassuring fact for the safety, well-being and privacy of our communities.

To view the original report by Rob Paral & Associates, which includes further explanations and tables, you can access the PDF of the report at <https://robparal.com/about/publications/>.

We know that demographic data isn’t enough to capture the full picture of aging while undocumented; therefore, we decided to create a collaborative that could provide an experiential perspective, whether personal or professional. We convened a collaborative of more than 30 individuals with personal and professional experiences related to undocumented older adults. We named the temporary collaborative the Illinois Collaborative on Undocumented Older Adults (ICUOA). This collaborative met on four occasions:

- **First Meeting:** to discuss priorities for the report and create a “Data Wish List” for our demographer
- **Second Meeting:** provided feedback on the draft of the demographic portion of the report
  - The first two meetings of the collaborative informed both the content and context of the report, as well as indicated what data the demographer would need to analyze.
- **Third Meeting** (recorded and transcribed): a focus group to discuss the political, community-level, and other structural implications of an aging undocumented population
- **Fourth Meeting** (recorded and transcribed): a focus group to discuss the individual, family, and clinical practice implications of an aging undocumented population

Once the meetings and focus groups were transcribed Padraic Stanley, Brittney Lange-Maia, Natasia Adams, Bonnie Ewald and Janna Gordon reviewed the transcripts and decided a socioecological approach would be best to organize the data. Once the transcripts were reviewed, the authors created a code book based on the socioecological model and coded the transcript. Once the transcript was coded, the final report was written by Stanley, Lange-Maia, Yumiko Gely and Nancy Cortes. The report includes both quantitative data from the population-based estimates and narrative reflective of the issues identified by the collaborative. We see the work in this report as a crucial first step of understanding this population, though further work is needed.

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Note: Some collaborative members chose to not include themselves in the final report.

## **Acknowledgements:**

Thank you to Robyn Golden, AM, LCSW and Erin Emery-Tiburcio, PhD, ABPP, co-directors of the Rush Center for Excellence in Aging, as well as Laurin Mack, PhD, Chair of the CEA Community Health Equity Core for your continued support of this project.

Thank you to Raj C. Shah, MD for the support of the Alzheimer's Disease Center and the Center for Community Health Equity.

Thank you to Grisel Rodríguez-Morales, MSW, LCSW and Walter Rosenberg, MSW, MS-HSM, LCSW for your support and advocacy.

Thank you to all members of the Rush Immigrant Health Working Group and the Illinois Alliance for Welcoming Health Care for your continued dedication to immigrant health and immigrant health care access.

Data visualization and report design completed by Padraic Stanley, LCSW. Icons obtained through a paid subscription to the Noun Project ([www.nounproject.com](http://www.nounproject.com))

## **Suggested Citation:**

Stanley, P. & Lange-Maia, B. (2020). *A Collaborative Report on the Aging Undocumented Population of Illinois*. Chicago, IL: Rush Center for Excellence in Aging.

## Appendix V: Glossary

- Federally Qualified Health Center (FQHC)** - according to FQHC.org, a health center that qualifies for funding under Section 330 of the Public Health Services Act and qualifies for enhanced reimbursement from Medicare and Medicaid, as well as other benefits because they serve an underserved area or population, offer sliding fee scales, and provide comprehensive services
- Free and Charitable Clinic**- a safety-net health care organization that utilizes a volunteer/staff model to provide a range of medical, dental, vision, and/or behavioral health services to economically disadvantaged individuals. While some offer free services and other offer sliding scale fees, offered services are provided regardless of the patients eligibility to pay, and prioritize patients who are uninsured, underinsured, or have no access to primary, specialty, or prescription health care (National Association of Free and Charitable Clinics, 2016)
- Immigrant** - a person born in a country other than the United States who has moved to the U.S. with the intention to reside permanently
- Legal Permanent Resident (LPR)** – also referred to as a “Lawful Permanent Resident” or “Green Card Holders,” LPRs are non-citizens who are lawfully authorized to live permanently within the United States
- Long-Term Care** – “a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own” (National Institutes of Health)
- Medicaid** – a public health insurance plan that provides health insurance coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by state and federal government. Individuals must meet certain guidelines, including income below a certain threshold, to qualify
- Medicare** – a federal health insurance program for people who are 65 or older, people with disabilities, or people with end-stage renal disease (ESRD), who meet certain federally standard requirements such as immigration status, work credits, and others
- Older Adult** – often refers to an adult age 65 and older; however, this varies by study, organization, and perception. In general, older adult can mean any adult age 55 or older, but typically speaks to those age 65 and older.
- Safety Net** – The metaphor of a “safety net” refers to the various Welfare Programs in the United States designed to protect low-income Americans from poverty and hardship. This includes program such as Medicaid, Medicare, Children’s Health Insurance program (CHIP), Temporary Assistance for Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP, also known as “food stamps”) (Epplin & Ford, 2018)
- Safety Net Hospital** - A hospital comprised of “providers that organize and deliver a significant level of both health care and other health-related services to the uninsured, Medicaid, and other vulnerable populations,” as well as providers “who by mandate or mission offer access to care regardless of a patient’s ability to pay and whose patient population includes a substantial share of uninsured, Medicaid, and other vulnerable patients” (IOM, 2000). “Most safety net hospitals—both public and private—receive subsidies from Medicaid and Medicare DSH payments because of the large amount of care they provide to uninsured people” (U.S. Dept of Health & Human Services, 2013)
- Social Security** – “the term used for the Old-Age, Survivors, and Disability Insurance (OASDI) program in the United States, run by the Social Security Administration (SSA), which is a federal agency. While best known for retirement benefits, it also provides survivor benefits and disability income. It is independent of a lump-sum pension” (Investopedia, 2020)
- Undocumented** – Used to describe an immigrant living within the United States without authorized immigration status. This includes individuals “who have entered the United States without inspection and permission from the United States government, as well as those who have entered with a legal visa that is no longer

valid” (US Legal, 2019). Undocumented individuals may also be referred to as “unauthorized immigrants.” Under no circumstances should undocumented immigrants be referred to utilizing the term “illegal.”

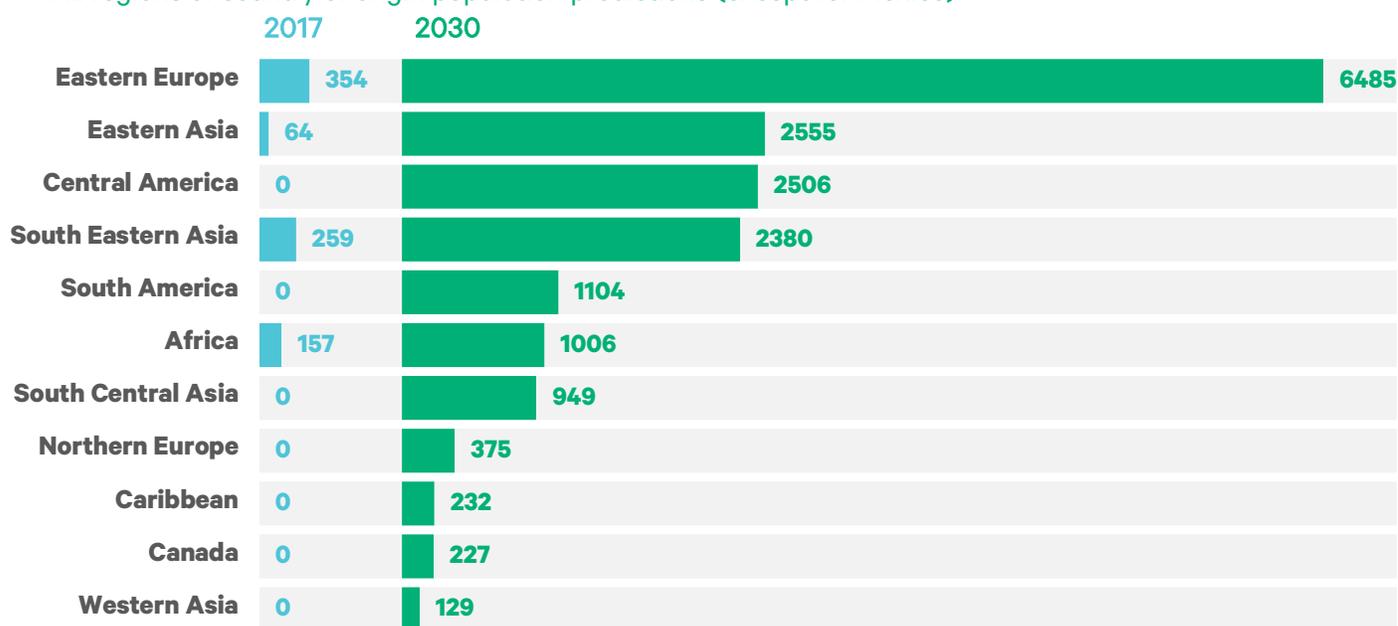
**Visa** – refers to an authorization given by the U.S. government to immigrants wishing to enter the U.S. There are many types of Visas depending on the initial purpose of travel. Some Visas provide a pathway to lawful permanent residencies, while others are intended to be temporary.

## Appendix VI: Additional Data and Tables

Projected Population Growth of Undocumented Immigrants by Region of Country of Origin and Age Cohort

Region and/or Country of Origin	2017 Population				2030 Projected Population				% Change
	Total	Age 65 to 74	Age 75 to 84	Age 85+	Total	Age 65 to 74	Age 75 to 84	Age 85+	
Mexico	3,153	3,042	110	-	37,195	32,144	4,955	95	1,080%
Eastern Europe	354	-	354	-	6,485	5,300	1,074	112	1,732%
Eastern Asia	64	64	-	-	2,555	2,257	299	-	3,892%
Central America	-	-	-	-	2,506	2,415	92	-	2,506%
South Eastern Asia	259	129	130	-	2,380	1,988	347	45	819%
South America	-	-	-	-	1,104	900	204	-	-
Africa	157	157	-	-	1,006	689	317	-	541%
South Central Asia	-	-	-	-	949	828	120	-	-
Northern Europe	-	-	-	-	375	304	72	-	-
Caribbean	-	-	-	-	232	180	52	-	-
Canada	-	-	-	-	227	138	89	-	-
Western Asia	-	-	-	-	129	129	-	-	-
<b>TOTAL</b>	<b>3,986</b>	<b>3,392</b>	<b>594</b>	<b>-</b>	<b>55,144</b>	<b>47,271</b>	<b>7,621</b>	<b>252</b>	<b>1,283%</b>

All regions of country of origin population predictions (except for Mexico)

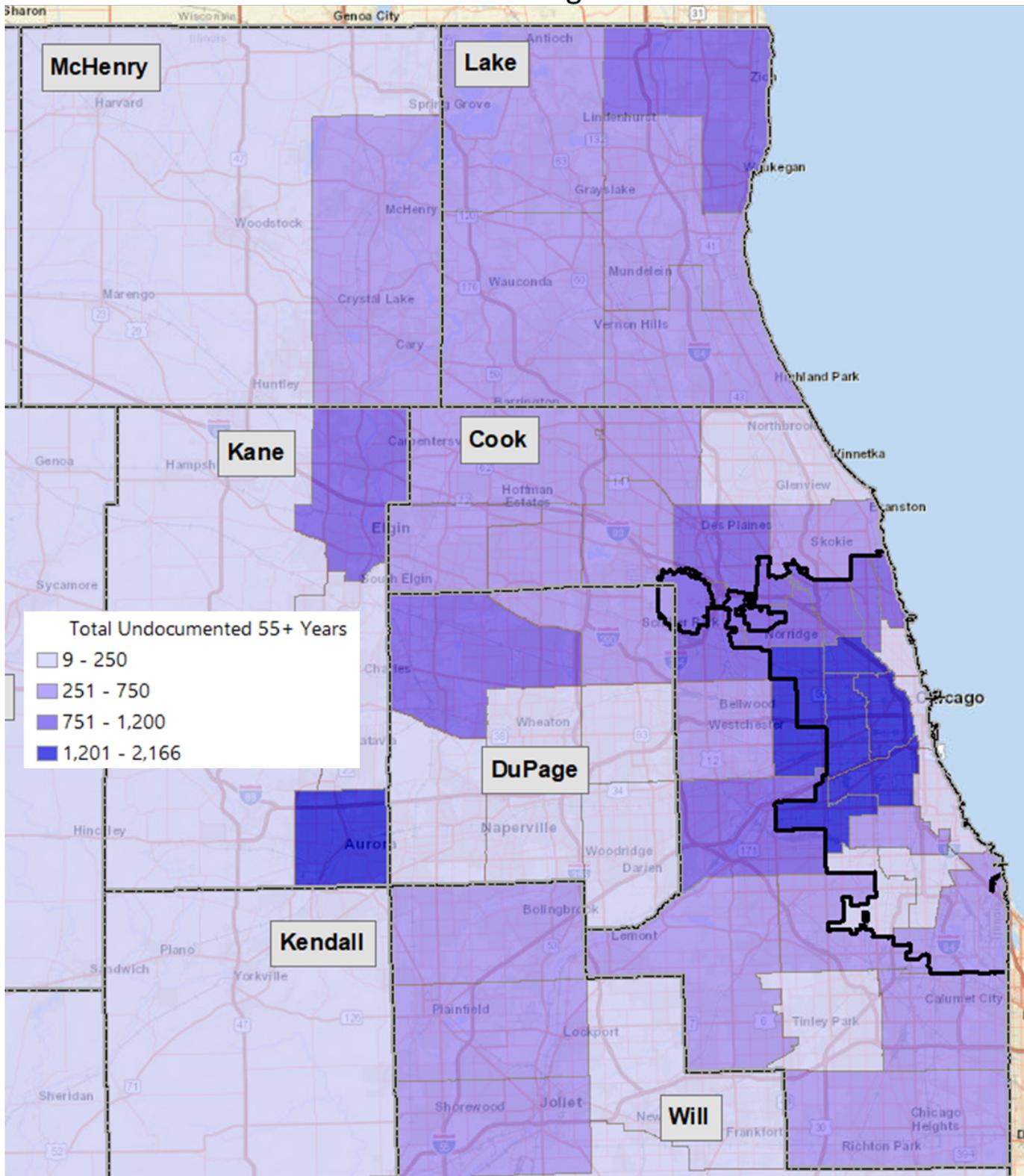


Household Characteristics of Undocumented Illinois Residents Aged 55+ Years, with Comparisons to Native Born Groups (NB=Native Born, NL=Non-Latino)

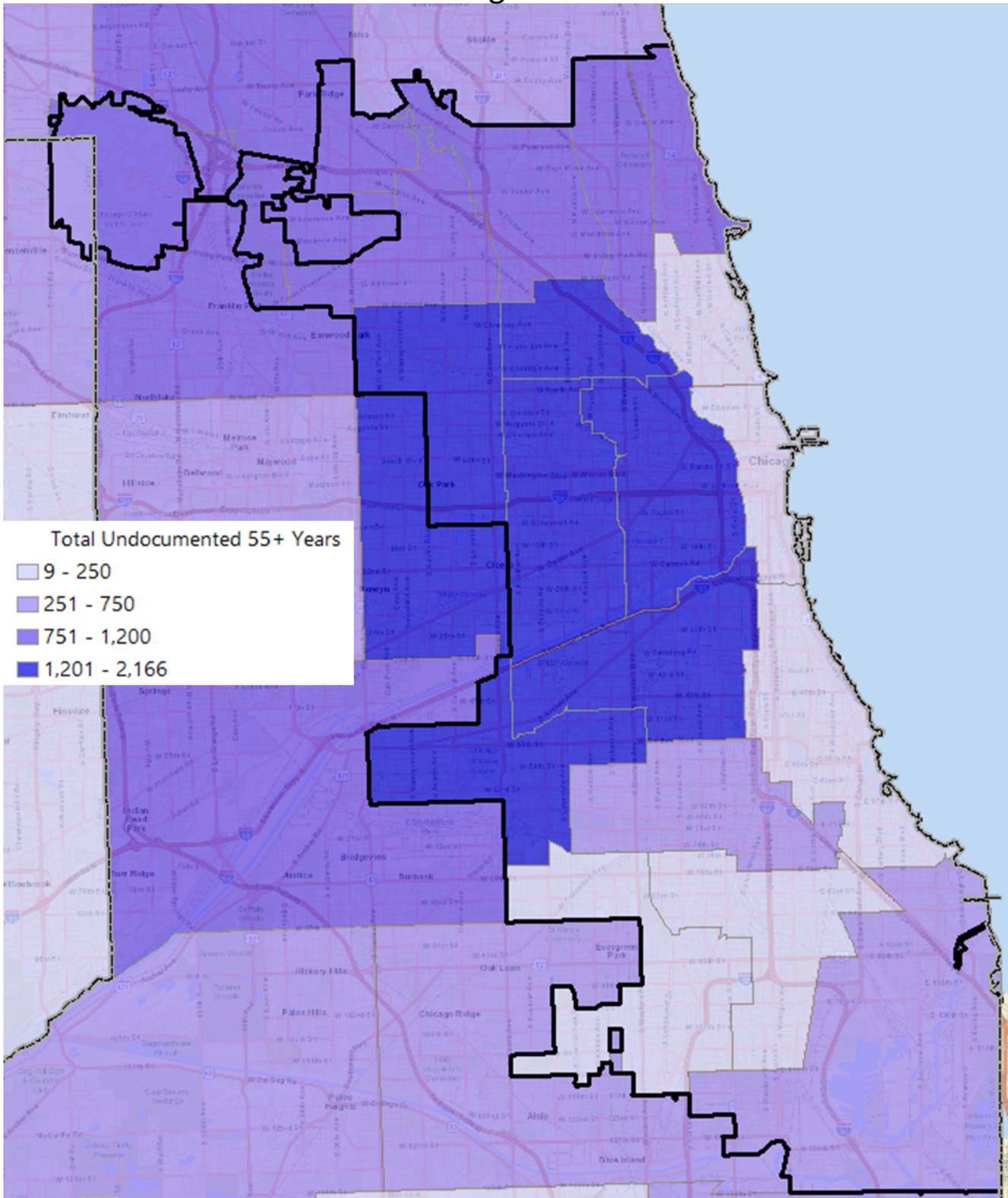
	Live Alone	In One-Generation Household	In Two-Generation Household	In Three-Generation Household	Live with a Child	Live with Younger Adults
<b>Undocumented</b>	8%	29%	38%	32%	39%	74%
<b>NB Total</b>	28%	72%	20%	5%	7%	26%
<b>NB Black NL</b>	35%	58%	27%	11%	14%	39%
<b>NB Asian NL</b>	23%	60%	29%	9%	12%	35%
<b>NB Latino</b>	23%	55%	29%	14%	17%	46%
<b>NB White NL</b>	27%	76%	18%	3%	6%	23%
<b>NB Other NL</b>	30%	70%	22%	7%	11%	34%



## Estimated Undocumented Immigrants Age 55+ Years: Metro Chicago 2017



# Estimated Undocumented Immigrants Age 55+ Years: Chicago 2017



## Appendix VII: About Rob Paral & Associates

Rob Paral and Associates have assisted more than 100 different human service, advocacy and philanthropic organizations in understanding the communities they are trying to serve. RPA works with large-scale data and geographic information systems to develop insight into community assets and needs.

Rob Paral is a Research Specialist with the Great Cities Institute of the University of Illinois at Chicago, a nonresident fellow in the Global Cities program of the Chicago Council on Global Affairs and a lecturer in the Latin American and Latino Studies Program of the University of Illinois at Chicago. He was the Senior Research Associate of the Washington, DC office of the National Association of Latino Elected and Appointed Officials, and was Research Director of the Latino Institute of Chicago. He has been a fellow or adjunct of the Institute for Latino Studies at Notre Dame University, DePaul University Sociology Department, and the American Immigration Council in Washington, DC. More information and reports may be found at [www.robparal.com](http://www.robparal.com)

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