#blacklivesmatter, #blackoutday
Outline

1 Motivation:
   - Geographic diversification of U.S. Latinx Settlement
   - Implications for health and well-being

2 Research Questions

3 Defining Destinations

4 Datasets and Results:
   - RWJ County Health Rankings
   - HPSA and MUA designations
   - AHRF health services data
   - 287g agreements

5 Summary and Future Directions

Please do not cite without author permission
Acknowledgements

Sung Hee Hong

Pedro Aristizabal Posada

Jessica Martinez

Gabriel van Praag

My Wonderful Undergrad RAs!
Rise of New Latinx Destinations

Figure 1. Hispanic Growth Patterns, 1990 to 2010


Source: Lichter, Sanders, and Johnson 2015

Please do not cite without author permission
New Latinx Destinations in the U.S.

- Places with negligible or small presence of immigrant groups prior to 1990; rapid growth thereafter

- Reasons for emergence:
  - Industrial restructuring (meatpacking, food processing, etc.)
  - Immigration laws and border control (IRCA, border fencing and patrol, etc.)

(Massey and Capoferro 2008)
New Destinations (cont’d.)

- By 2000, approximately 25% of Latinos/as were living outside of established gateways
  (Lichter and Johnson 2009)

- By 2010, approximately 32% of Latinos/as were living outside of established gateways
  (Author’s estimate based on 2010 decennial census data)

- Mainly driven by Mexican-origin population
  (Terrazas 2011)
New Latinx Destinations

**FIGURE 1. HISPANIC GROWTH PATTERNS, 1990 TO 2010**


Source: Lichter, Sanders, and Johnson 2015

Please do not cite without author permission
Why do destinations matter for Latinx Health and well-being?

1. Intergroup relations

(De Jong et al. 2017; Waters and Jiménez 2005)

Please do not cite without author permission
Destinations, Health, and Well-Being

Why do destinations matter for Latinx Health and well-being?

1. Intergroup relations
2. Size and potential for intergroup contact (segregation, isolation, etc.)

(Hall 2013; Lichter et al. 2010; Park and Iceland 2011; Waters and Jiménez 2005)

Please do not cite without author permission
Destinations, Health, and Well-Being

Why do destinations matter for Latinx Health and well-being?

1. Intergroup relations
2. Size and potential for intergroup contact
3. Institutional arrangements

(Derose et al. 2007; Waters and Jiménez 2005)

Please do not cite without author permission
Destinations, Health, and Well-Being

Intergroup Relations (Discrimination, Hostility, Etc.)

Size and Potential for Intergroup Contact (Residential Segregation, Isolation/Exposure, Etc.)

Institutional Arrangements (Health Care Supply, Bilingual Services, Etc.)

Health and Health Disparities

(Acevedo-García and Lochner 2003; Diez Roux 2001; Guttman et al. 2010; Hatzenbuehler et al. 2013; Kramer and Hogue 2009; Nicholl et al. 2007; Macinko et al. 2007; Ross and Mirowsky 2001; Samari 2016)

Please do not cite without author permission
Prior Research:

- Lower health utilization among Latinx population in new destinations:
  - U.S.-born Mexican American adults in new destination MSAs less likely to have a usual source of care and more likely to have unmet care need (Gresenz et al. 2012)

- Lower Latino/a adult health insurance coverage in some new destinations (Monnat 2016)

- Lower Latino/a child health insurance coverage and more delayed care in new destinations (Ackert and Potochnick, in progress).
Prior Research:

- Higher Latinx-White residential segregation in new v. established destinations
  
  (Hall 2013; Lichter et al. 2010)

- Native white out-migration in areas with rapidly growing immigrant pops.
  
  (Crowder, Hall, and Tolnay 2011; Hall and Crowder 2014)

- More negative “receptivity climate” in new destinations (but heterogeneity across destinations)
  
  (De Jong et al. 2017)
Prior Research:

- Lower school enrollment among adolescents in new destinations (Ackert 2017; Fischer 2010)
- Lower early childhood education participation in new destinations (Ackert et al. 2019)
- But... more positive educational resources in new destinations (Dondero and Muller 2012; Fry 2011)
Research Questions

1. Which contextual resources are available for health and well-being in new versus established Latinx destinations?

2. Do new destinations pose more contextual risks for health and well-being among Latinos/as than established destinations?
Defining Destinations

- Destinations (and their attributes) measured at the county level
- \(n = 3,147\) counties
- County boundaries harmonized to 2010 census boundaries.
Defining Destinations

- Decennial censuses (1990, 2010); Accessed through *Social Explorer*

- Group-specific typology (i.e., percent Latino/a)

- Latinx historical presence and growth:
  - Latino/a Base: County Latino/a (%) in 1990
  - Latino/a Growth: County Latino/a Growth (%) from 1990 to 2010

(See Hall 2013; Lichter and Johnson 2009; Singer and Suro 2002)
## Defining Destinations

<table>
<thead>
<tr>
<th>&lt;br&gt;Median Latino/a Growth 1990-2010</th>
</tr>
</thead>
</table>
| <br>&lt;9% Latino/a 1990 | Other  
| &gt;=9% Latino/a 1990 | Established | Established |
Defining Destinations

- Typology Exceptions:
  - $< 9\%$ Latino/a in 1990 $+  < \text{median Latino/a Growth} + 16\%$ Latino/a in 2010 $= \textit{New Destination}$
  - $< 9\%$ Latino/a in 1990 $+ \geq \text{median Latino/a Growth} +  < 5\%$ Latino/a in 2010 $= \textit{Other Destination}$
Defining Destinations

(Map by Jessica Martinez)

Please do not cite without author permission
## Defining Destinations

<table>
<thead>
<tr>
<th></th>
<th>Total counties</th>
<th>Percent of all counties</th>
<th>Percent of all Latinos/as*</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Destination</td>
<td>526</td>
<td>16.7%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Est. Destination</td>
<td>355</td>
<td>11.3%</td>
<td>68.4%</td>
</tr>
<tr>
<td>Other Destination</td>
<td>2,258</td>
<td>71.8%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

(*Author’s estimate based on 2010 decennial census data)
Datasets Overview

1. RWJ County Health Rankings (Health context)
2. HPSA and MUA designations (Health context)
3. AHRF health services data (Health context)
4. 287g agreements (Hostility context)

Note: Health context datasets not mutually exclusive
Analytic Approach

- Descriptive
- Spatial associations:
  - Destinations + Health context
  - Destinations + Hostility context
- All analyses are preliminary; we welcome feedback!
RWJ Health Rankings

- Robert Wood Johnson Foundation produces annual within-state rankings of counties according to health metrics
- Rankings in two domains:
  - Health Factors
  - Health Outcomes
- Rankings based on indices (with multiple items from multiple data sources)
## Family and Social Support Measures

Our Rankings show how healthy a community is as well as indicators for future health. This provides a starting point for action on improving health for all. Dig deeper into the measures below to learn more about our approaches to measuring health.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children in single-parent households</strong></td>
<td>Percentage of children that live in a household headed by single parent.</td>
</tr>
<tr>
<td><strong>Social associations</strong></td>
<td>Number of membership associations per 10,000 population.</td>
</tr>
<tr>
<td><strong>Residential segregation - black/white</strong></td>
<td>Index of dissimilarity where higher values indicate greater residential segregation between Black and White county residents.</td>
</tr>
<tr>
<td><strong>Residential segregation - non-white/white</strong></td>
<td>Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.</td>
</tr>
</tbody>
</table>

* Additional Measure (not included in ranks)
RWJ Health Rankings

- Rankings from 2016

- Counties placed into rankings quartiles

- Counties placed into top v. bottom 50% of county rankings (i.e. ranked in top half or bottom half of all counties in the state)

- Separate results for Health Factors and Health Outcomes
RWJ Health Factors Rankings

(Data prep by Gabriel van Praag; Map by Jessica Martinez)
RWJ Health Outcomes Rankings

(Data prep by Gabriel van Praag; Map by Jessica Martinez)
## RWJ Health Rankings

<table>
<thead>
<tr>
<th>Destination</th>
<th>Percent in bottom 50% for Health Factors Ranking</th>
<th>Percent in bottom 50% for Health Outcomes Ranking</th>
<th>n counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Destination</td>
<td>44.7%</td>
<td>39.2%</td>
<td>526</td>
</tr>
<tr>
<td>Est. Destination</td>
<td>52.3%</td>
<td>49.0%</td>
<td>355</td>
</tr>
<tr>
<td>Other Destination</td>
<td>49.1%</td>
<td>51.0%</td>
<td>2,258</td>
</tr>
</tbody>
</table>

Please do not cite without author permission
## RWJ Health Rankings

(Analysis and table by Gabriel Van Praag)

<table>
<thead>
<tr>
<th>Type of Destination</th>
<th>Health Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Latino/a Dest.</td>
<td>1st quart %</td>
</tr>
<tr>
<td></td>
<td>30.7</td>
</tr>
<tr>
<td>Established Latino/a Dest.</td>
<td>21.3</td>
</tr>
<tr>
<td>Other Latino/a Dest.</td>
<td>24.4</td>
</tr>
</tbody>
</table>

Please do not cite without author permission
## RWJ Health Rankings

<table>
<thead>
<tr>
<th>Type of Destination</th>
<th>Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st quart %</td>
</tr>
<tr>
<td>New Latino/a Dest.</td>
<td>34.3</td>
</tr>
<tr>
<td>Established Latino/a Dest.</td>
<td>23.1</td>
</tr>
<tr>
<td>Other Latino/a Dest.</td>
<td>23.3</td>
</tr>
</tbody>
</table>

(Analysis and table by Gabriel Van Praag)
RWJ Health Rankings: Findings Summary

- Heterogeneity across destinations in health rankings, but...

- New destinations less likely than established destinations to be in bottom half of rankings for state

- New destinations more likely to be in 1st quartile of rankings for state; established destinations more likely to be in 4th quartile for state
HPSA and MUA Designations

- **HPSA**: Health Professional Shortage Area
- 3 HPSA types:
  - Primary Care
  - Dental Care
  - Mental Health
- **MUA**: Medically Underserved Area
HPSA and MUA Designations

- Designated by the Health Resources and Services Administration
- Used to try to marshal resources towards communities and populations in need
- "Geographic" HPSAs: A shortage of providers for the entire population within a defined geographic area.

Note: We are using most recent designation status.
HPSA and MUA Designations

Health Professional Shortage Area (HPSA) & Automatic HPSA

We calculate HPSA scores based on discipline-specific methodology.
Three scoring criteria are common across all HPSA disciplines:

- Population to provider ratio
- Percentage of the population below 100% of the Federal Poverty Level (FPL)
- Travel time to the nearest source of care (NSC) outside the HPSA designation area

Review the HPSA scoring methodology, differentiated by discipline:

Primary Care HPSA Scoring

Primary Care HPSAs can receive a score between 0-25.

This is a broad overview of the four components we use in Primary Care HPSA scoring:

- Population-to-Provider Ratio [10 points max]
- Percent of Population below 100% FPL [5 points max]
- Infant Health Index (Based on IMR or LBW Rate) [5 points max]
- Travel Time to NSC [5 points max]

HPSA Score
Out of 25
HPSA and MUA Designations

Demographic and Health Indicators

- Provider per 1,000 population ratio
- % Population at 100% of the Federal Poverty Level (FPL)
- % Population age 65 and over
- Infant Mortality Rate

\[
\text{IMU Score} \quad \text{Out of 100}
\]

Please do not cite without author permission
HPSA and MUA Designations

Proportion of Counties with Primary Care HPSA Designations

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
Proportion of Counties with Dental Care HPSA Designations

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
HPSA and MUA Designations

Proportion of Counties with Mental Health HPSA Designations

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
Proportion of Counties with MUAP Designations

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
Mean Total Designations: All Counties and by Destination Type (2020)

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
HPSA and MUA Designations

The Destination Composition of Designation Types

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
HPSA and MUA Designations

Mean HPSA Scores by Destination Type

<table>
<thead>
<tr>
<th>Destination Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Counties</td>
</tr>
<tr>
<td>Established Latino/a Destination</td>
</tr>
<tr>
<td>New Latino/a Destination</td>
</tr>
<tr>
<td>Other Latino/a Destination</td>
</tr>
</tbody>
</table>

(Data prep, analysis, and figure by Pedro Aristizabal Posada)

Please do not cite without author permission
New destination counties less likely to be designated as HPSAs (all 3 types) and MUAs than established destinations

Among all HPSAs, new destination counties have slightly lower HPSA scores than established destination counties
AHRF Data

- AHRF: Area Health Resources Files
- Provided by the Health Resources and Services Administration
- County-level data on...
  - Health Care Professions
  - Health Facilities
  - Population Characteristics
  - Economics
  - Health Professions Training
  - Hospital Utilization
  - Hospital Expenditures
  - Environment

Please do not cite without author permission
AHRF Data

- Choosing and coding variables has been a major effort!

- Health Services and Health Facilities means (overall and by destination)

- Per capita measures:
  \[((\text{Total \#} / \text{Population total in 2010}) \times 1000)\]
# AHRF Data

<table>
<thead>
<tr>
<th>Health Services Personnel</th>
<th>All Counties</th>
<th>New Destinations</th>
<th>Established Destinations</th>
<th>Other Destinations</th>
<th>New-Established Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDs per capita (2017)</td>
<td>1.34</td>
<td>1.44</td>
<td>1.17</td>
<td>1.62</td>
<td>0.27</td>
</tr>
<tr>
<td>MDs, general practice, per capita (2017)</td>
<td>0.28</td>
<td>0.31</td>
<td>0.26</td>
<td>0.29</td>
<td>0.05</td>
</tr>
<tr>
<td>Pediatricians, general, patient care, per capita (2017)</td>
<td>0.08</td>
<td>0.08</td>
<td>0.07</td>
<td>0.10</td>
<td>0.01</td>
</tr>
<tr>
<td>Emergency medicine physicians per capita (2017)</td>
<td>0.07</td>
<td>0.07</td>
<td>0.06</td>
<td>0.08</td>
<td>0.01</td>
</tr>
<tr>
<td>Dentists per capita (2017)</td>
<td>0.38</td>
<td>0.42</td>
<td>0.33</td>
<td>0.45</td>
<td>0.09</td>
</tr>
<tr>
<td>Licensed psychologists per capita (2009)</td>
<td>0.13</td>
<td>0.16</td>
<td>0.10</td>
<td>0.14</td>
<td>0.06</td>
</tr>
</tbody>
</table>

(Data prep, analysis, and table by Sung Hee Hong)
# AHRF Data

<table>
<thead>
<tr>
<th>Health Services Facilities</th>
<th>All Counties Mean</th>
<th>New Destinations Mean</th>
<th>Established Destinations Mean</th>
<th>Other Destinations Mean</th>
<th>New-Established Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals per capita (2017)</td>
<td>0.05</td>
<td>0.05</td>
<td>0.06</td>
<td>0.04</td>
<td>0.00</td>
</tr>
<tr>
<td>Hospital beds per capita (2017)</td>
<td>2.65</td>
<td>3.10</td>
<td>2.42</td>
<td>2.65</td>
<td>0.69</td>
</tr>
<tr>
<td>Federal Health Centers per capita (2018)</td>
<td>0.07</td>
<td>0.05</td>
<td>0.09</td>
<td>0.03</td>
<td>-0.04</td>
</tr>
<tr>
<td>Community Health Centers per capita (2)</td>
<td>0.09</td>
<td>0.07</td>
<td>0.11</td>
<td>0.04</td>
<td>-0.04</td>
</tr>
</tbody>
</table>

(Data prep, analysis, and table by Sung Hee Hong)
AHRF Data: Findings Summary

- Lack of differences in many health services measures per capita between new and established destinations:
  - Pediatricians
  - Emergency medicine physicians
  - Hospitals

- *More* health supply per capita in new destinations:
  - Total MDs
  - Dentists
  - Licensed psychologists
  - Hospital beds

- *Less* health supply per capita in new destinations:
  - Federal Health Centers
  - Community Health Centers

Please do not cite without author permission
287g agreements

- Agreements between local law enforcement and ICE
- Allows state and local agencies to act as immigration enforcement agents
- Facilitates detaining and "handing off" suspected undocumented immigrants to ICE
287g agreements

- First agreement signed in 2002; most signed after 2006

- Hiatus/modification under Obama; brought back under Trump

- Most 287g agreements are jail enforcement:
  - Officer/s arrest/s individual for criminal or non-immigration civil offense
  - In jail facility, officer/s inquire about inmate’s immigration status, communicate this status to ICE, issue ICE detainers, transfer inmates to ICE custody
287g agreements

- Marker of hostility towards Latinos/as:
  “287(g) agreements lead to racial profiling, civil rights violations, isolation of immigrant communities, and family separations. When local officials are working with ICE, police stop and harass Latinx residents at increased rates, while immigrants withdraw from their communities, avoid business that requires them to give their personal information, and decline to participate in public events where law enforcement may be present.”
  -Immigrant Legal Resource Center
287g agreements

- Two data sources:
  - Migration Policy Institute (agreements signed before 2010)
  - Immigrant Legal Resource Center (agreements signed 2010 or later)

- Any 287g agreement: $=1$ if one or more agencies in the county (i.e. city within county and/or county sheriff’s office) have signed agreement at any time

- Total 287g agreements: Total number of agreements signed within the county over time

Please do not cite without author permission
287g agreements

(Data prep and map by Jessica Martinez)

Please do not cite without author permission
287g agreements

(Data prep and map by Jessica Martinez)

Please do not cite without author permission
## 287g agreements

What percentage of counties by destination have any 287g agreements?

<table>
<thead>
<tr>
<th>Destination</th>
<th>Percent 287g</th>
<th>n (all counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Destination</td>
<td>10.5%</td>
<td>526</td>
</tr>
<tr>
<td>Est. Destination</td>
<td>9.6%</td>
<td>355</td>
</tr>
<tr>
<td>Other Destination</td>
<td>13.5%</td>
<td>2,258</td>
</tr>
</tbody>
</table>
287g agreements

How many counties that have 287g agreements (n=124) are new, established, or other destinations?

<table>
<thead>
<tr>
<th>Destination</th>
<th>Percent of all 287g counties</th>
<th>Total counties with 287g</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Destination</td>
<td>44.4%</td>
<td>55</td>
</tr>
<tr>
<td>Est. Destination</td>
<td>9.6%</td>
<td>34</td>
</tr>
<tr>
<td>Other Destination</td>
<td>28.2%</td>
<td>35</td>
</tr>
</tbody>
</table>

Please do not cite without author permission
New destinations slightly more likely to have signed 287g agreements

Among all counties that have signed 287g agreements, new destinations are the largest group.

(But... 2/3rds of Latinx population lives in established destinations... need to look at weighted stats and consider individual-level exposure to these agreements.)
New destinations as more positive health and well-being contexts for all residents:
- Higher rankings on RWJ county health rankings
- Less likely to be HPSAs or MUAs; intensity of HPSA lower
- More MDs, more hospital beds per capita

New destinations may pose risks specifically for immigrant populations:
- Fewer federally qualified health centers and community health clinics per capita
- 287g slightly more common; of all 287g counties, largest group is new destinations
Q: Why is the Latinx population experiencing worse health access outcomes (lower health insurance rates, more delayed care) in new versus established destinations, if these destinations have many positive health contextual attributes?

A1: Latinx population faces unmeasured barriers to access in new destination communities (undocumented status, discrimination, etc.)

A2: Targeted resources are important for Latinx population (community health clinics, bilingual health care personnel, etc.)

A3: They aren’t experiencing worse outcomes (i.e., we need more studies)
Next Steps

- Hypothesis testing and multivariate models
- Check for correlations between health and hostility context measures; create new indices?
- Link contextual data to health outcomes
- Overarching Goal: Build a wider body of evidence about destinations and health and well-being among Latinx population (especially for children and youth)
R03 Conceptual Model

Health Care Context (Supply)

(Aim 1)

Latino/a Early Childhood Health Disparities (Health and Preventive Care Utilization and Health Outcomes)

(Aim 2)

Latino/a Destination (New, Established, Other)

(Aim 3)

National Origin and Parental Nativity
Acknowledgements

- UCSB Department of Geography
- UCSB Division of Mathematical, Life, and Physical Sciences (Dean’s Office)
- Population Research Center at UT-Austin

Collaborators:
- Dr. Robert Crosnoe, UT-Austin
- Matt Snidal, UT-Austin
- Jessica Martinez, Sung Hee Hong, Pedro Aristizabal Posada, Gabriel van Praag, UCSB

Please do not cite without author permission
Funding

- UCSB Faculty Enrichment Program

- *Eunice Kennedy Shriver* NICHD R03HD092644 (PI: Ackert)

- NSF SPRF 1810358 (PI: Ackert)

- IES Award R305A150027 (PI: Crosnoe and Leventhal)

- *Eunice Kennedy Shriver* NICHD R24 HD42849 (PI: Hayward)

- *Eunice Kennedy Shriver* NICHD T32 HD007081-35 (PI: Raley)

Please do not cite without author permission
Thank You!
ackert@ucsb.edu
www.lizackert.com