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ORIGINAL PAPER

DACA Recipient Health Care Workers' Barriers to Professionalization and Deployment of Navigational Capital in Pursuit of Health Equity for Immigrants

Christina M. Getrich[1] · Delmis Umanzor[1] · Alaska Burdette[1] · Ana Ortez-Rivera[1]

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Abstract
The COVID-19 pandemic has laid bare entrenched health inequalities in the U.S. health care system faced by structurally marginalized immigrant communities. Deferred Action for Childhood Arrivals (DACA) recipients are well suited to address these social and political determinants of health due to their large presence in service positions and skill sets. Yet their potential in health-related careers is limited by unique barriers related to uncertainty about their status and training and licensure processes. We report findings from a mixed-method (interview and questionnaire) study of 30 DACA recipients in Maryland. Nearly half of participants (14; 47%) worked in health care and social service fields. The longitudinal design featured three research phases conducted between 2016 and 2021, which enabled us to observe participants' evolving career trajectories and capture their experiences during a tumultuous period (due to the DACA rescission and COVID-19 pandemic). Using a community cultural wealth (CCW) framework, we present three case studies that demonstrate challenges recipients encountered as they embarked on health-related careers, including protracted educational journeys, concerns about program completion/licensure, and uncertainty about future employment. Yet participants' experiences also revealed valuable forms of CCW they deploy, including building on social networks/collective knowledge, forging navigational capital and sharing experiential knowledge, and leveraging identity to devise innovative strategies. Results highlight the critical value of DACA recipients' CCW that renders them particularly apt brokers and advocates in promoting health equity. Yet they also reveal the urgent need for comprehensive immigration and state-licensure reform to promote DACA recipients' inclusion in the health care workforce.

Keywords Deferred Action for Childhood Arrivals (DACA) · Policy · Health care · Medical education · Navigational capital

Background

The COVID-19 pandemic has laid bare deeply entrenched health inequalities in the U.S. health care system faced by structurally marginalized immigrant communities [1, 2]. Immigrants are particularly vulnerable due to substantial economic and legal barriers they confront in accessing the health care system, public benefits and programs, and services and treatments [1–3]. They have also been disproportionately impacted by other systemic factors including employment in high-risk-exposure environments, financial strain and unemployment, exclusion from pandemic economic relief, substandard housing conditions and housing instability, and food insecurity [1–4]. Immigrants' vulnerabilities are also compounded by anti-immigrant policies undergirded by structural racism [5] that have intensified immigration enforcement, stoked widespread fear in immigrant communities and resulted in Anti-Asian violence, and produced concerns that accessing government services will jeopardize future legalization [2, 4].

As the pandemic has raged on, Deferred Action for Childhood Arrivals (DACA) recipients have been identified as a group of immigrants particularly well-situated to address

✉ Christina M. Getrich
cgetrich@umd.edu

[1] Department of Anthropology, College Park, University of Maryland, 2138 LeFrak Hall, 7251 Preinkert Drive, College Park, MD 20742, USA

these social determinants of health due to their large presence in service positions and relevant skill sets. DACA was created by President Obama by Executive Order in 2012 to address the plight of millions of undocumented young adults who had migrated in early childhood but were raised and educated in the United States. DACA is a temporary status (lacking a pathway to citizenship) that provides work authorization and deferral of deportation. Approximately 825,000 individuals have received DACA [6]. However, their status became endangered when the Trump Administration announced the rescission of the program in September 2017, triggering multiple lawsuits in the aftermath and leaving recipients' fate in limbo.

In the aftermath of the rescission, the Association of American Medical Colleges (AAMC) filed an amicus brief in 2018 on behalf of 33 leading health organizations renouncing the rescission that would have affected ~ 30,000 health care workers [7]. Other professional organizations like the American Nurses Association, American Psychological Association, and National Association of Social Workers strongly renounced the rescission, called for removal of barriers to professional licensure, and held trainings in how to support DACA recipients [8–10]. Even before the pandemic, there was increasing recognition of unique barriers DACA recipients faced in pursuing medical education [11], including that schools may only accept state residents (which DACA recipients are not always recognized as), prioritize their own in-state residents, and offer little to no financial support for a population ineligible for federal aid [12]. By 2020, 75 accredited medical schools were deemed "DACA friendly," though varied in their policies [7]. Postgraduation, DACA recipients face complications in the medical licensure process, particularly since eligibility is governed by states, with only five allowing undocumented immigrants full access [11, 13]. These barriers also apply to other related occupational fields, as one in four jobs requires a license to practice [13].

Many of the arguments about the potential end of DACA are framed in terms of recipients' overall economic impact and contributions to addressing urgent workforce shortages, exacerbated by the pandemic. DACA recipients pay $6.2 billion in federal taxes and $3.3 billion in state and local taxes and hold $25.3 billion in spending power. Some 343,000 DACA recipients have been working on the frontlines of the coronavirus response in health care, education, and food services [14]. Yet DACA recipients are essential not *merely* to fill labor gaps and fuel the economy. Indeed, they are critical in diversifying the health care workforce, which still does not mirror the population of Hispanics and Blacks in the United States overall despite some modest progress in closing that gap [15]. They are also ideally situated to provide culturally and structurally appropriate services to address social [16, 17] and political [18, 19] determinants of health in pursuit of health equity. Yet less is known specifically about how DACA recipients leverage their experiential knowledge to perform these roles for the benefit of community members and health care systems.

Theoretical Framework

Using a community cultural wealth (CCW) framework, we argue that DACA recipients also possess experiential knowledge and navigational capital that enable them to provide nuanced care to structurally marginalized immigrants. Drawing from critical race theory (CRT), CCW is an important corrective to deficit approaches that regard immigrants as deficient in forms of knowledge deemed valuable by dominant society [20]. Instead, it centers the cultural knowledge, skills, and abilities of socially marginalized groups [20] and validates experiential knowledge [21]. CCW encompasses six alternative forms of capital possessed by socially marginalized groups, including aspirational, navigational, social, linguistic, familial, and resistant capital [20]. Navigational capital, our focus in this article, is defined as the skills of maneuvering through social institutions marked by inequality. Navigational capital acknowledges individual agency, but also centers social networks and collective knowledge [20], highlighting collective capacity for coping and resilience [21, 22].

Navigational capital has most frequently been examined in educational settings to illuminate how students of color persist and achieve [20–23]. Scholars have started describing health-related navigational capital by examining how Latinx communities leverage community resources to forge alternative health care spaces outside of the mainstream health care system [24]. Studies have demonstrated how community health workers (CHWs) in particular deploy CCW to improve community health and well-being through advocacy and research [25, 26] However, these studies do not elaborate how health care workers deploy their CCW specifically in health care settings. A separate literature on health care brokerage examines how immigrants and co-ethnics serve as intermediaries in facilitating immigrants' interface with the health care system [27–31]. Brokers are prized for their ability to flex to meet community needs and performing tasks that often extend beyond their envisioned or funded positions [32, 33]. They also play a critical role in buffering the impact of policy exclusions and system changes under health care reform [28–31], which has been particularly important with the emergence of new pandemic-related challenges. While focused on institutional settings, the brokerage literature does not describe how the experiential knowledge immigrants cultivate specifically informs

their brokerage. Our study thus brings together disparate literatures on CCW and brokerage in health care settings.

Methods

We present findings from an IRB-approved mixed-method study based in Maryland [34], a state ranking 17th nationwide in DACA approvals [6]. Maryland is regarded as a "DACA friendly" state [35] with policies that enable DACA recipients access to driver's licenses, in-state tuition, and state-based financial aid. Yet like the majority of states, Maryland still has status-related restrictions for accessing public benefits (like Medicaid) and securing occupational and professional licenses.

We conducted longitudinal research with DACA recipients between 2016 and 2021 during three distinct phases: (I) 2016 (before the 2016 Presidential election when DACA was intact), (II) 2017-18 (after the 2017 rescission announcement endangering DACA), and (III) 2020-21(after the 2020 Supreme Court decision overturning the DACA rescission). Phase I and II consisted of in-person semi-structured interviews and questionnaires, while Phase III consisted of Zoom interviews due to COVID research restrictions. Participants (DACA recipients 18 and older) were recruited via team members' social networks, youth-focused community-based organizations, a DREAMer social media group, and referrals.

Interview guides captured immigration history, family relationships, schooling, employment, DACA enrollment experiences, DACA impacts, health care access, well-being, and belonging. Questionnaires included measures assessing sociodemographic variables, education level, employment history and income, and insurance status; psychological distress per the validated PHQ-4 [36]; and access to care, health status, diagnosed conditions, and health-seeking practices per the Health Information National Trends Survey (HINTS) survey [37]. Additional items were added in Phase II and III to capture life changes, the shifting sociopolitical climate, bureaucratic challenges, and strategies for maintaining well-being.

Interviews were recorded and transcribed verbatim for analysis, which followed principles of grounded theory [38]. We first open coded an initial set of transcripts individually to identify emerging topics [39]. We then reviewed transcripts line by line as a team, establishing codes and developing a coding scheme. We continued to refine the coding scheme by testing additional transcripts until we constituted the full set of codes and reached consensus about their application. Three team members then coded a set of three transcripts to ensure inter-rater reliability. Transcripts were coded in QSR NVivo and questionnaire data was analyzed (for descriptive purposes only given the small sample size) using Statistical Package for the Social Science (SPSS). Given that the questionnaire data focused on individual experiences—not brokering services for others in work settings—we present only qualitative data in this article.

Participants (n = 30) came from 13 different countries of origin (see Table 1). We interviewed more females (21; 70%) than males (9; 30%) and participants were a median age of 21 in 2016, ranging between 18 and 28. Though not sampled by career aspirations, nine participants worked in health care and five in related social service positions (14; 47%); results focus on the experiences of these individuals. The longitudinal design was critical for understanding more about DACA recipients' changing lives during a chaotic period characterized by the aggressive targeting of immigrants and the COVID-19 pandemic; it also enabled us to observe participants' life course transition into adulthood as they embarked on careers.

Table 1 Participant Demographics, 2016

Birthplace (by country of origin)	El Salvador	9 (30%)
	Honduras	5 (17%)
	Mexico	3 (10%)
	Peru	3 (10%)
	South Korea	2 (7%)
	Argentina	1 (3%)
	Bolivia	1 (3%)
	Brazil	1 (3%)
	Colombia	1 (3%)
	Indonesia	1 (3%)
	Liberia	1 (3%)
	Nicaragua	1 (3%)
	Senegal	1 (3%)
Ethnoracial background	Hispanic or Latino/a	24 (80%)
	Asian or Asian American	3 (10%)
	African or African American	2 (7%)
	Other (Brazilian)	1 (3%)
Gender	Female	21 (70%)
	Male	9 (30%)
Age	Range	18–28
	Median	21

Results

Results illuminate barriers participants encountered in participants' professionalization processes as well as forms of CCW they cultivated and asserted. Though present across participants, we highlight three exemplary cases to provide fuller context in describing three emerging facets of CCW: building on social networks and collective knowledge, forging navigational capital and sharing experiential knowledge, and leveraging identity to devise innovative strategies.

Esme: Building on Social Networks and Collective Knowledge

Esme came from Honduras when she was five. Right after her family arrived, her seven-year-old sister Marcela was hospitalized for two weeks for dehydration and exhaustion, forcing her family to immediately interface with the health care system. Though she remembers her mother crying at the hospital out of concern over the bill, Esme's mother ultimately found an indigent care program to cover Marcela's care. As they became more established, Esme's mother became quite adept at identifying local resources for their regular health care, first a community health clinic (CHC) and then through a charity care program that covered the girls until age 19. As Esme reflected, "My mom spent a lot of time figuring things out for us, doing things behind the scenes." Yet many of these resources were not available to her mother, as an undocumented adult ineligible for government programs. Without status, Esme's mother also worried about what would happen to the girls if she was deported and struggled to find employment even as her daughters began working in high school when they received DACA.

When she was 18 in 2016, Esme was taking science classes in community college. Her sister Marcela was finishing her Associate's degree in forensic science, but had unfortunately discovered that DACA recipients were unable to work in the field given that positions typically required permanent residency or citizenship. Esme realized that she had to be deliberate in her career planning, and decided that health care would be a good fit given her temporary DACA status. She first completed an Associates of Applied Science in Radiography in community college and by 2018, had applied to and been accepted to a Nuclear Medicine program. Yet she worried that her work authorization would expire before she finished, complicating her job prospects. She also learned that she might not be able to take the boards and secure a state license, leading to a difficult decision to leave the program. A year later, during which she struggled to figure out an alternate career, she received a fortuitous call from a counselor who inquired about why she stopped. The counselor assured Esme that she would be okay with a permanent address and social security number but could also seek employment in next-door Washington, D.C., which does not have the same licensure system, as a fallback plan. Esme recalled, "It was such a relief, because that's really what I wanted to do from the beginning."

During her clinicals, she worked in a hospital and cardiology clinic, intense environments due to COVID. Esme noted that she had already developed an approach to providing immigrant patients culturally competent care, explaining, "I always have empathy with my immigrant families. I see other people who don't have immigrant parents come in and try to rush. Sometimes there are translators but people don't put things in the right words. I'm always thinking, 'if I was asking my mom, these are the questions she would have.'" Esme also understands intimately the structural challenges families face in accessing specialty care, having observed her own parents being excluded from care, asserting, "although the nuclear medicine field is small, we need to be fighting to get [immigrants] seen." Along her career pathway, Esme benefitted from the collective knowledge of her family, who gathered information about navigating the local health care system and career options for DACA recipients. She also benefitted from a proactive counselor, who provided her with the information and assurances she needed. As she transitioned into service provision, Esme shifted from being the recipient of this knowledge to assuming the responsibilities of applying it for the benefit of her immigrant patients, with attention to culturally appropriate care and structural change.

Rebeca: Forging Navigational Capital and Sharing Experiential Knowledge

Rebeca migrated from Peru at 15, making her barely eligible for DACA since the cutoff age is 16 years old. For eight years before receiving DACA, she worked without papers at a coffee shop and was only able to take nursing classes at a community college on a very part-time basis. With DACA, she was able to speed up her schooling slightly and get a far preferable job as a certified nursing assistant (CNA) in a major safety-net hospital. It ultimately took Rebeca 10 years to get her Bachelor's in Psychology, given that she had to take classes little by little and was also always working multiple jobs, eventually as a CNA and an interpreter. She was largely uninsured, given that she worked part-time jobs while pursuing school but had discovered a CHC where she and her undocumented parents got care on a sliding scale.

By 2018, Rebeca had decided to pursue a Master's in Social Work (MSW), which she felt was more in line with her Psychology degree. She paid her way through graduate school by working two jobs as an interpreter and family support worker. Like Esme, she harbored concerns that the DACA rescission would prevent her from finishing her program and securing employment. Though she initially planned to cut back hours during graduate school, she instead worked more hours to save money in anticipation of potentially losing status. Rebeca's MSW practicum was at a high school; as she recalled, "my advisor told me that when they saw my resume, they immediately thought about a school setting." Many of the students at the school were recent arrivals from Central America without permanent status; her mentors recognized that Rebeca was an ideal match due to her Spanish-language skills, experience migrating

and adapting as a teenage immigrant, and knowledge of health resources. She shared, "I've made good connections with the students. They're always asking me, 'How was it for you? How did you adapt?' I tell them, 'This is what worked for me and what didn't.' I share that with them and give them resources and help." Rebeca noted that she was able to share her own experiences with the students, but also concrete information about clinic-based services and other programs for which immigrants were eligible.

By 2020, Rebeca had completed a second year at the school at their request, noting that her skill set "was helpful not only for the students but also for the teachers. There were some teachers who weren't really familiar with international students. It's also [helpful] for the families—a lot of them are really lost with the school system and many people there aren't Spanish speaking." As she prepared for her licensure exam after graduation, Rebecca anticipated continuing work with immigrant youth as her area of specialization, saying, "I wish I would have had a counselor or somebody to have done the same thing for me."

While Rebeca's path to her career was more circuitous than Esme's given that she spent more time as an undocumented adult, she had amassed substantial knowledge about navigating local health resources from her own experiences seeking care and working in multiple health care positions. Indeed, she was well positioned to direct her clients to more traditional clinical sites as well as educational and mental health resources outside of these settings. Yet it was also her own experiential knowledge about negotiating her undocumented and DACA status as a young adult that enabled her to provide even more tailored and nuanced advisement to her students as precisely the type of resource she lacked.

Lucas: Leveraging Identity to Devise Innovative Strategies

Lucas migrated from Mexico with his parents at age 10. In high school when he was undocumented and unable to legally work, he started volunteering as a health advocate at Children's Hospital. After receiving DACA at 18, he took a position in information technology, but still felt drawn to public health, so began working at a Latinx-serving CHC. By 2018, Lucas had started working as a CHW at an HIV/AIDS-focused non-profit working with LGBTQ + people of color, which resonated with him as a community member. Yet when he received his DACA renewal approval letter without an actual work permit, he could not work for two months due to the administrative error. His employer valued Lucas and held the position, though it was an incredibly stressful period for him. By late 2021, Lucas' public health career focused on HIV/AIDS prevention was flourishing and he had been asked to serve on a state task force in recognition of his invaluable community knowledge.

Even as he became active in advocacy on a larger scale, Lucas remained focused on direct care provision. As the pandemic hit, Lucas rolled COVID into his usual workflow, sharing, "We have a mobile unit, and can do HIV testing and COVID vaccination at the same time. It works really well." He acknowledges, "it was really scary at first, because we didn't know much about the pandemic…we were screening patients in full PPE gear. But people still needed to get care, so we didn't stop." Despite their successes, Lucas started realizing that they needed to be even more innovative in their outreach given that "there's lots of hesitancy and medical mistrust among immigrant populations and Latinx folks."

Lucas also came to realize that sharing his own identity was a critical strategy for cultivating trust. He recalled, "We started a web series through Instagram and Facebook live talking about our experiences getting the COVID vaccine, in English and Spanish." As he shared, "People were asking questions, like, 'What's going to happen with my information? Will it go to the government?' And I came forward and was like, 'I'm on DACA and I'm doing this because it's the right thing to do to protect myself and others." Lucas reflected, "I've been very hesitant in general to say that I'm undocumented. But I realized it's better for me to be vocal about it, so other people can see and relate. I just want to push more now." While Lucas had been a passionate health advocate since he was a teenager, he came to realize the value of sharing his experiences with community members as a strategy tied explicitly to the increased vulnerability of Latinx immigrants due to Trump's anti-immigrant policies and the pandemic. As with Esme and Rebeca, Lucas' actions make it clear that DACA recipients' work in a variety of health care roles is uniquely tailored to the needs and concerns of structurally vulnerable immigrants.

Esme, Rebeca, and Lucas's experiences—both the barriers they encountered and their deployment of navigational capital—strongly resonate with the additional 11 participants working in health care and social service settings. Like Esme, several others (like Jenny who worked as a pharmacy technician and Emine who worked as a registration specialist) made practical choices about career directions in health care based on status considerations. Antônia, a medical sonographer, and Laura, a social worker, also shared Esme's and Rebeca's concerns about obtaining professional licenses in their respective fields after spending years pursuing their degrees. Yet Angélica, an extremely well-networked social worker in a large public-school system, built on her family's experiences in finding care without insurance to map out local resources for immigrant families, and shares these resources frequently and freely with clients, family

members, and friends alike. Roger, also a social worker, leveraged the navigational capital he forged on his career path in providing workforce development training to teenaged Latinx immigrants. Nadya, a mental health technician in a major health care system, went from being a Muslim woman who struggled to find mental health resources to being a self-described "resource finder" who assisted clients and even her sister (who experienced deep anxiety during the pandemic) in accessing affordable and culturally competent care options. Their brokerage is unquestionably beneficial for the clients these DACA recipients serve in their professional capacities, though it is also clear that its reach extends beyond their workplaces as a family and community resource.

Conclusions

These snapshots reveal the significant barriers DACA recipients face in the professionalization process: complicated decision-making about careers in which they can actually work, protracted and interrupted educational journeys, financial strain, and lack of access to health care. Though our sample size is small and the original study was not focused solely on DACA recipients in the health care workforce, participants' experiences nonetheless speak to a broad range of challenges DACA recipients encounter as they pursue training and positions in a range of health careers. Large numbers of DACA recipients have also reported losing their jobs or having their work hours or pay reduced due to the pandemic, underscoring broader challenges they face in career attainment. [40] Given uncertainty about DACA, these case studies provide nuanced insight into DACA recipients' very-real concerns about program completion and licensure, interruptions in employment, and concerns about future employment. These barriers are pronounced even with DACA status, and thus illuminate how urgent more permanent immigration reform is to address these political determinants of health [37, 38] so that DACA recipients can more effectively perform their brokerage on more secure legal ground.

Yet participants also clearly demonstrated individual and collective resilience [22] in pursuing and actualizing careers in allied health careers, underscoring the importance of access to appropriate training and employment and the need for state-level licensure policies to facilitate access. Their circuitous career pathways also highlight the need to more systematically document how DACA recipients negotiate the professionalization process. Their experiences also underscore forms of CCW that they bring to the health care workforce, highlighting new institutional platforms for deploying CCW and illuminating how experiential knowledge and immigrant identities inform brokerage. Indeed, the experiences of Esme, Rebeca, and Lucas highlight important dimensions of CCW: how collective knowledge is shared, the importance of mentors (both informal and formal), the value of navigational capital, the utility of sharing experiential knowledge in institutional contexts (and non-clinical settings), and the effectiveness of leveraging identity to promote community well-being.

Their stories demonstrate that DACA recipients are particularly apt advocates for immigrants within the health care system in promoting health equity, bolstering calls to better promote and support their inclusion in the health care workforce [11, 13, 15]. While DACA recipients' participation in the health care workforce has been acknowledged (particularly in 2017-18 as their employability was jeopardized by the rescission announcement), DACA recipients should be valued in more than just economic terms for the sensitivities and skill sets they bring to the critical work they perform, not only benefitting immigrant patients but health care systems overall.

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