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# Understanding the Barriers and Challenges of Spanish-Speaking Latinos Who Received CalAIM Initiative Social Support Services

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Abstract

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## Abstract

Spanish-speaking Latinos continue to face significant barriers when attempting to access social support services through healthcare initiatives such as California Advancing and Innovating Medi-Cal (CalAIM). Despite previous efforts to address this issue, this population continues to encounter barriers such as systemic discrimination, language barriers, and limited access to culturally responsive care. This qualitative study was guided by the consolidated framework for implementation research and used an interpretative phenomenological analysis approach to explore the lived experiences of Spanish-speaking Latino parents whose children received CalAIM asthma home remediation (AHR) services. The purpose of this study was to understand the barriers and challenges Spanish-speaking Latino face in accessing support services. Semistructured telephone interviews were conducted with a purposive sample of five Spanish-speaking Latino adults whose children received AHR services. The central research question was "What are the barriers and challenges of Spanish-speaking Latinos who received social support services through the newly implemented CalAIM initiative?" The data were analyzed using a seven-step thematic coding process to identify experiential themes. This study uncovered insights into how organizational and individual-level factors affect access to and engagement with CalAIM services. By focusing on the voices of Spanish-speaking Latinos, this research contributes to a deeper understanding of how underserved populations experience CalAIM. The potential for positive social change includes advancing health equity by informing strategies to deliver more inclusive and effective care for Spanish-speaking Latino communities.

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# Dedication

This work stands as a testament of years of hard work, late nights, and perseverance. None of it would have been possible without my mother, Maria. Her unconditional love, support, and encouragement helped carry me through every step of this journey. She has been my biggest believer and my forever inspiration. To my husband, Salomon, thank you for cheering me on when I wanted to quit, and reminding me why I started in the first place. Your support means everything.

Reaching this milestone in a time of uncertainty and struggle makes it even more meaningful. It is a reminder that resilience lives in us, that even when the world feels heavy. We persist. We fight. We rebuild. And no matter what, we keep going.

# Acknowledgments

I would like to thank my committee members, Dr. Ethel Perry and Dr. Jay Greiner, for their guidance. Both of you helped the process move smoothly, shared your expertise, and provided invaluable feedback and guidance that I will take with me beyond Walden.

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# Chapter 1: Introduction to the Study

Latinos continue to face significant barriers when attempting to access needed social support services, which contribute to poor social and health outcomes (Sanchez-Birkhead et al., 2011). Latinos encounter barriers including the fear of deportation, little to no information on available social support services, language difficulties, and systemic discrimination (Jacquez et al., 2016; Lopez Mercado et al., 2023; Ornelas et al., 2020). Despite the many attempts to address these barriers through targeted healthcare campaigns and interventions, Latinos continue to experience poor social and health outcomes. Existing research attempting to understand these barriers has focused chiefly on collecting insights from frontline workers and direct service providers (Aridomi et al., 2023; Doshi et al., 2020; Jacquez et al., 2016; Lopez et al., 2023). Through this study, I gathered feedback directly from Spanish-speaking Latinos on the barriers and challenges they encountered when accessing needed social support services through the newly implemented CalAIM initiative. Insights from this study will help refine existing public health models and interventions to meet this population's needs better.

Chapter 1 provides the background information for this study, including a summary of the existing literature, gaps in the knowledge around the topic, and the importance of this study. The chapter provides an overview of the research problem and purpose statement, articulating how the research addresses the problem. This chapter also introduces the research question being answered by this study and the theoretical framework that guided the data collection and interpretation of the findings. The nature of the study is also discussed, specifically providing a rationale for the study design, the

phenomenon being investigated, and the methodology employed for this study. Key concepts are also defined to ensure clarity and an agreed consensus on terms used throughout the document. The chapter also articulates any assumptions, scope, delimitations, limitations, and biases of this study to assist with interpreting the findings. Lastly, this chapter describes the significance and contributions of this study to the field and how it may be used to advance clinical practice and health policy.

## Background

Often, Spanish-speaking Latinos face ongoing and complex barriers when seeking to access social support services through healthcare interventions and initiatives like the California Advancing and Innovating Medi-Cal (CalAIM). Literature has consistently highlighted challenges such as language barriers, fear of deportation, limited access to culturally appropriate health information, and cultural differences in navigating healthcare systems (Jacquez et al., 2016; Lopez Mercado et al., 2023; Ornelas et al., 2020). These challenges often result in delayed or foregone care, leading to poor health and social outcomes compared to other populations (Sanchez-Birkhead et al., 2011).

While prior research has explored these issues, it has been from the service providers' and organizational or administrative perspectives. There are few studies that capture the firsthand experiences of Spanish-speaking Latinos. This gap is important because understanding patient perspectives is important for designing effective, culturally responsive interventions. This study addresses this knowledge gap by centering on the voices of Spanish-speaking Latinos and applying the consolidated framework for implementation research (CFIR) to examine how CalAIM's implementation affects their

ability to access and benefit from social support services. The CFIR framework offers a comprehensive lens to analyze how intervention characteristics, organizational contexts, and individual factors shape program delivery and patient experiences (Damschroder et al., 2009, 2022a, 2022b). Its use is especially valuable for investigating the complexities of implementing programs in culturally and linguistically diverse communities.

In addition, existing literature emphasizes that culturally competent care and meaningful community engagement are essential to overcoming barriers to service utilization. Language-concordant services and culturally tailored interventions have improved health outcomes, increased patient satisfaction, and built trust in healthcare systems (Chandrashekar et al., 2022; Lopez Vera et al., 2023). Addressing broader social and political factors, including immigration status and systemic discrimination, is also critical for promoting equitable access to care (Misra et al., 2021; Perreira & Pedroza, 2019). Given these findings, this study was needed to deepen the understanding of the specific barriers Spanish-speaking Latinos face under CalAIM, identify opportunities for program improvement, and inform the development of culturally and linguistically appropriate interventions that advance health equity for this underserved population.

## Problem Statement

The ongoing disparities that Spanish-speaking Latinos face when looking for or attempting to access needed social support services through the newly implemented CalAIM initiative. This population encounters significant barriers, including fear of deportation, lack of information on available social services, language difficulties, and systemic discrimination (Jacquez et al., 2016; Lopez Mercado et al., 2023; Ornelas et al.,

2020). These barriers contribute to poor social and health outcomes (Sanchez-Birkhead et al., 2011). Despite the numerous healthcare campaigns and interventions to reach this vulnerable population, this population continues to experience poor social and health outcomes.

The specific research problem addressed through this study is understanding the barriers and challenges experienced when accessing needed social supports through the newly implemented CalAIM initiative, as experiences have not previously been reported from those who are more likely to experience these disparities, Spanish-speaking Latinos (Aridomi et al, 2023; Doshi et al, 2020; Jacquez et al, 2016; Lopez et al, 2023). While recent research has documented systemic and provider-level challenges related to CalAIM's implementation (Aridomi et al., 2023; Doshi et al., 2020), few studies have focused on capturing the firsthand experiences of Spanish-speaking Latinos themselves, representing a critical gap in the literature that this study seeks to fill. By addressing this gap, the study contributes to advancing the discipline of public health implementation science and health equity research by providing insights needed to inform culturally and linguistically responsive program improvements that promote equitable access to social support services.

## Purpose of the Study

The purpose of this qualitative study was to describe the barriers and challenges Spanish-speaking Latinos experience who received needed social supports through the newly implemented CalAIM initiative.

## Research Question

What are the barriers and challenges of Spanish-Speaking Latinos who received social support services through the newly implemented CalAIM initiative?

## Conceptual Framework for the Study

The theory that guided this study was the CFIR, which integrates multiple implementation theories to provide a comprehensive guide for studying the implementation of interventions in complex settings (Damschroder et al., 2009, 2022a, 2022b). CFIR identifies five major domains that shape implementation outcomes: (a) intervention characteristics, (b) outer setting, (c) inner setting, (d) characteristics of individuals, and (e) the implementation process (Damschroder et al., 2009, 2022a, 2022b). These five domains are the primary theoretical foundation for this study, and a detailed explanation of each domain is provided in Chapter 2.

CFIR is a good fit for this study because it has been used extensively to study the implementation of new interventions in the healthcare field (Damschroder et al., 2009, 2022a, 2022b). Specifically, it guided the research question by examining how factors like the program, organization, community, and individual characteristics affect Spanish-speaking Latinos' experiences with CalAIM social support services. Using CFIR helped this study find key factors that impact equitable access to these services, aligning with understanding the barriers and challenges this population faces. A more detailed analysis of the conceptual framework and its application to this study is provided in Chapter 2.

## Nature of the Study

To address the research question in this qualitative study, the specific research design includes an interpretative phenomenological analysis (IPA) approach developed by Jonathan Smith and utilized by Peart et al. (2020) on a similar study where patients who received a care coordination intervention were interviewed to examine their perceptions of their care experience. This design is appropriate because it focuses on understanding how people make sense of their lived experiences. This aligns with purpose of the study to explore the experiences of Spanish-speaking Latinos while access CalAIM social support services.

Data for this study were collected using semistructured interviews with Spanish-speaking Latino adults whose children received asthma home remediation (AHR) services. Interview transcripts were analyzed using a seven-stage thematic coding process adapted from Smith et al. (2022): reading and re-reading, exploratory noting, constructing experiential statements, searching for connections across experiential statements, naming the personal experiential themes and consolidating and organizing them in a table, continuing the individual analysis of other cases, and working with personal experiential themes to develop group experiential themes across cases.

## Definitions

*Access to healthy food*: Limited access to nutritious food in Latino immigrant neighborhoods increases chronic disease risk and impacts overall health (Varela et al., 2023).

*Asthma care and remediation:* Home-based environmental interventions to reduce asthma triggers improve health outcomes and reduce emergency visits among children (Aratani et al., 2020; Moore, 2024).

*Built environment & housing quality:* Poor housing conditions (mold, pests, overcrowding, ventilation) directly exacerbate asthma symptoms and other health issues (Chinchilla et al., 2022).

*California Advancing and Innovating Medi-Cal (CalAIM):* A California statewide initiative launched in 2022 to reform and improve Medi-Cal by integrating medical, behavioral, and social services, including offering enhanced care management and community supports (California Department of Health Care Services, 2022).

*Community-based organizations:* Nonprofit or grassroots organizations that provide community-specific services, often play a crucial role in delivering culturally responsive healthcare and social support services to underserved populations (California Department of Health Care Services, 2022).

*Consolidated framework for implementation research (CFIR):* A comprehensive theoretical framework used to assess factors affecting the implementation of interventions, encompassing five domains: intervention characteristics, outer setting, inner setting, characteristics of individuals, and the implementation process (Damschroder et al., 2009, 2022a, 2022b).

*Culturally competent care:* Healthcare or social services that are respectful of, and responsive to, the cultural and linguistic needs of patients or clients, promoting effective communication and trust (Chandrashekar et al., 2022).

*Cultural responsiveness:* Ability of systems, organizations, and individuals to understand, respect, and effectively respond to the cultural and linguistic needs of diverse populations (Lopez Vera et al., 2023).

*Enhanced care management:* A component of the CalAIM initiative designed to provide coordinated, comprehensive, and person-centered care management services to Medi-Cal beneficiaries with complex health and social needs (California Department of Health Care Services, 2022).

*Environmental hazards:* Exposure to indoor and outdoor pollutants such as air pollution and poor water quality worsens respiratory illnesses (Islam et al., 2024).

*Equitable access:* Fair and just opportunities to obtain healthcare and social services that accommodate the cultural, linguistic, and social needs of diverse populations (Chandrashekar et al., 2022).

*Equitable Implementation:* The intentional process of implementing interventions in ways that reduce disparities by ensuring all populations have equal access, opportunity, and benefit from the intervention (Damschroder et al., 2022a, 2022b).

*Experiential themes:* Patterns or categories of meaning identified during qualitative data analysis that capture shared or divergent aspects of participants lived experiences (Smith et al., 2022).

*Fear of deportation:* Anxiety or apprehension experienced by immigrants or their family members that interactions with social or healthcare services could result in detection by immigration authorities or lead to deportation proceedings (Ornelas et al., 2020).

*Healthcare access and utilization:* Barriers such as language, fear of deportation, and mistrust reduce timely asthma care and follow-up, increasing emergency room visits (Aratani et al., 2020; Sanchez-Birkhead et al., 2011).

*Health disparities:* Differences in health outcomes and their determinants between segments of the population, influenced by social, economic, and environmental disadvantages (Aratani et al., 2020).

*Health equity:* The attainment of the highest level of health for all people, achieved by addressing avoidable inequalities and eliminating disparities caused by social, economic, or environmental disadvantages (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.).

*Health literacy:* An individual's capacity to obtain, process, and understand basic health information to make appropriate health decisions, often negatively impacted by language barriers and education levels (Escobedo et al., 2023).

*Implementation science:* The study of methods and strategies that promote the adoption, integration, and sustainability of evidence-based practices in healthcare and public health systems (Damschroder et al., 2009, 2022a, 2022b).

*Interpretative phenomenological analysis (IPA):* A qualitative research approach focused on exploring and interpreting how individuals make sense of their lived experiences through detailed examination of personal narratives (Smith et al., 2022).

*Language-concordant services:* Services provided in a patient's or client's preferred language to ensure accurate understanding, effective communication, and culturally appropriate care (Chandrashekar et al., 2022; Lopez Vera et al., 2023).

*Lived experiences:* The personal knowledge and insights individuals gain through direct, first-hand involvement in everyday life events, which qualitative researchers aim to explore deeply (Smith et al., 2022).

*Social determinants of health (SDOH):* Conditions in the environments where people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.).

*Social support services:* Programs, interventions, or resources that assist individuals and families in meeting essential social needs, including housing, food security, transportation, and health-related supports (Sanchez-Birkhead et al., 2011).

*Spanish-speaking Latinos:* Individuals of Latin American origin or descent residing in the United States who primarily speak Spanish and may prefer receiving services in Spanish (Jacquez et al., 2016; Lopez Mercado et al., 2023).

*Systemic discrimination:* Institutionalized patterns, policies, or practices within systems that disadvantage individuals based on race, ethnicity, immigration status, or other marginalized characteristics (Misra et al., 2021).

## Assumptions

This study is based on several assumptions that guided and demonstrated its meaningfulness. The first assumption was that Spanish-speaking Latino parents can accurately recall and share their experiences with CalAIM AHR community support, which is important for collecting valid qualitative data. Another assumption is that CalAIM AHR community support positively impacted participants' overall well-being,

making their experiences important to explore. The study also assumed that social determinants, including quality of housing, neighborhood safety, access to healthy food, and experiences of discrimination, were important in shaping the health outcomes of Latino children. Another assumption is that language and cultural barriers impacted access to and the quality of healthcare for Spanish-speaking Latino families. Lastly, this study assumed that the experiences of study participants are reflective of challenges faced by all Latino immigrants, supporting the generalizability of findings to similar populations. These assumptions were necessary to justify using qualitative methods focused on lived experiences and emphasize the importance of social and cultural factors in addressing health disparities. Without these assumptions, the study would have lost its meaning and reliability.

## Scope and Delimitations

This qualitative study's scope was to better understand the barriers and challenges of Spanish-speaking Latinos who received social support services through the newly implemented CalAIM initiative. The focus of this study addressed a gap in the existing literature on the direct experiences of Spanish-speaking Latinos who received social support services through the CalAIM initiative. This study included adult parents (at least 18 years old) of children who received AHR support through the CalAIM initiative. Study participants were asked to consent to participate in a semistructured interview. Demographic characteristics were collected from participants during the interview to describe the study population. These data included age, gender, race/ethnicity, and relationship to the child receiving the support services. All participants were asked to

confirm that they are at least 18 years of age and that their child had received CalAIM AHR community support.

Transferability is the extent to which findings from one study can be applied to other situations (Merriam & Tisdell, 2016). To ensure the transferability of this study, a clear or thick description of the study setting and population were provided, as well as a detailed description of the findings that include direct quotes from participant interviews (Merriam & Tisdell, 2016). However, I acknowledge that despite this effort to increase transferability, this study's findings may not reflect the experiences of all Spanish-speaking Latinos who received CalAIM AHR community support.

## Limitations

This study presents some limitations related to its design and methodology. First, IPA involves collecting subjective data from a small group of participants, limiting the ability to generalize the findings of this study to other populations. While I provide detailed descriptions to ensure readers understand participants' experiences, the findings may not represent the experiences of all Spanish-speaking Latinos accessing CalAIM social supports. Another limitation is the potential for researcher bias due to the qualitative nature of data collection and interpretation. To reduce potential bias, I maintained a reflective journal throughout the research process, acknowledged my role and perspective as a researcher, and regularly engaged with colleagues and mentors to review and validate my interpretations. Lastly, dependability was also a potential limitation because qualitative data interpretation can differ among researchers. To ensure dependability, detailed documentation of research procedures, including data collection

methods, coding procedures, and data analysis decisions, were kept throughout the study. Despite these strategies, readers should interpret the results carefully.

## Significance

This study provides several important contributions for both research and clinical practice. Gathering first-person insights from Spanish-speaking Latino families accessing social support through CalAIM addresses the existing gap in the literature, which currently only provides insights from healthcare providers and organizations. These insights help deepen the understanding of this population's unique barriers and advance the knowledge within the fields of public health and implementation science. These findings could be used to inform improvement strategies for the CalAIM initiative by highlighting areas that need improvement and help to shape future policy decisions, service delivery models, and healthcare interventions and programs. Insights from this study may also help healthcare providers and policymakers in designing interventions to reduce disparities and enhance equitable access to care for Spanish-speaking Latinos. Lastly, findings from this study have potential for contributing to positive social change by guiding interventions to reduce systemic barriers for Spanish-speaking Latinos and other marginalized populations through designed interventions that consider language barriers, immigration-related fears, and overall well-being.

## Summary

This study focused on understanding the barriers and challenges that Spanish-speaking Latinos experience when accessing social support through California's CalAIM initiative. Latinos often face unique challenges, including language issues, fear of

deportation, and systemic discrimination, which often leads to poorer health outcomes compared to other groups. Previous research has presented the views and perspectives of healthcare providers and organizations rather than directly hearing from those affected. To address this gap in the literature, my study directly engaged with Spanish-speaking Latino parents whose children received AHR support from CalAIM. Using an IPA, I interviewed parents about their experiences receiving CalAIM AHR community support. The study used CFIR to explore the factors that impact access to these services. Lastly, this chapter provides an overview of the key concepts and constructs, outlines important assumptions guiding my research, discusses potential limitations of study findings, and highlights the study's contributions to public health and implementation science. This study provides insights into improving health programs and policies and promoting better health equity among underserved communities. Chapter 2 provides a synthesis and critical analysis of the existing literature to support the premise of this study. Chapter 2 also lists and defines key concepts and constructs to help orient readers themselves and to further support the basis for this study.

# Chapter 2: Literature Review

There continue to be ongoing disparities that Spanish-speaking Latinos face when looking for or attempting to access needed social support services through the new implemented CalAIM initiative. This population encounters significant barriers, including fear of deportation, lack of information on available social services, language difficulties, and systemic discrimination (Jacquez et al., 2016; Lopez Mercado et al., 2023; Ornelas et al., 2020). These barriers contribute to poor social and health outcomes (Sanchez-Birkhead et al., 2011). Despite the numerous healthcare campaigns and interventions aimed at reaching this vulnerable population, this population continues to experience poor social and health outcomes.

The purpose of this qualitative study was to understand better the barriers and challenges Spanish-speaking Latinos experience who receive needed social support through the newly implemented CalAIM initiative (California Health Care Foundation, 2021). Existing literature continues to demonstrate that ongoing disparities exist among Spanish-speaking Latinos when looking for or attempting to access needed social support services. However, few studies directly gather the Spanish-speaking Latino's unique perspectives on the barriers and challenges they encounter when accessing needed social support services through the newly implemented CalAIM initiative.

This chapter provides an overview of the existing literature on the subject, the varied experiences, and perspectives on these barriers, and why they exist. This chapter also provides information on the databases and keywords used to search for existing literature and provide an overview of the study's conceptual framework.

## Literature Search Strategy

Numerous peer-reviewed journals were reviewed to gain an understanding of the existing literature on the experiences of Spanish-speaking Latinos and the barriers they face when accessing social support services through the newly implemented CalAIM initiative. Journals were accessed via databases in the Walden Library and Google Scholar. These databases included PubMed, the National Library of Medicine, PloS One, APA PsychInfo, PsycARTICLES, ScienceDirect, and the National Institute on Minority Health and Health Disparities. Key phrases used to locate peer-reviewed articles related to this study included *CalAIM, California Advancing and Innovating Medi-Cal, CFIR, Consolidated Framework for Implementation Research, first-generation immigrant, healthcare, health-related social needs, immigrant, Interpretative phenomenological analysis, Latino, Latinx, marginalized, minority, patient experience, qualitative, social needs, social supports, Spanish-speaking, Spanish speaking Latinos,* and *whole-person care*. Variations of these keywords were used to identify relevant peer-reviewed articles across the various databases. In addition, the searches were narrowed by publication date to only include articles published in the last 5-10 years. Lastly, the reference sections of these journals were also reviewed to locate additional articles.

## Conceptual Foundation: Consolidated Framework for Implementation Research

The CFIR is a framework presented by Laura J Damschroder in 2009 that is commonly used to guide implementation science research that includes various constructs that help identify barriers and facilitators during the implementation of a new program (Damschroder et al., 2009, 2022a, 2022b). CFIR provides a detailed guide that includes

constructs that must be considered when exploring barriers and facilitators of any new intervention (Damschroder et al., 2009, 2022a, 2022b). CFIR allows researchers to articulate contextual factors that impact implementation outcomes (Damschroder, 2020). CFIR was an essential guide for this study because it allowed for the use of various lenses or domains (inner setting, outer setting, individual characteristics, process of implementation, and intervention characteristics) to explore the experiences of Spanish-speaking patients who received social support services through the newly implemented CalAIM initiative (Damschroder et al., 2009, 2022a, 2022b).

**Intervention Characteristics**

This domain focuses on the intervention itself, including its complexity, adaptability, cost, and the perceived strength of the evidence. Key aspects of this domain are how well stakeholders understand the intervention and how adaptable it is to the different contexts (Damschroder et al., 2009). This domain is important because it focuses on fine-tuning a new intervention in an active, reiterative process of engaging stakeholders to modify and adapt an intervention (Damschroder et al., 2009, 2022a, 2022b). In the most recent CFIR 2022 update, generating strong evidence, the intervention design, and the user-centered improvements for better implementation are key (Damschroder et al., 2022a, 2022b).

**Outer Setting**

The outer setting domain refers to the economic, political, and social contexts in which an organization operates. It encompasses external influences such as policies, incentives, and patient needs or preferences. As Damschroder et al. (2009) explained,

relationships with external networks and the influence of peer organizations also affect implementation success. In 2022, the framework update highlighted the importance of socio-political and regulatory factors, particularly how they intersect with organizational needs (Damschroder et al., 2022a, 2022b). More specifically, the updated CFIR framework highlighted the importance of sociocultural values and beliefs and local conditions (i.e., economic, environmental, political, and technological conditions) on entities' ability to support the implementation and delivery of a new program or innovation (Damschroder et al., 2022a, 2022b). This is important for the CalAIM program since a primary implementation requirement is the partnership of health systems with community-based organizations to provide community-based social support to its members.

**Inner Setting**

The inner setting domain captures the internal context of the implementing organization, including structural characteristics, culture, and communication processes. Implementation is affected by organizational readiness, leadership engagement, and resource availability (Damschroder et al., 2009). The update integrating feedback on how culture, organizational priorities, and resource commitment influence success (Damschroder et al., 2022a, 2022b). The additional subdomain of culture looks at culture through four lenses: human equality-centeredness, recipient-centeredness, deliverer-centeredness, and learning-centeredness (Damschroder et al., 2022a, 2022b). The addition of these subdomains is a consideration when implementing a new program

because the focus is on equitable implementation of a new program (Damschroder et al., 2022a, 2022b).

**Individual Characteristics**

The individual characteristics domain examines those involved in implementation, considering their knowledge, beliefs, self-efficacy, and personal motivations. As Damschroder et al. (2009) noted, organizations are composed of individuals; therefore, reflecting on how individual behaviors, motivations, beliefs, and attitudes contribute to, and impact implementing a new program is essential. In addition, this domain considers the dynamics of how individuals learn and adapt over time and, therefore, how this impacts the implementation of a new program (Damschroder et al., 2009). The 2022 revision emphasizes the importance of ongoing training, user engagement, and the personal characteristics of implementers, like leadership traits (Damschroder et al., 2022a, 2022b).

**Process of Implementation**

The implementation domain refers to the stages and actions involved in implementing a new program, such as planning, engaging stakeholders, executing, reflecting, and evaluating. According to Damschroder et al. (2009), effective implementation requires ongoing monitoring and the engagement of opinion leaders (i.e., experts and peers), internal implementation leaders (i.e., organizational coordinator, program manager, team leader), champions, and external change agents to ensure adherence or fidelity to a model or program (Damschroder et al., 2009). The updated CFIR integrates further recommendations for engaging a broader range of stakeholders

and iterative adaptation of processes during implementation (Damschroder et al., 2022a, 2022b). This domain's goal is to document the degree to which an implementation framework or model was followed and how those impacts implementation outcomes (Damschroder et al., 2022a, 2022b).

**How CFIR Relates to the Study**

CFIR is particularly useful in examining interventions like the CalAIM initiative because it offers a structured approach to examine key factors influencing the implementation successes and challenges of the CalAIM initiative among Spanish-speaking Latinos (Damschroder, 2020; Damschroder et al., 2022a, 2022b). One important domain is intervention characteristics, which helps to understand how this population perceives CalAIM's components, such as care coordination and cultural responsiveness, and can also shed light on the program's acceptance or resistance. Similarly, the Outer Setting domain brings forth any systemic inequities, language barriers, and sociopolitical factors that influence access to and satisfaction with the CalAIM services provided.

CFIR also considers the Inner Setting domain, which highlights those delivering CalAIM services and their ability to deliver them in a way that is responsive to service recipients' cultural and linguistic needs (Damschroder et al., 2022a, 2022b). This domain is critical because staffing, training, and resources significantly bridge gaps for Spanish-speaking Latinos. Additionally, the Characteristics of the Individual domain allows for the investigation of how patients' and providers' attitudes, trust, and prior experiences can shape program engagement and success (Damschroder et al., 2022a, 2022b). The

CFIR domains helped identify barriers and facilitators specific to this population, providing insights to improve implementation and outcomes.

By applying CFIR to a real-world case like CalAIM implementation, the study enriched the framework by highlighting the importance of culturally responsive strategies in implementation science (Damschroder et al., 2009, 2022a, 2022b). Insights from the study could lead to refinements in CFIR, including developing sub-constructs or practical tools for addressing cultural and linguistic diversity in health interventions.

**How CFIR Relates to the Research Question**

The current study builds on the CFIR by examining how systemic and contextual factors influence Spanish-speaking Latinos' experiences with CalAIM's social support services. This study aligns with CFIR domains by exploring factors such as poverty, food insecurity, and housing instability (outer setting), organizational processes accommodating Spanish-speaking populations (inner setting), and cultural norms and language barriers (characteristics of individuals) (Damschroder et al., 2009, 2022a, 2022b).

This research adds to CFIR's application by addressing cultural and linguistic gaps within program implementation frameworks. While CFIR is commonly applied in healthcare settings, limited research explores its use with Spanish-speaking populations, particularly how this intersects with SDOH. The study challenges CFIR to address systemic inequities, particularly language equity and cultural responsiveness, which are often underexplored (Berger & Peled, 2022; Escobedo et al., 2023).

By focusing on the barriers and challenges unique to Spanish-speaking Latinos, this research builds upon CFIR by further refining its domains. For instance, inner setting constructs could be expanded to emphasize continuous self-reflection and learning led by an organization and lead to providing inclusive and equitable services, while the characteristics of individual domains might integrate language-specific barriers and their impact on health access (Moyce et al., 2022; Varela et al., 2023). The study contributes to CFIR's ongoing refinement, enhancing its relevance for equity-focused initiatives like CalAIM and further contextualizing its constructs for culturally diverse populations (Chinchilla et al., 2022; Sanchez-Birkhead et al., 2011).

**Rationale for Selecting CFIR**

The CFIR framework was chosen for the current study because it allowed for the exploration of important contextual factors, its flexibility to be applied across different settings and contexts, its natural ability to identify barriers and facilitators, and generate actionable steps to improve programs (Damschroder et al., 2009, 2022a, 2022b). CFIR's five domains (intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation process), offered a comprehensive structure to evaluate complex systems like CalAIM. It is also beneficial when analyzing Spanish-speaking patients' experiences, as the framework allows for a multi-level exploration of social, cultural, and systemic barriers (Damschroder et al., 2009, 2022a, 2022b). CFIR is also flexible in that it enables its application in various contexts, including diverse populations with unique barriers, such as language or socioeconomic disparities. CFIR's flexibility is critically important for understanding how interventions, such as CalAIM, address SDOH

for marginalized groups. Lastly, CFIR's framework supports implementation science by identifying barriers and facilitators, ensuring the research generates actionable insights for improving program delivery and sustainability (Damschroder et al., 2009, 2022a, 2022b). This rationale aligns with the study's goal that explored the experiences of Spanish-speaking patients and identified gaps in program implementation.

## Literature Review

CalAIM initiative is an effort aimed at transforming Medi-Cal by addressing health inequities through enhanced care coordination, community-based interventions, and a focus on SDOH (California Health Care Foundation, 2021). For Spanish-speaking Latinos, the CalAIM initiative represents an opportunity to address historical disparities in access to care and support. Understanding these barriers through a review of relevant research can highlight actionable strategies to optimize CalAIM's implementation for this population (Faiz et al., 2024; Lopez Vera et al., 2023).

This review synthesizes key findings on barriers faced by Spanish-speaking Latinos, including language barriers, structural inequities, and cultural differences in accessing healthcare and social services (Chandrashekar et al., 2022; Escobedo et al., 2023). Through the lens of the CFIR framework, it delves into the systemic and historical challenges facing this population. It highlights evidence-based, culturally tailored approaches that can enhance the success of initiatives such as CalAIM (Damschroder et al., 2022a, 2022b).

## Barriers to Healthcare and Social Support Services for Spanish-Speaking Latinos

Spanish-speaking Latinos represent one of the largest and most vulnerable groups served by Medi-Cal in the state of California. While initiatives like the expansion of the Affordable Care Act (ACA) and CalAIM aims to improve access to integrated services for Latinos, systemic barriers such as language, immigration status, and fear of institutional systems prevent equitable participation (Allen & Perreira, 2021; Lines & Weech-Maldonado, 2024).

### *Language and Communication Challenges*

One of the most significant barriers for Spanish-speaking Latinos in healthcare is language. This challenge is exacerbated by the lack of adequate translation services and culturally competent materials, which makes it difficult for Spanish-speaking individuals to understand eligibility requirements, application processes, and available services. Lopez Vera et al. (2023) highlighted that Spanish-speaking families often struggle to navigate complex legal and medical forms due to limited access to translated materials, which directly affects their ability to enroll in programs designed to address SDOH, such as food insecurity, housing instability, and healthcare access. The inability to understand these forms leads to the underutilization of critical services, contributing to health disparities within the Latino community.

In addition to the challenges with written materials, Escobedo et al. (2023) emphasized that policy complexities often remain unclear and confusing for those with limited English proficiency. This lack of clarity and accessibility often deters Spanish-speaking individuals from seeking help and engaging in programs such as Medicaid or

CalFresh (Escobedo et al., 2023). Without bilingual support, the enrollment process becomes even more overwhelming, which results in many Latino families missing out on benefits intended to address their basic needs. This is particularly problematic as it continues the cycles of poverty and health inequities within the Latino community.

Language barriers extend beyond the written word to interactions with service providers. Schulson et al. (2019) noted that language discordance in healthcare settings contributes to a sense of exclusion and perceived discrimination, discouraging Spanish-speaking Latinos from seeking care and services. In many cases, the absence of Spanish-speaking staff and interpreters makes it difficult for individuals to initiate program enrollment, even when eligible for services, further exacerbating existing health disparities.

The importance of understanding these barriers is highlighted by Nguyen et al. (2024), who conducted a qualitative study examining the in-patient hospital experience for Spanish-speaking patients, caregivers, and community leaders. The study found that language barriers negatively impacted the perceptions of Spanish-speaking patients, caregivers, and community leaders' care quality. This led to a greater sense of feeling excluded from the healthcare process. When patients feel disconnected from their healthcare provider because of their inability to communicate effectively, they are less likely to engage in preventive care, follow-up appointments, or healthcare programs to improve health outcomes. This reluctance can further add to health risks and worsen health outcomes.

Bilingual medical interpreters and community health navigators have been shown to improve enrollment and healthcare access for Spanish-speaking populations (Escobedo et al., 2023; Shommu et al., 2016). However, Escobedo et al. (2023) pointed out that shortages of interpreters, especially in rural areas, limit the effectiveness of these services. Likewise, Shommu et al. (2016) found that while community health navigators play a crucial role in helping Spanish-speaking individuals understand the enrollment process, their availability remains inconsistent across different healthcare settings. This inconsistency prevents the widespread use of community health navigators, hindering their ability to bridge the gap in healthcare access for Spanish-speaking Latinos.

The impact of language barriers extends beyond enrollment and impacts patient-provider relationships. Escobedo et al. (2023) emphasized that language discordance between healthcare providers and Latino patients often leads to gaps in understanding medical advice, which undermines treatment adherence. For example, Chandrashekar et al. (2022) found that non-Spanish-speaking providers often struggle to explain complex health concepts, leading to poorer outcomes among Spanish-speaking patients who have diabetes. Similarly, Diamond et al. (2019) stressed that patient-physician language concordance is crucial for improving health outcomes. Otherwise, miscommunication can result in misdiagnoses and inappropriate treatments, further exacerbating health disparities within the Latino population.

Language barriers in healthcare for Spanish-speaking Latinos present significant challenges not only in understanding medical advice but also in enrolling in programs that could address critical social determinants of health. Policymakers, healthcare

systems, and providers must address the complexities of language access, improve the availability of translated materials, and expand the presence of bilingual staff and interpreters to ensure that Spanish-speaking individuals can fully participate in healthcare programs and receive equitable care.

### *Immigration Status*

Fear of deportation or legal consequences often deters Latinos from seeking healthcare services, even those who are eligible, a concern that is also common among mixed-status families. Existing research highlights the role immigration status has on healthcare access. Bernstein et al. (2020) show that fear of deportation and restrictive immigration policies create a negative effect because they prevent both undocumented individuals and legal residents in mixed-status families from seeking needed medical care. Similarly, Doshi et al. (2022) found that during the Trump administration, Latino immigrants, specifically undocumented individuals, avoided healthcare services due to heightened anti-immigrant rhetoric and policy changes, such as the expansion of public charge rules. This fear extends to the individual; entire families avoid accessing services, even families with members who are eligible.

The psychological distress associated with immigration-related stress is another major deterrent. Garcini et al. (2021) conducted a systematic review highlighting Latinx immigrants' stress due to uncertainty around their legal status and exposure to discrimination. Heightened stress often contributes to poor mental and physical health consequences, yet the fear associated with immigration prevents individuals from seeking needed medical care. Wang et al. (2022) provided additional evidence that such

restrictive federal policies disproportionately impact Latino immigrants. Their study of immigrant patients at a safety-net hospital found that many Latino immigrants feared seeking medical care due to concerns about legal consequences (Wang et al., 2022). The significant impact of immigration policies on health outcomes is evident in the growing body of research linking legal status to adverse physical and mental health conditions. Latino immigrants who fear deportation report higher levels of anxiety, depression, and chronic stress, conditions that are exacerbated by limited access to healthcare resources (Castañeda et al., 2015; Ornelas et al., 2020). Chronic stress related to legal status has also been associated with increased risks of cardiovascular diseases and other chronic conditions (Perreira & Pedroza, 2019). The reluctance to seek healthcare contributes to health disparities, reinforcing cycles of poor health that primarily impact Latino immigrant communities.

Beyond the fear of deportation, the structural barriers associated with immigration status further exacerbate disparities in healthcare access. Latino immigrants, particularly those who are undocumented, often lack health insurance due to restrictive policies barring them from enrolling in federal and state-funded healthcare programs such as Medicaid and the ACA marketplaces (Allen & Perreira, 2021). Even documented immigrants face restrictions based on the five-year waiting period imposed on legal permanent residents before they qualify for federally funded healthcare programs (Bernstein et al., 2020). These limitations discourage preventive care and force individuals to delay seeking treatment until conditions become severe, leading to increased emergency room visits and higher healthcare costs (Hacker et al., 2015).

Immigration policy plays a crucial role in shaping healthcare access for Latino immigrants. Lines and Weech-Maldonado (2024) discussed the "immigrant paradox," highlighting the health advantages and the barriers foreign-born individuals experience. Callaghan et al. (2019) demonstrated how political rhetoric contributes to fluctuating disparities in healthcare access. Young et al. (2024) noted that restrictive policies disproportionately impact Latino health, leading to increased vulnerability among immigrant communities. Additionally, Young et al. (2024) argued that immigration policies impose "disproportionate costs" on Latino and Asian immigrants, exacerbating financial and social barriers to healthcare access.

Addressing the impact of immigration status on Latino immigrant health requires policy interventions that expand healthcare access regardless of legal status, increase funding for community health programs, and enhance protections for mixed-status families. Efforts to create "safe spaces" in healthcare settings, where patients are assured that their immigration status is not reported, have shown promise in improving healthcare utilization among immigrant populations (Hacker et al., 2015). Additionally, expanding state-level Medicaid programs and community-based health initiatives can help mitigate the adverse effects of restrictive federal policies and improve health outcomes for Latino immigrants.

### *Structural Racism*

Structural racism has a significant impact on the health and well-being of Latinos in the United States. Systemic inequities embedded in healthcare policies, economic structures, and social determinants of health create significant barriers to care. Spanish-

speaking Latinos often face significant challenges in accessing healthcare due to complex policies that often restrict access to needed healthcare, language barriers, and institutional discrimination. These barriers often contribute to poor health outcomes and increased rates of chronic disease among Latino communities.

Health insurance access, for example, is an area where structural racism is evident. Immigration policies and restrictive eligibility criteria particularly impact immigrant Latino's access to public health programs and services. According to the Pew Research Center, Hispanic adults are often less likely than non-Hispanic whites to have health insurance, leading to delays in seeking medical care and higher rates of untreated conditions (Funk & Lopez, 2022). Research by Misra et al. (2021) explained that structural racism within healthcare institutions contributes to distrust and underutilization of services among Latino immigrants. In healthcare, structural racism can be seen in a variety of ways, such as:

- Complicated health insurance enrollment and renewal process (Bernstein et al., 2020),
- Anti-immigrant policies and rhetoric contribute to the shaping of social and policy environment (Islam & Ahmed, 2021) and
- Lack of multi-lingual health materials and information, discriminatory practices that stigmatize certain groups like Latinos, and a lack of culturally competent care (Escobedo et al., 2023).

As Allen and Perreira (2021) and Misra et al. (2021) explained, while attempts at easing access for immigrant populations are made, sometimes these processes are instead

intentionally or unintentionally aimed at increasing accessibility for groups with better access to resources, such as white individuals, further marginalizing nonwhite and immigrant populations. Policies that fail to consider Latino communities' cultural and linguistic needs add to the inequities (Perreira & Pedroza, 2018; Ramos-Gomez & Kinsler, 2022). Also, the lack of Latino representation in healthcare leadership and policymaking often adds to the marginalization of Latinos (Islam & Ahmed, 2021; Misra et al., 2021). The cumulative effect is a system that prioritizes the needs of English-speaking, higher-income populations while neglecting the specific challenges faced by Latinos (Misra et al., 2021).

**SDOH**

An individual's overall health and well-being are shaped by the different environments in which they are "born, live, learn, work, play, worship, and age" (Gómez et al., 2021). To better understand these environments or systems, it is important to understand the varied conditions within these environments that impact individuals' health, functional, and quality-of-life outcomes (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.). These conditions are known as the SDOH. The SDOH is shaped by the distribution of wealth, power, and resources at the global and community levels and is seen to contribute primarily to health inequities (Gómez et al., 2021). To explain these conditions, the SDOH is grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (U.S. Department of Health and Human Services, Office of Disease Prevention and Health

Promotion, n.d.). Each domain is composed of several topics that explain the different factors that contribute to and drive health outcomes and disparities.

### *Economic Stability*

Economic stability is something that most people work towards to have a healthy and long life. It is also a significant SDOH that encompasses employment status, food insecurity, housing instability, and poverty. For Latino immigrants, and all immigrants, economic instability can exacerbate health disparities by limiting access to necessary resources, such as quality healthcare, healthy food, stable housing, and safe living conditions.

Employment status is seen as a strong predictor of economic stability. Stable employment provides individuals the financial means to access healthcare, secure housing, and maintain a healthy lifestyle. However, many Latino immigrants face challenges in obtaining stable, well-paying jobs due to language barriers, lack of formal education, and discrimination in the workplace. According to Gómez et al. (2021), Latino immigrants are more likely to be employed in low-wage, high-risk jobs that offer little to no health insurance and paid time off benefits. These jobs are often in sectors like agriculture, construction, and hospitality, exposing workers to higher rates of injury, chronic illness, and poor mental health due to job insecurity, unsafe working conditions, and discriminatory employment practices (Misra et al., 2021). Unfortunately, undocumented immigrants are more likely to experience on-the-job exploitation and often avoid seeking healthcare due to fears of being deported (Krause et al., 2021). The lack of stable or insufficient employment not only limits access to health insurance but

also increases stress and anxiety, which can negatively affect physical and mental health outcomes.

Food insecurity, or the lack of access to healthy foods, is another key factor of economic stability affecting immigrant communities' health. Previous research has shown that Latino households are disproportionately affected by food insecurity, with many struggling to provide adequate nutrition for their families (Varela et al., 2023). Food insecurity has been linked to a range of adverse health outcomes, including an unhealthy diet, higher rates of obesity, and high rates of chronic diseases, including diabetes and hypertension (Varela et al., 2023). The economic instability experienced by Latino immigrant families often forces them to prioritize daily needs (i.e., quick and inexpensive food, transportation, housing, etc.) over long-term health considerations. This problem is further exacerbated by a lack of access to food assistance programs due to a lack of awareness of available resources and fear of interacting with government institutions due to concerns about immigration status (Bernstein et al., 2020). Addressing food insecurity is essential for improving the overall health of Latino immigrants and breaking the cycle of poverty and poor health.

Housing instability (i.e., the risk of eviction, overcrowding, and poor living conditions) impacts the overall well-being of Latino immigrants. According to Chinchilla et al. (2022), housing insecurity is a serious issue for many Latino families, especially those living in areas with high rents. Unstable housing can lead to anxiety and depression, as well as physical health problems, including respiratory issues, due to exposure to mold and poor ventilation in overcrowded or poorly maintained housing (Chinchilla et al.,

2022). In addition, housing instability would lead to individuals prioritizing immediate needs versus seeking needed medical care (Krause et al., 2021). Latino immigrants are particularly susceptible to experiencing barriers when seeking stable housing, such as discrimination when seeking housing and limited access to affordable housing; further contributing to the overall vulnerability of this population.

Poverty is the root cause of many of society's economic challenges faced by individuals, specifically immigrants like Latinos. Living in poverty presents challenges when addressing necessities, such as healthy food options, adequate housing, and healthcare services. Krause et al. (2021) emphasized that individuals living in poverty are more likely to experience poor health outcomes, including higher rates of chronic conditions and mental health disorders. For Latino immigrants, poverty is often exacerbated by low wages, lack of access to social services, and the economic strain of supporting extended family members in their home countries (Galvan, et al., 2022; Schumacher, et al., 2024). This financial strain leads to high levels of stress, which can negatively affect both physical and mental health (Gómez et al., 2021). Also, poverty always limits a Latino family's ability to invest in preventive health measures, such as annual medical checkups and healthy food, which are essential for maintaining long-term health.

Economic stability is one of the most critical SDOH because it directly influences the overall well-being of Latino immigrants. The challenges related to employment, food insecurity, housing instability, and poverty create significant barriers to accessing healthcare and maintaining good health. Addressing these issues requires policies that

help improve access to stable, well-paying jobs, expand food assistance programs, and ensure affordable and safe housing for all immigrants.

### *Education Access and Quality*

Education is fundamental right in the United Status of American and therefore a strong predictor of overall well-being of individuals. However, access to and the quality of education varies across society. It can shape our everyday life opportunities, economic stability, and access to healthcare. For Latino immigrants in particular, these factors are crucial in determining their health outcomes, especially given the additional challenges they face, such as language barriers, financial limitations, and discrimination. Education access and quality can be examined through several key topic areas: early childhood development and education, higher education attainment, high school graduation rates, and language and literacy levels (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.).

Access to early childhood education is important for children's cognitive, social, and emotional development. According to Gómez et al. (2021), early childhood development programs are essential in reducing health inequities by providing children with the foundational skills needed for later success in life. However, many Latino immigrant families face challenges in accessing quality early childhood education due to financial constraints, language barriers, and a lack of culturally relevant programs (Suárez-Orozco et al., 2021). These challenges are further exacerbated by limited information or awareness about available services, resulting in delayed school enrollment and lower educational outcomes in the long run (Krause et al., 2021). As a result,

children in Latino immigrant households are more likely to experience developmental delays, which can affect their academic performance and overall health later in life.

Higher education attainment is a known predictor of health outcomes, as individuals with higher education levels are more likely to have stable, well-paying jobs, access to health insurance, be health literate, and experience health outcomes (Gómez et al., 2021). Latino immigrants face significant barriers to higher education, including financial hardships, limited access to resources, and the challenges associated with navigating an unfamiliar education system. The high cost of tuition and the lack of financial support make it difficult for many Latino immigrants to pursue higher education, particularly for undocumented individuals or those with limited English proficiency (Suárez-Orozco et al., 2021). Additionally, discriminatory policies and practices in higher education, such as racial profiling and exclusionary admission policies, further hinder access to educational opportunities for Latino immigrants, thus limiting their ability to secure economic stability and better health outcomes (Perreira & Pedroza, 2019). This fact will be further exacerbated by the recent process to dismantle Diversity, Equity, and Inclusion programs and initiatives in the United States, which will further destabilize Latino immigrants and communities.

High school graduation is an important milestone influencing an individual's future opportunities for Latino immigrants who often face systemic barriers to completing high school, including language difficulties, lack of familial support, and economic hardship; high school attainment is less common. Research by Krause et al. (2021) underscored those students from low-income backgrounds, particularly those from

immigrant families, are more likely to experience academic underachievement and lower graduation rates. Language barriers are a significant challenge for Latino immigrant students, many of whom are English language learners. This language gap can lead to academic struggles and lower graduation rates compared to non-immigrant peers (Gómez et al., 2021). In addition, undocumented students face the added challenge of legal uncertainties, which can hinder their ability to attend school consistently and pursue post-secondary education (Suárez-Orozco et al., 2021). This will be further magnified by the recent changes to immigration laws in the United States, which have United States Border Patrol stalking Latino communities, including schools, searching for individuals suspected of being undocumented. This has begun to deter people from going to work and school. Consequently, low graduation rates limit access to higher-paying jobs, health insurance, and opportunities for better health outcomes.

Language and literacy are important factors that contribute to education and health outcomes. As discussed in previous sections, Latino immigrants' language barriers can interfere with their ability to access not just health care but also education (Krause et al., 2021). Similarly, low literacy levels can affect health literacy, which is its essential for navigating the healthcare system, understanding medical instructions, and making informed health decisions (Gómez et al., 2021). Many Latino immigrants, particularly recent arrivals, face significant challenges in acquiring sufficient English proficiency, limiting access to both educational opportunities and healthcare (Chandrashekar et al., 2022). Lastly, their inability to communicate effectively with healthcare providers can reduce trust and quality of care, leading to worse health outcomes for this population.

Access to quality education is important for improving the health and well-being of Latino immigrant populations (Gómez et al., 2021; Krause et al., 2021). Early childhood education, higher education attainment, high school graduation rates, and language proficiency all directly impact the health outcomes of these communities (World Health Organization, n.d.). Addressing the barriers that Latino immigrants face in accessing quality education can help reduce health disparities and improve overall well-being (Perreira & Pedroza, 2019). Policymakers and public health professionals must prioritize educational equity as a strategy for promoting health equity and addressing the broader social determinants of health (Chinchilla et al., 2022). However, in 2025 this may be challenging as the existence of the United States Department of Education hangs in the balance.

### *Health Care Access and Quality*

Health care access and quality are defined by three topic areas including access to health services, access to primary care, and health literacy. These factors play a pivotal role in determining health outcomes for Latino immigrant populations.

Access to healthcare services is essential for preventing, detecting, and treating diseases. However, Latino immigrants frequently experience difficulties obtaining necessary medical care due to multiple barriers, including lack of insurance, financial constraints, and immigration status concerns, to name a few. According to the U.S. Dept. of Health & Human Services (2024), Latino are more likely to be uninsured, making it difficult for them to seek timely medical attention. Additionally, restrictive healthcare policies further make it difficult or impossible for undocumented immigrants to access

public health programs. Work-related barriers also contribute to limited access to health care. Many Latino immigrants work in low-wage jobs that do not offer health insurance, forcing them to rely on community health centers or emergency services. Moyce et al. (2022) found that many Spanish-speaking Latinos avoid seeking medical care out of fear of losing wages due to time off work. The necessity to prioritize income over health leads to the postponement of medical visits, often resulting in the progression of preventable diseases.

Regular access to primary care services is important to maintaining long-term health, yet Latino immigrants often struggle to obtain consistent medical attention. The most often cited challenges include immigration status, poverty, language barriers, culturally appropriate care, and perceived discrimination. One challenge I have not discussed is the shortage of culturally competent providers who can effectively communicate with Spanish-speaking patients (Escobedo et al., 2023). Cultural competence is defined as providing care considering a person's race, ethnicity, cultural background, English proficiency, or literacy (Georgetown University Health Policy Institute, n.d.). As previously discussed, language is a significant barrier for Latinos when trying to receive medical care. There are often inadequate or not culturally insensitive translation services available or a lack of bilingual healthcare professionals, which often deter Latino immigrants from seeking medical care. Another issue is that of discriminatory behaviors of providers or organizations towards immigrants. Ramos-Gomez and Kinsler (2022) highlight that perceived discrimination often leads to mistrust of medical professionals and, hence, the avoidance of healthcare. Fear of racial profiling,

judgment, or mistreatment often discourages many Latino immigrants from following up on medical treatments or preventive care visits.

Like cultural competence, health literacy, or the ability to obtain, process, and understand basic health information, is crucial for making informed health decisions (Escobedo et al., 2023). However, many Latino immigrants struggle with low health literacy due to language barriers and limited formal education. This affects their ability to navigate healthcare systems, understand medical instructions, and adhere to medical treatments (Escobedo et al., 2023). A lack of culturally appropriate health education materials further compounds the problem. Many public health messages are often than not designed with English-speaking populations in mind, making it difficult for non-English speakers to access critical health information.

Latino immigrants encounter numerous challenges when attempting to access healthcare services in the United States. These challenges contribute to health disparities and poor health outcomes.

### *Neighborhood and Built Environment*

Neighborhood and built environment include four topic areas: access to healthy foods options, crime and violence, environmental conditions such as water quality, air quality, and weather/climate change, and physical quality of housing and neighborhood conditions. These factors impact the overall well-being of Latino immigrant communities who very often live in poor areas that are unsafe, lack the needed infrastructure and services, and have limited access to essential services.

Access to healthy food options is another challenge within many Latino immigrant neighborhoods. Food deserts—areas with limited access to fresh and nutritious food—are common in under-resourced communities, forcing many Latino families to rely on processed, unhealthy foods that contribute to obesity, diabetes, and other chronic conditions (Varela et al., 2023). The inability to afford nutritious and healthy food further adds to the health risks, as financial constraints often force families to prioritize inexpensive, unhealthy foods over fresh produce and lean proteins (Varela et al., 2023). Also, the constant worry about having enough food can lead to chronic stress and anxiety, which contribute to poor mental and physical health outcomes (Varela et al., 2023). This issue is particularly concerning for Latino children, as inadequate nutrition during early development can lead to cognitive delays and increased susceptibility to chronic diseases later in life (Varela et al., 2023).

Exposure to crime and violence has immediate and long-term health effects. Physical injuries can result in long-lasting disabilities and chronic pain, and the psychological effects of crime exposure are equally significant. Many Latino immigrants live in high-crime neighborhoods due to strained financial resources and limited housing options. The areas Latino immigrants can afford tend to have higher rates of gang activity, drug-related violence, and property crime, which can create an environment of fear and insecurity (Escobedo et al., 2023). These areas often have higher rates of gang activity, drug-related violence, and property crime, which can create an environment of fear and insecurity (Escobedo et al., 2023). Ornelas et al. (2020) further explained that individuals who witness or experience violence are at an increased risk of developing

post-traumatic stress disorder, depression, and other mental health conditions. Studies show that children with early exposure to violence can lead to developmental delays, behavioral issues, and difficulty concentrating in school (Chinchilla et al., 2022). In addition to street violence and unsafe neighborhoods, Latino immigrants also tend to experience domestic violence at higher rates, where many victims avoid seeking help due to fear of deportation, language barriers, and a lack of trust in law enforcement (Ramos-Gomez & Kinsler, 2022). The stress associated with growing up in unsafe environments leads to long-term health problems, including cardiovascular disease and weakened immune function (Chinchilla et al., 2022).

Poor environmental conditions tend to go hand-in-hand with living in areas with high crime and violence rates. As mentioned earlier, many Latino immigrants are often limited by their financial resources in terms of the communities and neighborhoods they can live in. These communities are more often disproportionately exposed to environmental hazards, including high pollution levels, poor water quality, and extreme weather events (Islam et al., 2024). Air pollution, often a consequence of residing in industrialized or congested areas, is linked to increased respiratory illnesses such as asthma and chronic obstructive pulmonary disease. Additionally, poor water quality can contribute to gastrointestinal illnesses and other chronic conditions, further exacerbating existing health disparities. These environment stressors often are contributing factors to poor overall well-being of Latino immigrants.

The quality of housing plays an important role in shaping the overall well-being of an individual. High-quality housing is important and contributes to the overall well-

being of individuals. On the other hand, poor housing conditions can lead to various adverse health effects. Latino immigrant communities face significant challenges related to substandard housing, environmental hazards, and inadequate infrastructure, all of which contribute to health disparities. Substandard housing conditions, such as overcrowding, poor ventilation, mold, pest infestations, and lead exposure, are linked to numerous adverse health outcomes. For example, exposure to mold and damp conditions is associated with respiratory illnesses, including asthma and chronic bronchitis (Chinchilla et al., 2022). Similarly, the presence of lead in older housing units increases the risk of lead poisoning, particularly in children, which can result in cognitive impairment and developmental delays. Overcrowded living conditions, another primary concern, are prevalent among the Latino immigrant community. Often, multiple families share homes that are not large enough due to financial constraints. As experienced during the COVID-19 epidemic, overcrowding contributes to higher rates of infectious disease transmission, mental health stressors, and limited access to personal space, all of which can negatively impact well-being (DeCastro Mendez et al., 2021).

The neighborhood and built environment play a critical role in shaping the health and well-being of Latino immigrant populations. All aspects of an individual's neighborhood band environment collectively contribute to disparities in health outcomes.

### *Asthma and Home Remediation in Latino Communities*

Asthma is a chronic respiratory condition that impacts about 6% of children in the United States (Centers for Disease Control and Prevention, 2023). However, some studies have demonstrated that asthma disproportionately affects Latino communities in the

United States, especially those living in low-income or immigrant households (Heintzman et al., 2020; National Heart, Lung, and Blood Institute, 2023; Pérez & Coutinho, 2021). These disparities are shaped by social and environmental factors, including poor housing conditions, exposure to indoor and outdoor pollutants, and poor-quality healthcare (Banta et al., 2021). Aratani et al. (2020) added that language also negatively contributed to increased return visits to emergency rooms. More specifically, Aratani et al. (2020) found that Latino children had a high prevalence of asthma-related emergency room visits and hospitalizations. In addition, children with asthma whose parents' primary language is not English were less likely to have an asthma care plan or regular communication with doctors about their children's asthma, often resulting in return emergency room visits after initial visits and leading to hospitalizations and poor asthma control overall (Aratani et al., 2020; Banta et al., 2021)

AHR programs have emerged across the United States as a public health strategy to address asthma. One such public health strategy is California's CalAIM initiative, where the state partnered with managed care plans, like Kaiser Permanente (KP), to offer 14 community supports to Medi-Cal beneficiaries. These community supports include services such as medically tailored meals, housing navigation, and AHR, among others aimed at improving health outcomes and reducing hospitalizations (Moore, 2024). CalAIM's goal for AHR is to eliminate home environment triggers that might contribute to asthma exacerbations leading to urgent care or emergency room visits (Moore, 2024).

Although past studies have evaluated previous AHR impacts on clinical outcomes, there are currently no published studies documenting the lived experiences of Spanish-speaking Latinos whose children received CalAIM AHR support services.

### *Social and Community Context*

Lastly, social and community context plays a pivotal role in shaping the health and well-being of Latino immigrants. The social and community context encompasses four topics: civic engagement, structural and individual discrimination, impact of incarceration on the individual and their family, and social environment as defined by relationships and sense of community.

Civic engagement refers to the active participation of individuals in political, social, and community affairs, including voting, volunteering, and other forms of community involvement. For Latino immigrants, civic engagement can be a critical pathway to improving health and social outcomes. However, barriers such as legal status, language, and lack of familiarity with the political system can hinder Latino immigrants' ability to engage fully in their communities. Studies have shown that increased civic engagement can lead to better health outcomes by promoting a sense of agency and access to supportive networks (Sanchez-Birkhead et al., 2011). Immigrant communities that are more engaged in civic activities often experience greater success mitigating the effects of social determinants like poverty and healthcare disparities (Gómez et al., 2021).

Structural and individual discrimination significantly impacts the health and well-being of immigrants, including Latinos. Structural discrimination refers to systemic policies and practices embedded within institutions (e.g., healthcare, education, and

housing systems) that marginalize certain groups, including Latino immigrants (Misra et al., 2021). These policies tend to limit access to resources, exacerbate poverty, and perpetuate inequities in health care and employment (Misra et al., 2021). For example, immigration policies that exclude specific populations from healthcare benefits create barriers to access and exacerbate chronic health issues in these communities. Individual discrimination involves direct, person-to-person interactions where individuals experience prejudice based on race, ethnicity, or immigration status (Misra et al., 2021). This type of discrimination can take the form of racial profiling, biased treatment in healthcare settings, or discrimination in the workplace. Research indicates that experiencing discrimination increases stress levels and contributes to poor health outcomes for Latino immigrants, further entrenching health disparities (Misra et al., 2021). Both types of discrimination create an environment where Latino immigrants feel distrustful of institutions and health providers, resulting in reduced healthcare utilization and worsened health conditions.

Incarceration has significant consequences for Latino immigrants and their families. Incarceration can also disrupt family structures, leading to economic instability, emotional stress, and the loss of social support for children and other family members (Saadi et al., 2025; Turney & Goodsell, 2018). In addition, families of incarcerated individuals may struggle with stigma and discrimination, which further exacerbates the social and economic challenges they face (Turney & Goodsell, 2018). For immigrant families, the consequences of incarceration can be even more severe, as many face additional challenges related to legal status, including deportation, access to family

support, and financial instability (Saadi et al., 2025). The trauma of incarceration is compounded by the fear of deportation, which is a constant stressor for many Latino immigrants who may be undocumented (Saadi et al., 2025). Research has also shown that children of incarcerated parents are at greater risk for behavioral issues, academic difficulties, and mental health problems, which can create a cycle of disadvantage that is hard to break (Sanchez-Birkhead et al., 2011).

The social environment, defined by relationships and a sense of community, is also a crucial determinant of health for Latino immigrants. Strong support networks can alleviate stress, isolation, and discrimination, providing a foundation for mental and physical well-being (Castañeda et al., 2015). However, many Latino immigrants face challenges in building these networks due to social isolation, cultural differences, and fear of discrimination or deportation (Jacquez et al., 2016; Sanchez-Birkhead et al., 2011). For example, Latino immigrants may live in communities where their language, cultural practices, and immigration status isolate them from the broader society, reducing opportunities for connection and support (Jacquez et al., 2016). The sense of community is particularly important for Latino immigrants as it fosters belonging, safety, and shared resources, all coping mechanisms used to deal with the stressors associated with immigration and settlement (Garcini et al., 2021). Other studies have shown that Latino immigrants in strong, supportive communities have better access to healthcare, healthier lifestyles, and improved mental health (Sanchez-Birkhead et al., 2011). On the other hand, communities that lack resources and are heavily stigmatized can intensify feelings of social isolation and worsen mental health outcomes (Garcini et al., 2021).

## CFIR

Utilizing an evidence-based approach to identifying barriers and tailoring solutions such as CFIR is critical to implementing CalAIM successfully. The framework's outer setting highlights the importance of engaging with external factors, such as community needs and available resources. In contrast, its inner setting domain examines the readiness of healthcare organizations to adopt changes. The CFIR framework also emphasizes the role of adaptability in implementation. Faiz et al. (2024) suggested that programs designed for broader populations must be modified to reflect specific subgroups' cultural and linguistic realities. For CalAIM, this means tailoring interventions to reflect Latino values and providing family-centered care.

## Culturally Competent Approaches to Care

There have been many studies around the issues of developing and implementing culturally competent approaches in healthcare in order to improve the patient's experience and satisfaction. Language concordance in healthcare has been shown to improve health outcomes for patients significantly. Chandrashekar et al. (2022) reported that Spanish-speaking patients receiving care in their native language often demonstrated better adherence to treatment plans for chronic illnesses such as hypertension and diabetes. Similarly, Lopez Vera et al. (2023) found that implementing medical Spanish training programs for healthcare providers increased patient satisfaction by 30% among Spanish-speaking Latino populations. These findings suggest that expanding such initiatives across organizations offering CalAIM services could enhance language access and improve patient outcomes. Culturally tailored programs also play a vital role in

healthcare effectiveness. Rosas et al. (2018) revealed that diabetes prevention workshops conducted in Spanish at community centers were twice as practical as standard educational programs offered in English. This is evidence that integrating cultural values into healthcare delivery can significantly enhance program acceptance and effectiveness. Another issue is the ongoing mistrust of the healthcare system among marginalized communities, particularly Latinos and undocumented individuals. Sanchez-Birkhead et al. (2011) recommended forming long-term partnerships with trusted community organizations, such as Latino churches or advocacy groups, to build trust and increase engagement with healthcare services.

The CFIR framework helps understand the challenges such approaches face in various contexts. CFIR has been effectively applied in various healthcare contexts. For example, CFIR has supported the implementation of community-based programs, including mental health and chronic disease management interventions. For instance, Kirk et al. (2016) identified outer-setting challenges, such as resource limitations, and inner-setting factors, like organizational culture, that influence evidence-based interventions. Escobedo et al. (2023) also demonstrated how language barriers affect individual and organizational outcomes, aligning with CFIR's "characteristics of individuals" and "inner setting" domains.

Additionally, studies on programs addressing social determinants of health found that outer-setting barriers, including poverty and housing instability, significantly impact adoption rates (Allen & Perreira, 2021). These findings demonstrate similar challenges faced by CalAIM initiatives in supporting Spanish-speaking patients. CFIR's robust

framework is an ideal and relevant tool for evaluating initiatives like CalAIM to improve care for Spanish-speaking Latinos.

## Summary and Conclusions

This study explored the barriers and challenges Spanish-speaking Latinos faced in accessing social support services through the CalAIM initiative. The literature highlights several key challenges, including language barriers, fear of deportation, limited access to culturally appropriate health information, and cultural differences, which disproportionately affect Latinos when attempting to navigate the healthcare system to obtain social support (Jacquez et al., 2016; Lopez Mercado et al., 2023; Ornelas et al., 2020). These barriers often lead to adverse health and social outcomes for this population, highlighting the need for tailored interventions to ensure equitable access to services (Sanchez-Birkhead et al., 2011).

Previous research has mainly focused on service providers' perspectives, with fewer studies capturing the voices of Spanish-speaking Latinos. This study aimed to fill this gap by applying the CFIR framework to understand how CalAIM's implementation affects this population. The CFIR framework examines the interaction of intervention characteristics, external and internal settings, and individual characteristics. It provides a comprehensive view of the factors influencing service delivery and how they affect the patient experience (Damschroder et al., 2009, 2022a, 2022b). The CFIR approach is particularly valuable for examining the complexities of program implementation in an integrated healthcare system, especially in culturally and linguistically diverse populations.

The literature review also emphasizes the importance of culturally competent care and the need for community engagement. Studies indicate that language concordance and culturally tailored interventions significantly improve health outcomes and promote a positive patient experience, leading to high satisfaction (Chandrashekar et al., 2022; Lopez Vera et al., 2023). Additionally, addressing the socio-political factors affecting Spanish-speaking Latinos, such as immigration status and systemic discrimination, is important for improving access to healthcare and services (Misra et al., 2021). Chapter 3 outlines the overall study design, providing a clear framework for the research. It details the research design and its rationale, the role of the researcher, the chosen methodology, considerations for trustworthiness, and the ethical procedures followed.

# Chapter 3: Research Methods

This qualitative study aims to understand the barriers and challenges faced by Spanish-speaking Latinos in accessing essential social support through the newly implemented CalAIM initiative. Data for this study were collected through semistructured interviews conducted via Microsoft Teams. In the following chapter, a detailed overview of the research design and the rationale is provided. It also outlines the role of the researcher, including disclosure of potential biases and strategies for mitigating their impact, as well as an examination of ethical considerations that may arise throughout the study. The study methodology is discussed, including the study population, sampling methods, participant selection criteria, recruitment strategies, and data collection procedures. Finally, this chapter addresses issues related to trustworthiness, including validity concerns and ethical considerations, ensuring the integrity and credibility of the research findings.

## Research Design and Rationale

This qualitative study uses an IPA. The following research question guided this study: What are the barriers and challenges of Spanish-Speaking Latinos who received social support services through the newly implemented CalAIM initiative?

### Research Tradition

Qualitative designs are ideal for exploring individual experiences because they allow researchers to inquire, document, and interpret how individuals make sense of the world around them (Merriam & Tisdell, 2016; Patton, 2015). Unlike quantitative approaches that focus on measurement and generalizability, qualitative research focuses

on depth, richness, and the complexity of the individual human experience (Merriam & Tisdell, 2016). The qualitative approach is most valuable when wanting to understand the meaning individuals or groups ascribe to a social or human phenomenon because it requires that the situational and cultural context in which experiences occur be central to making meaning (Merriam & Tisdell, 2016). This approach helps to develop a deeper understanding of the phenomenon of interest and often uncovers themes and patterns that may not have been previously identified (Merriam & Tisdell, 2016).

**Interpretative Phenomenological Approach**

IPA offers a framework for investigating the complex barriers and challenges Spanish-speaking Latinos face in accessing social support services under the CalAIM initiative. IPA is rooted in phenomenology, hermeneutics, and idiography, and emphasizes how individuals make sense of their lived experiences in particular socio-cultural contexts, making it especially suitable for understanding the unique realities of Latinos engaging in social support services (Smith et al., 2022). IPA effectively captures both the experiences, and the meaning individuals assign to those experiences (Palmer et al., 2010).

Given that Spanish-speaking Latinos often encounter systemic, linguistic, and cultural barriers in accessing CalAIM services, IPA allowed me to explore challenges from the individual perspectives of those experiencing them. The focus on the individual experience allows for a rich, in-depth understanding of how these barriers are encountered in real-world settings. Further, IPA may be applied to examine challenges individuals may face when accessing needed healthcare (Smith et al., 2022).

Understanding unique challenges, such as language barriers, mistrust in the system, or difficulties accessing culturally competent care, requires an approach that captures their unique experiences meaningfully.

IPA also provides a framework for interpreting the psychological and social aspects of lived experiences, making it ideal for exploring issues related to healthcare and social support accessibility (Tuffour, 2017). Since CalAIM aims to improve care coordination for vulnerable populations, IPA offers a way to examine how these types of policies are experienced. Specifically, where there are disconnects between how these policies were designed and then implemented, highlighting unique challenges that Spanish-speaking Latinos may face.

Further, by using IPA, researchers can engage with participants in a way that honors their unique cultural and social contexts (Alase, 2017), which is crucial for accurately capturing the experiences of Spanish-speaking Latinos. Tran et al. (2024) also illustrated the effectiveness of IPA in examining the lived experiences of individuals facing systemic challenges in healthcare settings. Their findings highlight the importance of understanding patient experiences, reinforcing the relevance of IPA for analyzing the barriers within CalAIM services. Overall, IPA is among the most appropriate qualitative traditions for exploring Spanish-speaking Latinos' challenges in accessing social support services under CalAIM. Its emphasis on lived experiences, subjective meaning-making, and cultural sensitivity provides a comprehensive understanding of possible barriers, ultimately contributing to more effective and inclusive policy implementation (Smith et al., 2022; Tuffour, 2017).

## Role of the Researcher

In qualitative research, the researcher plays a central and multifaceted role, serving as the primary instrument for data collection and interpretation (Merriam & Tisdell, 2016; Patton, 2015). A researcher may play one of three roles: observer, participant, or observer-participant. An observer is detached and observes by watching, recording, and interpreting what they observe and holds minimal influence on subjects. The role of participant is when a researcher becomes an active member of a group that is being studied and gains an insider's perspective of a phenomenon. Lastly, an observer-participant role is when both roles are balanced by observing, participating, and interacting with subjects to collect data but not fully interacting with a phenomenon (Merriam & Tisdell, 2016; Patton, 2015). Based on these descriptions, my role as a researcher is that of observer-participant as I observed and collected data while maintaining distance enough to engage in meaningful and unbiased analysis.

The qualitative researcher must approach the inquiry with an open mind, a deep curiosity, and a willingness to engage directly with participants in their natural settings (Patton, 2015). Building trust and rapport with participants is essential to creating an environment where individuals feel safe sharing their unique stories and perspectives. Qualitative researchers must also be self-aware, acknowledging their positionality, biases, and assumptions (Merriam & Tisdell, 2016). Reflexivity, the continuous examination of how one's background, beliefs, and presence influence the research process, is essential for maintaining integrity and credibility (Merriam & Tisdell, 2016). Because the researcher's interpretations are shaped by their worldview, transparency about their role

and influence enhances the trustworthiness of the findings (Merriam & Tisdell, 2016). The researcher must remain methodical yet flexible, empathetic yet analytical, and consistently committed to representing participants' voices with respect and depth (Merriam & Tisdell, 2016; Patton, 2015). In addition, it is important to recognize any pre-existing professional or institutional connections a researcher may have, as such relationships may create a power imbalance that influences how participants engage in my research (Merriam & Tisdell, 2016; Patton, 2015). Given that I am an employee of the organization that is offering and providing CalAIM social supports to participants, there are risks that participants may feel coerced, obligated to participate, or uncomfortable sharing negative experiences or feelings, which may affect the ethical integrity and validity of the study (Merriam & Tisdell, 2016). To this end, my study information sheet and interview guide disclosed the following information:

- purpose of the study,
- expectations and duration of study participation,
- confidentiality,
- potential benefits and risks associated with study participation,
- right to withdraw from the study at any time, and
- study and Institutional Review Board (IRB) contact information for questions and concerns.

As an employee of the organization that provides CalAIM services to participants, I recognize the potential for bias and power imbalances to influence the process. To manage these concerns, I utilized strategies based on best practices. To address potential

biases, I maintained a reflexive journal that documents and examines my background, assumptions, and positionality (Merriam & Tisdell, 2016). According to Merriam and Tisdell (2016), reflexivity is an important strategy for helping to maintain self-awareness and ensure that interpretations are grounded in the study participant's own experiences.

Power relationships may also exist between myself, as a researcher and as an employee of the organization delivering CalAIM services, and a study participant. This power relationship may impact a participant's willingness to speak honestly and openly (Merriam & Tisdell, 2016; Patton, 2015). To prevent potential power imbalances, participants were informed during the consenting process that their participation in the study was voluntary, confidential, and would not impact their access to services. Lastly, I did not recruit individuals whom I have direct professional or supervisory relationships to help reduce the risk of coercion or perceived obligation (Patton, 2015). Doing all of this helped uphold the ethical integrity of the study, and accurate representation of a participant's true experiences.

## Methodology

### Participant Selection Logic

#### *Population*

The study was conducted to understand the barriers and challenges Spanish-speaking Latinos face in accessing social support services under the CalAIM initiative. As such, the target population are individuals who identify as Latino, primarily speak Spanish, adults who are at least 18 years old, are Medi-Cal recipients, and parents of children who received AHR support services through the CalAIM initiative.

### *Sampling and Sampling Procedures*

The study sample purposefully identified individuals to enable a more in-depth learning, understanding, and gains insights into the phenomenon of interest, Spanish-speaking Latinos and the barriers and challenges they face in accessing AHR support services under the CalAIM initiative (Merriam & Tisdell, 2016). This study utilized criterion purposeful sampling to select individuals who met specific criterion to explore and understand the unique perspectives and lived experiences of individuals who were most knowledgeable about or directly impacted by the phenomenon being studied (Merriam & Tisdell, 2016). In this study, Spanish-speaking Latinos were uniquely positioned to provide rich data on how language, cultural factors, and systemic barriers may impact policy implementation, such as the CalAIM initiative. By intentionally sampling participants with direct lived experience accessing CalAIM AHR community support, the study was more likely to uncover insights that may not be as apparent or are unique to them. A list of parents whose children received CalAIM AHR community support was obtained directly from the healthcare system to identify the correct participants. Patients were then contacted over the telephone to invite them to participate in the study. Once participants agreed to participate, they were asked a set of questions to confirm that they identify as Latino, primarily speak Spanish, are at least 18 years old, and parents of children who received AHR community support through the CalAIM initiative (see Appendix A).

Criterion purposeful sampling allows researchers to “discover, understand, and gain insight from” those who can provide the most information-rich cases (Merriam and

Tisdell, 2016). The sample size for a study depends on several factors, including the study content, data being collected, analysis being carried out, and available resources to carry out the data collection (Merriam & Tisdell, 2016). This study's intended sample size was five to eight interviews or until saturation was reached. According to Merriam and Tisdell, saturation during data collection is typically reached once there is redundancy in the information that is being collected. Data analysis and data collection were simultaneously carried out to determine the saturation point.

## Instrumentation

### *Interview Guide*

A researcher-developed semi-structured, open-ended interview guide was used to collect feedback from study participants. A semi-structured interview guide was developed to allow the researcher flexibility in following the natural progression of the interview to solicit the lived experience of a participant (Merriam & Tisdell, 2016). The interview guide included 19 open-ended interview questions, as well as additional follow-up and probes, which guided the interview (see Appendix B). The guiding domains and concepts of the interviews included overall satisfaction with services received, perceived health benefits of the services received, challenges and barriers encountered when receiving services, and suggested improvements to avoid encountering challenges and barriers.

## Researcher-Developed Instrument

The interview guide was researcher-produced and informed using existing literature, including prior studies focused on soliciting feedback on similar interventions

that providing participants with social support services. Aldirawi et al. (2024) investigated how housing conditions affect mental and physical health outcomes among families receiving support services. This study highlighted the importance of environmental asthma triggers like mold and pests and the perceived impact on health following services. Crocker and Stout (2023) examined satisfaction and access issues in community food programs, specifically around logistical challenges, and service perceived usefulness. Lange et al. (2025) explored the alignment between participant needs and service delivery in chronic care programs, specifically how the relevance of support services received impacts mental health, daily life, and the burden on families. Prather et al. (2020) explored how systemic barriers, including institutional trust and stigma, shaped the experiences of Black women when receiving maternal care, specifically asking participants about trust, communication, and safety concerns when receiving services. Additionally, Wilson et al. (2022) investigated service delivery challenges and opportunities for program improvement. Overall, these studies helped develop the interview guide to capture the experiences of those receiving asthma-related services in under-resourced communities.

**Piloting Interview Guide**

To ensure that “good data” is gathered during interviews, the interview guide was piloted (Merriam & Tisdell, 2016). The interview questions were shared with research colleagues, family, and friends to gather feedback. The feedback was used to refine the interview guide and ensure that the questions were easily understood and clearly structured.

## Procedures for Recruitment, Participation, and Data Collection

### *Recruitment*

The study aimed to understand the barriers and challenges Spanish-speaking Latinos face in accessing AHR support services under the CalAIM initiative. All study participants were required to meet inclusion criteria: individuals who identify as Latino, speak Spanish, are at least 18 years old, are Medi-Cal recipients, and are parents of children who received AHR support services through the CalAIM initiative. Participants for the study were preselected using existing organization reports that list members who received CalAIM AHR community support and electronic health records to verify that their preferred speaking language is Spanish, are at least 18 years of age, race and ethnicity, and are Medi-Cal recipients.

### *Participation*

Prior to beginning the interview, a secondary eligibility review was conducted with the participants over the telephone as part of the consent (See Appendix A) process to verify that they met study eligibility criteria. In addition, a detailed consent script (See Appendix B) was read to the participant that provided an overview of the study including the purpose of the study, expectations and duration of study participation, confidentiality, potential benefits and risks associated with study participation, the right to withdraw from the study at any time, and study and IRB contact information for questions and concerns about the study. In addition, a detailed study information sheet (See Appendix C) was emailed to participants.

### *Data Collection*

Interviews were conducted with participants who met the eligibility criteria using Microsoft Teams and were completed by the researcher, myself. Interviews took 25-30 minutes and, if a participant agreed, were recorded and transcribed via Microsoft Teams to accurately represent a participant's comments. Data collection continued until the minimum sample size of five and saturation was reached. Participants were interviewed once.

## Data Analysis Plan

The study utilized the step-by-step thematic coding approach Smith et al. (2022) developed to analyze the qualitative data collected from semi-structured interviews. This method was well suited for exploring the in-depth lived experiences of Spanish-speaking Latinos receiving AHR support services under the CalAIM initiative. The coding process allowed experiential themes to emerge organically from the data. Analysis was completed in seven stages: reading and re-reading, exploratory noting, constructing experiential statements, searching for connections across experiential statements, naming the personal experiential themes and consolidating and organizing them in a table, continuing the individual analysis of other cases, and working with personal experiential themes to develop group experiential themes across cases.

### *Step 1: Reading and Re-reading Transcripts*

The first step in the analysis was to immerse myself in the data by reading and re-reading the interview transcripts to ensure a comprehensive understanding of each participant's experience. At this stage, recorded interview transcripts were reviewed to

capture impressions and notable expressions relevant to barriers and challenges accessing CalAIM services. This step allowed me to engage with the text and develop a strong foundation and understanding of the language, culture, and emotional tone—critical considerations when analyzing data from Spanish-speaking Latino populations (Braun & Clarke, 2006; Lopez & Willis, 2004).

***Step 2: Exploratory Noting***

Following step 1, a detailed review of the transcripts was conducted through exploratory commenting. This included descriptive comments focused on the content of what was said, analyzing how it was said, and exploring interpretative meanings (Smith et al., 2022). This level of analysis allowed for deeper engagement with participants lived experiences and laid the foundation for identifying patterns.

***Step 3: Constructing Experiential Statements***

From exploratory noting, experiential statements were developed by converting notes into short statements that reflected the essence of a participant's experience (Smith et al., 2022). Experiential statements allowed me to better describe a participant's experience but also integrate my interpretation of those experiences into my own words into clear sentences (Smith et al., 2022).

***Step 4: Searching For Connections Across Experiential Statements***

Once experiential statements were developed, connections or mapping of how these statements cluster together were completed. I performed this step manually using Excel. I grouped statements that reflect a similar theme like "child's asthma history" and "satisfaction and health impacts."

### *Step 5: Naming the Personal Experiential Themes and Consolidating and Organizing Them in a Table*

Once connections across experiential statements were mapped, I created a table that organized all the identified PETs. Each PET included all identified sub-themes, page number of the associated transcript where it can be found, and associated experiential statements (Smith et al., 2022). Another strategy I utilized to help identify connections across statements is color coding. Color coding allowed me to visually see the connections across statements and experiential themes in my Excel Spreadsheet (Smith et al., 2022).

### *Step 6: Continuing the Individual Analysis of Other Cases*

Steps 1-5 were repeated for each interview transcript, treating each transcript independently in line with IPA's promise of exploring each participant's perspective (Smith et al., 2022). This process ensured that any new exploratory notes or experiential statements that emerged from additional interview transcripts were uniquely considered, so as not to be influenced by prior findings.

### *Step 7: Working with Personal Experiential Themes to Develop Group Experiential Themes Across Cases*

The final stage of the analysis involved looking at pattern similarities and differences across PETs and developing a set of Group Experiential Themes (GETs) (Smith et al., 2022). This ensured that themes were representative of the collective experiences of study participants but still considered individual experiences that varied from the group (Smith et al., 2022). Organizing these PETs and GETs into tables allowed

me to organize my coding, make sure that broad similarities are supported by evidence, and that I captured individual experiences.

Throughout the analysis, rigor was maintained by adhering to the trustworthiness criteria including credibility, dependability, confirmability, and transferability (Nowell et al., 2017). Thematic findings were supported with illustrative quotes from participants to ensure authenticity and provide each participant with their unique voice.

### *Data Analysis Tool*

Microsoft Excel was used as the primary tool for organizing and analyzing the interview transcripts. Excel provided a flexible and accessible way to manage the large among of text, facilitated systematic coding, theme development, and allowed me to easily recognize patterns across interview scripts. Each transcript was imported into the spreadsheet, where rows were used to separate individual responses by study participant. The columns were used to document initial notes, statements, and themes. This layout allowed me to easily compare cases throughout the various stages of the IPA analysis (Smith et al., 2022). I also used Excel's filtering, sorting, and color-coding features to support the iterative process of refining themes.

### *Treatment of Discrepant Cases*

Discrepant cases are cases where participant accounts diverge from dominant themes (Merriam & Tisdell, 2016). In this study, discrepant cases were considered valuable as they provided important insights beyond the common themes. During the comparison phase of the analysis, these discrepant perspectives were examined to assess how they might expand, refine, or complicate the emerging themes. Instead of excluding

these cases, they were used to identify context-specific differences within the shared experiences.

When discrepancies emerged, they were seen as an opportunity to revisit the earlier stages of analysis (e.g., steps 1-5 of the IPA process) to ensure that the thematic structure is reflective of all the participants' experiences. According to Nowell et al. (2017), this iterative process only strengthens the credibility and confirmability of findings. Also, these discrepant cases were used to identify quotes in the analysis to illustrate important differences between participant experiences.

## Issues of Trustworthiness

According to Merriam and Tisdell (2016), data trustworthiness issues are directly correlated with the trustworthiness of the researcher. Merriam and Tisdell (2016) further pointed out that rigor is not ensured by a study's method, research design, or analytical techniques and procedures. Instead, it solely depends on a researcher's ability to think rigorously and be trustworthy and ethical. Nowell et al. (2017) explained that to do this, it is necessary for research to be easily understood as trustworthy by researchers, practitioners, policymakers, and the public. For the current study, trustworthiness was established in a few ways that address the four key criteria (Nowell et al., 2017): credibility, transferability, dependability, and confirmability.

### Credibility (Internal Validity)

Credibility, or internal validity, was enhanced through engagement with the data, iterative analysis, and ongoing reflection on decisions. A study journal was maintained to document ongoing reflections and internal dialogue, allowing for self-monitoring of bias,

assumptions, and changing or evolving interpretations. Additionally, the use of rich, participant quotes helped to ground findings in participants' own words and experiences, supporting and enhancing the believability and authenticity of the results (Nowell et al., 2017).

**Transferability (External Validity)**

Transferability, or external validity, is concerned with the extent to which the findings of a study are generalizable (Merriam & Tisdell, 2016). The idea of transferability in this study was supported by rich, thick descriptions of individual, environmental, and social contexts (Merriam & Tisdell, 2016). This level of detail allows readers, practitioners, and researchers alike to determine if the findings of the study are relevant and applicable to other contexts, populations, or settings (Merriam & Tisdell, 2016; Nowell et al., 2017).

**Dependability**

Dependability, or consistency, was addressed by establishing a detailed audit trail so that other researchers can determine if the study results make sense and align with the data collected (Merriam & Tisdell, 2016). To do this, an audit trail that documents all analytical procedures, coding decisions, and methodological changes was kept along with detailed justifications (Merriam & Tisdell, 2016). This documentation allowed the research process to be tracked and evaluated, ensured that findings are based on a logical analytic process (Nowell et al., 2017).

## Confirmability

Confirmability is the degree to which study findings are reflective of study data and study participants (Merriam & Tisdell, 2016). In this study, confirmability was maintained by triangulating data analysis with reflective journaling and external discussions with research mentors and colleagues. These practices helped to reduce individual bias and increase the objectivity of interpretations. The audit trail also supported confirmability by enabling an independent reviewer to trace the analytic steps from raw data to findings (Nowell et al., 2017). Integrating these practices are critical to all research because it ensures that other researchers can replicate and understand study processes and facilitate a researcher's ability to communicate and report on study procedures (Nowell et al., 2017).

## Ethical Procedures

### *IRB Approval*

IRB approval was granted by Kaiser Permanente of Southern California (KPSC) Institutional Review Board, IRB # 14293, and submitted to Walden University IRB for approval. Approval was obtained before beginning any data collection activities, and the study followed KPSC and Walden University's IRB ethical guidelines.

### *Consent*

Verbal consent was obtained from each study participant before beginning the interview. A detailed consent script (See Appendix B) was developed that described in detail the purpose of the study, expectations and duration of study participation, confidentiality, potential benefits and risks associated with study participation, right to

withdraw from the study at any time, and study and IRB contact information for questions and concerns about the study. In addition, a study information sheet (See Appendix C) was developed that included a detailed summary of the purpose of the study, expectations and duration of study participation, confidentiality, potential benefits and risks associated with study participation, right to withdraw from the study at any time, and study and IRB contact information for questions and concerns about the study. Study participants also received an electronic copy of the information sheet via email. Lastly, participants were told that they are able to opt out of the study at any time without their CalAIM support services and medical care from KPSC being impacted by their participation or non-participation in the study.

### *Ethical Concerns Related to Recruitment*

As a researcher employed by the organization (KP) providing CalAIM social support services, it is important to acknowledge potential power imbalances that could influence participant engagement (Merriam & Tisdell, 2016; Patton, 2015). This pre-existing relationship may lead participants to feel coerced, obligated to participate, or hesitant to share negative experiences. To mitigate these risks, participants were informed during the consent process that their involvement was voluntary, confidential, and would not affect their access to services. Additionally, I did not recruit individuals with whom I have direct professional or supervisory relationships to further reduce the risk of perceived coercion (Patton, 2015).

### *Ethical Concerns Related to Data Collection*

The primary ethical concern associated with the data collected for this study is confidentiality. To ensure that a study participant's privacy and confidentiality was maintained, all interview transcripts were stored in a restricted folder on KP's server that only the researcher had access to.

### *Treatment of Data*

To protect participant confidentiality, all interview transcripts were cleared of all names and identifiers. Instead, each interview transcript were assigned a unique study identifier. A password-protected document stored each unique study identifier with the study participant information. These practices ensured that only the researcher accessed sensitive study participant information and interview transcripts via a secure server.

## Summary

This study used a qualitative interpretative phenomenological approach to explore Spanish-speaking Latinos' barriers to accessing AHR services under California's CalAIM initiative. The research design was selected to help understand participants lived experiences, allow for deep engagement with personal narratives, and was well-suited for examining complex social and cultural phenomena (Merriam & Tisdell, 2016; Patton, 2015). IPA was specifically chosen because it captures how individuals make sense of their healthcare experiences (Smith & Osborn, 2015), particularly in contexts involving language, trust, and systemic access issues (Peart et al., 2020; Smith et al., 2022; Tuffour, 2017).

The study included adults who spoke Spanish, identify as Latino or whose child identified as Latino, who are Medi-Cal beneficiaries and whose children received CalAIM AHR community support. Criterion purposeful sampling was used to select participants who met specific inclusion criteria: identify as Latino (or whose child identified as Latino), spoke Spanish in the home, were enrolled in Medi-Cal, and is a parent of a child who received CalAIM AHR community support. Sampling continued until thematic saturation was reached (Merriam & Tisdell, 2016).

Participants were identified using a combination of organization lists of patients who received AHR support services and electronic health records to verify their eligibility, followed by a verbal consent process conducted via Microsoft Teams. Participants were contacted by telephone and asked questions to verify their eligibility. Once eligibility was confirmed, verbal consent was obtained using a standard script, and an information sheet that was emailed to the participant upon their request. Interviews were conducted via Microsoft Teams and lasted 15-25 minutes. A semi-structured interview guide was used to guide the interviews. Interviews were also audio-recorded, with consent, to ensure accurate transcription and note-taking.

Data were analyzed using a seven-stage thematic coding process adapted from Smith et al. (2022): reading and re-reading, exploratory noting, constructing experiential statements, searching for connections across experiential statements, naming the personal experiential themes and consolidating and organizing them in a table, continuing the individual analysis of other cases, and working with personal experiential themes to develop group experiential themes across cases.  Microsoft Excel was used as the primary

data management tool, allowing systematic and organized coding and identification of patterns.

Trustworthiness was established through reflexive journaling, audit trails, and adherence to credibility, dependability, confirmability, and transferability standards (Merriam & Tisdell, 2016; Nowell et al., 2017). Discrepant cases were analyzed to explore differences and ensure the themes reflect all participants' experiences.

I played a central role in all study phases and maintain reflexivity by actively considering how my personal experiences and biases could influence interpretation (Patton, 2015). Ethical considerations and protections included obtaining IRB approvals from KPSC and Walden University, having detailed consent protocols, placing robust confidentiality measures in place, including anonymization of transcripts and secure data storage, and acknowledging and managing existing power imbalances. Given my dual role as a researcher and employee of KP, which delivers CalAIM services, I did not recruit individuals with whom I have a direct professional or supervisory relationship. To minimize perceived coercion, I also emphasized with participants that participating in the study is voluntary and confidential.

Overall, this study's rigor and ethical integrity ensured a credible understanding of how Spanish-speaking Latinos experience CalAIM, contributing important insights for improving equitable healthcare access in California. The following Chapter 4 presents a summary of the findings of the study.

# Chapter 4: Results

The goal of this qualitative study was to understand the barriers and challenges faced by Spanish-speaking Latinos in accessing essential social support through the newly implemented CalAIM initiative. The study question being studied was: What are the barriers and challenges of Spanish-Speaking Latinos who received social support services through the newly implemented CalAIM initiative? Data for this study were collected from KP members who identify as Latino, primarily speak Spanish, adults who are at least 18 years old, are Medi-Cal recipients, and parents of children who received AHR support services through the CalAIM initiative. Chapter 4 provides an overview of setting, participant demographics, data collection process and analysis, evidence of trustworthiness, and study results.

## Setting

Participants' experiences with CalAIM AHR community support may have been shaped by a combination of organizational and personal factors. At the organizational level, the maturity of the program and use of subcontracted vendors, rather than direct service provision by KP, may have affected the overall experience for participants. At the personal level, participants' experiences may have been further shaped by language barriers, immigration-related concerns, and long-standing mistrust of health care institutions.

Organizational factors often shape how individuals experience a program like CalAIM. Because CalAIM was launched in January of 2024, the relative early maturity of the program may have shaped how a participant experienced the program, as key

workflows like referral processes and important operational components were still being developed and refined during the first year of implementation. Additionally, CalAIM services were subcontracted to external vendors rather than provided directly by KP staff. This may have affected the coordination, consistency, and quality of services delivered to participants, further affecting participants' experiences and how the CalAIM services were perceived.

Equally important considerations are how personal factors shape an individual's experience with a program like CalAIM. Often, individual's decisions to engage in social support services can be heavily shaped by language, immigration-related anxiety, and distrust of the healthcare system. Language barriers have been historically known to contribute to low healthcare access and utilization for Spanish speaking individuals, often due to the lack of or limited availability of Spanish speaking healthcare staff, interpreters, and cultural and linguistically appropriate health information (Barajas et al., 2025). Additionally, immigration-related policies directly shape the health and well-being of immigrants as they often increased distrust of and demotivates individuals to seek health care and services (Tafolla et al., 2025; Young et al., 2023). Therefore, it is possible that these personal factors may have shaped an individual's experience with the CalAIM program.

From expected limitations common in the first year of any new program implementation to the limitations of limited language availability of Spanish-speaking healthcare staff or healthcare information to the impact of the current sociopolitical environment directed at Latino immigrants. The combination of these organizational and

personal factors may have shaped participants' experiences. Recognizing these overlapping factors is important for interpreting participant experiences within the broader implementation of CalAIM's first year.

## Demographics

Study participants were all mothers of the children who received AHR services through the CalAIM program. All five participants spoke English and Spanish in the home; however, participants preferred to complete interviews in English. On average, participants were 42.4 years of age and ranging between 37- and 51-years old age. Four of the five mothers identified as Hispanic. The fifth mother identified as Black although her child was of mixed ethnicity, Hispanic and Black. Three of the five participants reported living in an apartment and two of the five lived in a single-family home. See Table 1 for demographic characteristics of each participant.

**Table 1**

*Participant Profile*

| Participant | Relationship for AHR community support recipient | Language(s) spoken in the home | Gender | Age | Race/ethnicity |
|---|---|---|---|---|---|
| Participant 1 | Mother | English and Spanish | Female | 37 | Hispanic |
| Participant 2 | Mother | English and Spanish | Female | 38 | Hispanic |
| Participant 3 | Mother | English and Spanish | Female | 44 | Hispanic |
| Participant 4 | Mother | English and Spanish | Female | 51 | Hispanic |
| Participant 5 | Mother | English and Spanish | Female | 42 | Black (child is mixed race – Hispanic and Black) |

## Data Collection

IRB approval was granted by KPSC on July 24, 2025, IRB # 14293, and submitted to Walden University IRB and approved August 9, 2025. Data collection took place between September and October 2025. Interviews were conducted with five participants who met the study's eligibility criteria. Each interview was held one-on-one via Microsoft Teams and lasted approximately 20-35 minutes. Prior to each interview, participants provided consent to be audio-recorded. Recordings and automated transcripts were generated through Microsoft Teams. Transcripts were reviewed and verified by the researcher to ensure accurate representation of participant's comments. Interviews occurred one-on-one with each participant. The same procedures were followed for each interview to maintain consistency across participants.

## Data Analysis

Using Smith et al.'s (2022) seven-step IPA framework, I moved inductively through each of the seven steps. After the interviews were completed, individual transcripts were reviewed and cross-checked against the audio recordings for accuracy. Each interview transcript and recording was then saved in its own folder labeled with an assigned study identifier. Individual transcripts were then organized and segmented in Microsoft Excel.

Step 1 involved multiple rounds of reading and re-reading the transcripts to become familiar with each case. I captured descriptive and linguistic notes in my Microsoft Excel database. This allowed me to gain an understanding of important

information, including participants' tone during the interview, the language used to describe their experiences, and other unique factors crucial for data analysis.

Step 2 focused on exploratory noting. I documented descriptive comments and notes in my Microsoft Excel database for each transcript. The notes captured special words or descriptions that participants shared, important descriptive information about the interview and participants, and conceptual notes that participants used to describe their experiences. It was at this step that I was able to recognize emerging patterns.

In Step 3, I used the detailed notes from Step 2 to construct experiential statements that reflected the essence of the participant's experience (Smith et al., 2022). These statements captured discrete meanings or descriptions to describe participants' individual experience connected to CalAIM AHR community support. This allowed me to begin conceptualizing and interpreting how individual participants experienced AHR.

Step 4 focused on finding connections across experiential statements. The process included clustering statements across participants by grouping experiential statements into preliminary themes. Preliminary themes emerged, including early asthma diagnosis, ongoing concerns, environmental and physical triggers, mixed satisfaction with AHR services, symptom improvement following AHR, and continued skepticism due to changes in season. This step produced groupings that represented participants' unique experiences and perspectives.

Once connections were made in Step 4, I moved to Step 5 to create PETs. I developed a table that aligns each PET with its associated sub-themes, the page number of the associated transcript, and the associated experiential statements (Smith et al.,

2022). The table included columns for each PET, associated subthemes by PET, the associated participant ID by PET, and illustrative quotes by participant for each PET.

In Step 6, I reviewed each transcript desperately and repeated Steps 1-5 previously outlined. I sought to identify differences in participants' experiences, which led to the emergence of additional themes. Then I proceeded to the final step of developing group experiential themes.

Step 7 focused on finding similarities and differences across PETs and developing GETs. This ensured that themes were representative of the collective experience while also taking into consideration individual experiences that varied from the collective (Smith et al., 2022). For example, one theme focused on describing early asthma diagnosis and visiting an emergency room as moments that shaped participants' ongoing concern about their child's asthma. One participant described that "two years ago, my daughter was hospitalized. It was when her asthma was really out of control." Similarly, another participant recalled, "he [son] was diagnosed at about four or five months, I believe it has just been ongoing since then." Another theme was around environmental and physical triggers. Participants acknowledged that seasonal changes and environmental quality had a direct impact on their child's asthma. One participant mentioned, "When the weather changes, like in fall when it gets colder, if he's [child] outside in the cold, he'll start coughing first, and then that's when his asthma starts flaring up."

Based on the feedback collected from participants, 18 PETs were created:

1. Early diagnosis as a defining event shaping long-term concern.

2. Family history creates normalization of illness but also fear of repeating.
3. Frequency of symptoms and attacks triggered by physical activity environmental factors, or changes in season.
4. Recognition of environmental triggers and anticipatory response.
5. Motivated to participate because parents are willing to try anything to help their children deal with their asthma.
6. Most received humidifiers, vacuums, air purifiers, cleaning supplies.
7. Some were very satisfied and reported that the process was smooth.
8. Most were somewhat satisfied due to the poor communication or long, confusing process.
9. Experienced symptom improvement due to AHR services/items received.
10. Continued skeptical due to change in season.
11. Managing child's asthma is emotionally challenging and stressful.
12. Environmental management becomes central to daily care.
13. Asthma management becomes daily habit and integrated into identity.
14. Slow and confusing process
15. Unclear communication and uncertainty about who to contact.
16. Improve communication between KP vendor assigned and patient.
17. Improve coordination of overall process with quicker turnaround of service delivery.
18. Improve labeling of items delivered to home.

Each of the 11 personal experiential themes were supported by and based on participants' individual feedback. One exception was the PET "Family history creates normalization of illness but also fear of repeating," which was represented by one case. This PET was not excluded because it provided important context for shaping the participants' experience and perceptions in response to the CalAIM AHR community support.

Overall, this inducive process helped to transform small, experiential statements into GETs that represented a shared experience among participants, while still maintain the unique individual experiences and perceptions in how Spanish-speaking Latino families navigated asthma management through CalAIM home remediation services.

## Evidence of Trustworthiness

The trustworthiness of this study was ensured in a few ways. First, I consistently engaged with the data, kept a reflexive journal, and documented any changes to the analytical approach. Credibility was ensured by immersing myself in the interview transcripts and recordings, through iterative coding, and the use of rich participant quotes, which ensured that findings were based on participants' individual feedback in their own words. Transferability was maintained by documenting participants' descriptions of their social and environmental settings, which will enable others to determine the relevance and applicability of findings to broader contexts. Dependability was established by maintaining an audit trail that recorded any changes in codes or themes, analytical steps, and procedural changes, along with the reasons for those changes. This ensured that the analysis approach could be replicated in the future. Confirmability was ensured through

reflective journaling, debriefing with my peers, and triangulation between codes and themes, notes, and the final themes. All of these steps ensured that the findings from this study accurately represented participants lived experiences and that the methods were replicable and transparent.

## Results

The following research question guides this study: What are the barriers and challenges of Spanish-Speaking Latinos who received social support services through the newly implemented CalAIM initiative? Five participants were asked 16 semistructured questions that explored their unique experiences with CalAIM AHR community support. Participant experiences were mostly aligned across all cases which demonstrated strong thematic convergence. However, Participant 5 was slightly different given that they viewed their child's asthma as hereditary rather than driven by the environment. Participant 5 also reported a more seamless experience than the other participants. This case was included in the analysis to provide contrasting perceptions and context to findings. A total of nine GETs emerged from the data analysis, as seen in Table 2.

**Table 2**

*Group Experiential Themes and Personal Experiential Themes*

| GET | PET |
|---|---|
| 1. Asthma diagnosis and severity | 1. Early diagnosis as a defining event shaping long-term concern.<br>2. Family history creates normalization of illness but also fear of repeating. |
| 2. Frequency of asthma symptoms and attacks | 3. Frequency of symptoms and attacks triggered by physical activity, environmental factors, or changes in season.<br>4. Recognition of environmental triggers and anticipatory response. |
| 3. Motivation to participate in the CalAIM AHR community support | 5. Motivated to participate because willing to try anything to help children deal with their asthma. |
| 4. Types of CalAIM AHR community support services received | 6. Most received humidifiers, vacuums, air purifiers, cleaning supplies. |
| 5. Satisfaction with CalAIM AHR community support and experience | 7. Some were very satisfied and reported that the process was smooth.<br>8. Most were only somewhat satisfied due to the poor communication or long, confusing process. |
| 6. Changes in symptoms after receiving CalAIM AHR community support | 9. Experienced symptom improvements due to AHR community support and items received.<br>10. Continued skepticism due to change in season. |
| 7. Impact of managing child's asthma on caregivers' well-being and daily routines | 11. Managing child's asthma is emotionally challenging and stressful.<br>12. Environmental management becomes central to daily care.<br>13. Asthma management becomes daily habit and integrated into identity. |
| 8. Challenges experienced during receipt of CalAIM AHR community support | 14. Slow and confusing process.<br>15. Unclear communication and uncertainty about who to contact. |
| 9. Suggested improvements to CalAIM AHR community support | 16. Improve communication between KP vendor assigned and patient.<br>17. Improve coordination of overall process with quicker turnaround of service delivery.<br>18. Improve labeling of items delivered to home. |

**GET 1: Asthma Diagnosis and Severity**

GET 1 captures how participants described their child's early asthma diagnosis and long-term concerns about their child's asthma. Across all participants, their child's initial asthma diagnosis was seen as a frightening and pivotal moment that began their ongoing concerns and vigilance journey. Participant 1 shared, "He [child] was diagnosed at about four or five months old, and it has just been ongoing since then." Participants associated their child's early respiratory issues, visits to the emergency room, or even hospitalizations with the realization that their child's condition would require not only long-term management but also changes in how the family household functioned. Participant 3 shared,

> He was about a month old when we first had to take him to the emergency room because his breathing was labored. Over time, he began having shortness of breath at night and later developed croup, which got so bad that we had to rush him to the emergency room. It progressed as he got older, although it is now under control. Usually, it starts acting up again around this time of year.

Participants' experiences illustrate how asthma diagnosis at an early age was not only a pivotal moment in their child's life, but it was also a life-altering moment that reshaped a family's daily routines. A different perspective provided by Participant 5, was about the family history of asthma and how both the participant and her husband felt it was "It was heartbreaking for me because my husband had asthma as a kid, and then I had it during my youth too." Parents can sometimes feel at fault or responsible for their child's health issues.

Based on these shared participant experiences, the early diagnosis and severity of their child's asthma represents not only the beginning of a lifelong clinical journey to manage their child's asthma but also the beginning of an emotionally exhausting one. It is clear that early asthma diagnosis really changes how parents view their role and responsibility for their child's current health journey but also acknowledges how the early diagnosis will impact their child in the future.

**GET 2: Frequency of Asthma Symptoms and Attacks**

GET 2 explores how participants observed and described their child's asthma symptoms and attacks. Across most participants, parents describe recognized factors that were most associated with the activation of their child's asthma. Commonly mentioned factors include physical activity, environmental triggers, and seasonal changes. Recognition of these patterns allowed parents to anticipate and prepare for possible asthma symptoms and attacks.

Most participants clearly understood and articulated the connection between their child's asthma symptoms and attacks related to either strenuous physical activity, their environment, or changes in seasons. Participant 2 said, "Maybe two or three times a week, when she's [child] running around, going up and down the stairs. But lately, I don't know if it's the season or what, her allergies and asthma have really been acting up." Participant 1 associated their child's asthma symptoms with not only strenuous physical activity, but in combination with drastic changes in the weather, "Lately he's [child] been using his inhaler pretty often, probably because of the weather changes, it was really hot last week and now it's cooled down, which always seems to affect

him. He's very active, so on average he uses it once a day, but sometimes another one or two times depending on what he's doing." Participant 3 shared similar experiences, stating, "Attacks happen maybe once every other month, depending on the environment and how active he [child] is. He'll start coughing when there's dust or dirt in the air, or when he's running around."

Overall, GET 2 highlights how participants have learned to read and respond to their child's physical and environmental factors. Ongoing management of their child's asthma has become part of their everyday life. Parents are easily able to recognize and even anticipate when their child's asthma symptoms and crises occur.

**GET 3: Motivation to Participate in the CalAIM AHR Community Support**

GET 3 describes participants' reasons or motivations for participating in CalAIM AHR community support. All participants' decisions to participate was driven by their desire to alleviate their child's asthma symptoms and prevent future asthma exacerbations. Participants described their feelings of being exhausted by their child's repeated asthma episodes and feeling hopeful that AHR community support would provide them and their child with some relief from that exhaustion.

Participants consistently expressed a sense of need, urgency, and even desperation to find "anything that could help" their child manage their asthma. Participant 1 explained, "My son was having a lot of difficulty breathing, and Kaiser could help me. If there were things that they saw that could be a trigger point. At this point, anything helps, I don't know what else I can do." Similarly, Participant 2 stated, "We're [child's parents] willing to do anything to help my son. It's been challenging, especially since he was

little, because he starts panicking when he has an attack, and we have to take him to the emergency room." Participant 4 also expressed a sense of hope that AHR community support would help their child, sharing, "I figured that they [Vendor X] would be able to let us know if something that I had in my house was making him have an asthma flare up." Lastly, Participant 5 mentioned that their motivation was also to help their child, but also that it was free, "Because they [KP] told me that it was free of charge and I would do anything for my child."

This theme describes participants' motivations to agree to participate in the AHR community support. However, it also demonstrates a parent's search for relief, not just for their children who consistently experience these asthma episodes, but also for alleviating the constant stress and exhaustion that parents experience as a result of their child's ongoing asthma episodes. One might also interpret participants' motivation to agree to participant in the AHR community support as a sign of trust in KP's commitment to their child's well-being.

**GET 4: Types of CalAIM AHR Community Support Services Received**

GET 4 describes the range of services provided by the AHR community support, particularly asthma-related items, that participants received. All participants received items and supplies that were provided to help reduce environmental asthma triggers. These items mostly included air purifiers, HEPA vacuums, dehumidifiers, cleaning products, mattress and pillow covers, and air filters. Across all participants, they expressed appreciation for these items and reported integrating these products into their

cleaning routines. Overall, the supplies that participants received helped them improve the air quality in their homes and reduce asthma triggers for their children.

**GET 5: Satisfaction with CalAIM AHR Community Support and Experience**

GET 5 theme describes participants' overall satisfaction with the CalAIM AHR community support. Participants' responses indicate an overall appreciation for the support received, but some also expressed frustration with the AHR process. All participants recognized the usefulness and value of the services, particularly the items they received. However, satisfaction ratings varied between "very satisfied" and "somewhat satisfied." These ratings were dependent on how well the AHR process was coordinated and the timeliness of service delivery.

All participants expressed appreciation and gratitude for the AHR community support and reported that the items they received have a positive impact on their child's asthma. Participants who reported being "very satisfied" shared that the AHR community support was helpful and appreciated the KP assigned Vendor X, as being very attentive. Participant 1 shared that they were "very satisfied. I think it was a really good service. Like, it really has helped him [child]." Participant 5 further added,

> They [Vendor X] seemed really involved and caring and wanting to know what was going on and if I received all the supplies. They [Vendor X] were calling me to check to make sure I received everything, and they were mentioning things that I had no idea that they would even send. They would call me every like 2 weeks. How is it going? Do you need anything? They were very attentive, very attentive.

In contrast, despite participants expressing appreciation for the items received, most reported being only “somewhat satisfied” due to long waiting times, unclear instructions, and a lack of follow-up. Participant 3 stated,

> “I’m kind of in the middle because I appreciate the assistance and the fact that Kaiser was willing to help us out. But I’m kind of disappointed with, you know, the other half because it wasn’t followed through, and that’s fine. But as long as someone would have communicated that to me, I feel like they [Vendor X] just kind of left us hanging. So we just kind of, you know, gave up. I was looking forward to the bigger air purifier in the living room because I can’t afford to get another one right now.”

Similarly, Participant 4 rated the satisfaction as “somewhat satisfied”, “I’d say I’m somewhat satisfied. The humidifier they gave us was really big, good for the living room, but not so practical for other areas. Maybe two smaller ones would’ve worked better instead of one large one.” Lastly, Participant 2 mentioned that during the first home visit, Vendor X had missed a crucial issue in their home, “so a thing that it was crucial and they missed when they did the home visit was that there was actual mold in the showers. So, for that reason we moved.”

Overall, participants were grateful for the AHR community support and recognized its value. Participants were “very satisfied” when they perceived the AHR community support to be well coordinated, timely, and consistent. However, those who rated their satisfaction as “somewhat satisfied” when communication was slow or nonexistent.

**GET 6: Changes in Symptoms After Receiving CalAIM AHR Community Support**

GET 6 captures participant reflections on changes in tehri children's asthma symptoms after receiving AHR community support and associated items. All participants described noticeable improvements in their children's breathing, having fewer asthma flare-ups, and a general sense that their home environment felt cleaner and easier to maintain. However, it is important to mention that participants also recognized that symptom improvements may be seasonal and would likely fluctuate as the seasons changed. It is fair to say that participants were cautiously optimistic about the long-term impact of the AHR items on their children's asthma.

Most participants shared that participation in the AHR community support improved their child's asthma. Some participants mentioned that their children were experiencing less coughing, improved sleeping, and improved air quality in their home. Participant 1 shared how the new vacuum they received through the AHR community support improved their home cleanliness, "I had a good vacuum. I just didn't realize that the filter system was bad as when I like switched to the new vacuum and I was like, oh my god, there is like such a big difference because it picks up so much more dust than the original one that I have." Participant 3 also credited their child's asthma symptom improvement to the AHR community support, "He [child] seems to be doing a bit better in the last few months. I want to partially credit it to possibly that because I do run the air purifier in his room." Participant 4 shared that the cleaning supplies provided by the AHR community support helped improve her child's symptom as it was natural, "I try and like the cleaning supplies, I think a lot of the stuff that they gave me did help a little bit. It's

kind of pricey for me to continue to buy but I try to go for more natural stuff in the house." Participant 5 shared that the dehumidifier they received through the AHR community support helped improve the entire families sleeping, "Because of the weather and the humidity, she's she was dealing with allergies maybe about two weeks ago, stuffy, runny nose. I run the dehumidifier to keep the air clean. It helps me to sleep better, and I'm pretty sure it helps her [child] to sleep better. She doesn't wake up in the middle of the night complaining. She doesn't wake up lethargic."

Despite these notable improvements to their child's asthma symptoms, participants were cautiously optimistic given the pending changes in seasons. Most recognized that their children often experienced an increase in asthma symptoms during certain times of the year. Participant 2 shared, "It [asthma symptoms] had improved for a while, but lately it's been acting up again, maybe because of the season change. It's been worse over the past week or two." Participant 4 also mentioned that although their child's asthma symptoms had improved because they "run the air purifier in his [child's] room" they also recognize that it's not "high-trigger season" but that in the "next couple of months things usually start flaring up". All these shared reflections demonstrate that although symptom improvement was experienced as a result of the items received through the AHR community support, parents recognized that asthma management is long-term and often season-dependent.

**GET 7: Impact of Managing Child's Asthma on Caregivers' Well-Being and Daily Routines**

GET 7 describes how care for a child with asthma affects parents' emotional well-being and daily routines. Participants describe managing their child's asthma as time-consuming, stressful, and emotionally taxing. Participants expressed relief whenever their child's symptoms were controlled but also that they were exhausted from constantly monitoring their child's asthma and making sure that their home environment was free of allergy triggers.

Most participants described feeling "fear" and "exhausted" when their child experienced asthma attacks. Participant 1 explains, "he's [child] had asthma since he was a baby, so he knows to tell me, 'I need my inhaler or nebulizer.'" However, participant 1 also adds that, "sometimes he [child] gets scared during an attack, and we end up in the bathroom with the steamer on, then off to the hospital if it gets bad." Participant 2 shared that they found it "difficult" to manage their child's asthma and take time off of work stating, "it does get difficult, managing it isn't easy, but I'm a mom of three, so I don't really have a choice. It's hardest when she's hospitalized, though, because then I have to take time off work." Another example of how challenging it is to manage children with asthma is where there are more than 1 child in the household with asthma. Participant 3 shares, "It's very difficult. And I'll tell you why. I also have a 5-year-old daughter, and she has asthma too and she gets really bad. So, they both get triggered around the same time and they kind of bounce off each other." Overall, participants share that they are physically and emotionally exhausted but demonstrate their resilience and commitment to

their children's well-being. But knowing that there may be another asthma attack around the corner causes participants anxiety.

Given that participants recognize that managing their child's asthma is a normal part of their daily routines. This includes cleaning their home to eliminate asthma triggers like dust, cleaning their home air with air purifiers and humidifiers, and constantly monitoring their children for potential asthma symptoms or attacks. Participant 5 illustrates this well stating, "When she's having symptoms, it's scary. Knowing your child has asthma is frightening, even if it's common." Monitoring and managing their children's asthma has just become part of life.

**GET 8: Challenges Experienced During Receipt of CalAIM AHR Community Support**

GET 8 captures the challenges participants experience during the AHR process. Commonly cited challenges include delays in the overall process, inconsistent or nonexistent communication between Vendor X and the participants, and confusion about who participants should contact for questions. These challenges contributed to the shared frustrations and confusion that participants experienced, which at times overshadowed the positive aspects of the AHR community support.

Delays in or a lack of communication from Vendor X were commonly cited by participants. Several participants described long wait times between outreach to schedule the in-home assessment, approval of services, and delivery of items. Participant 2 shared that:

> They [Vendor X] did take a long time to process everything from beginning to end. Like that they told me about the services and then they still took like a month to reach out and then they took another month to come and do the home visit and then they took another like two, three weeks to see and all the things.

Participant 3 also shared that they attempted to contact Vendor X, stating, “I’ve called them several times. I’ll leave voicemails. No one ever calls me back. It’s very hard to get a hold of anybody.” Participant 5 also shared their frustration about “not knowing who to call or where to reach out” after receiving a letter stating that all recommended items had been delivered, but they had not. Overall, the inconsistent communication between Vendor X and participants added unnecessary stress to families.

Another challenge mentioned by participants was the variation in the coordination of services. While some participants described the overall process as “pretty smooth,” others did not have the same experience. Participant 5 shared that although their overall experience with the process went well, receiving a call from a phone number they “didn’t recognize” caused confusion. These differences in experiences may indicate varying follow-up procedures among vendor locations or staff.

**GET 9: Suggested Improvements to CalAIM AHR Community Support**

GET 9 captured participants’ recommendations for improving the CalAIM AHR community support. While participants expressed appreciation for the AHR community support and recognized the positive impact it had on their children, they also identified areas that need improvement, particularly in the areas of communication, timeliness, and coordination of the overall process.

Most participants recommend more consistent and timely communication, from initial outreach to schedule the in-home assessment, through to completing the in-home assessment, and to the delivery of recommended services and items. Participant 2 recommended being “more consistent about reaching out.”. Participant 3 also added that it is important to “reach out to check if the goal was actually met. Kaiser and the parents are trying to work together to help manage the kids’ symptoms and keep them out of the ER.” Participant 1 suggested that shipping labels included “Kaiser because at first I was like, where did this package even come from?” Participants see value in the AHR community support but feel that there are communication gaps that undercut its value and patient confidence.

Participants also suggested improving coordination between KP and Vendor X. Participant 5 noted, “You guys [Kaiser and Vendor X] have done a tremendous job. I see the change. I could see it in her [child].” However, at times, it was unclear to participants who to contact and what part of the process KP or Vendor X was responsible for. Participant 3 shared, “If you [researcher] hadn’t called me, I wouldn’t have known who to reach out to.”

Overall, participants recognized the value of AHR community support, acknowledging the positive impact it had on their children’s asthma. The recommendations participants shared weren’t shared to be critical of the support. Instead, the recommendations shared were intended to ensure that future families who received this support had a smoother, better coordinated, and less confusing experience.

## Summary

This study aims to address the research question: What are the barriers and challenges faced by Spanish-speaking Latinos who have received social support services through the newly implemented CalAIM initiative? During data analysis, a total of nine GETs and 18 PETs were uncovered. The GETs included: GET 1, asthma diagnosis and severity, GET 2, frequency of asthma symptoms and attacks, GET 3, motivation to participate in the CalAIM AHR community support, GET 4, types of CalAIM AHR community support services received, GET 5, satisfaction with CalAIM AHR community support and experience, GET 6, changes in symptoms after receiving CalAIM AHR community support, GET 7, impact of managing child's asthma on caregivers' well-being and daily routines, GET 8, challenges experienced during receipt of CalAIM AHR community support, and GET 9, suggested improvements to CalAIM AHR community support. The GETs were based on the interview questions and participants' feedback.

The data analysis revealed that participants shared some similarities but also had some key differences. Participants all shared that their children had been diagnosed at an early age, which often occurred as a result of a severe asthma episode. Participants also had in common the emotional toll that managing their child's asthma has on them and their families. All participants also understood that their child's asthma was often triggered by their environment and seasonal changes. All were motivated to participate in the AHR community support because they wanted their child's asthma to improve and because they would "try anything" to help their child. All participants noted improved asthma control and symptoms after receiving AHR community support; however, there

was shared frustration and confusion regarding the AHR process. All suggested improvements included enhanced coordination, communication, and timeliness of service delivery.

Despite these similarities, there were also some differences in participant experiences. Perceptions about what caused their child's asthma were mostly shared, but in one case, Participant 5 attributed it to being hereditary since both parents also had asthma. Another difference among participants was their satisfaction levels with the AHR community support; three of the five were only somewhat satisfied, while two of the five were very satisfied. Although most participants shared some challenges with the overall AHR community support process, Participant 5 reported having a smooth experience. Another important difference among participants is that Participant 3 expressed financial strain, while the other did not. Participant 3 shared that they would not be able to continue purchasing the same products the program had provided because they were too expensive. Lastly, Participant 3 shared that they were managing asthma for two children, while the other participants only reported managing asthma for one child.

In Chapter 5, I provide an interpretation of the findings, discuss the study's limitations, and offer recommendations for future research. I also discuss future implications for positive social change and provide concluding thoughts that reflect the study findings.

# Chapter 5: Discussion, Conclusions, and Recommendations

The qualitative, phenomenological study explored the lived experiences of Spanish-speaking Latinos who received AHR services through the newly implemented CalAIM initiative A total of five semistructured interviews were completed over Microsoft Teams. IPA was chosen to guide the study because it focuses on understanding how people make sense of their lived experiences. Therefore, it aligns well with the study's purpose. The seven-step IPA process resulted in the identification of nine GETs and 18 PETs. The GETs were asthma diagnosis and severity, frequency of asthma symptoms and attacks, motivation to participate in the CalAIM AHR community support, types of CalAIM AHR community support services received, satisfaction with CalAIM AHR community support and experience, changes in symptoms after receiving CalAIM AHR community support, impact of managing a child's asthma on caregivers' well-being and daily routines, and challenges experienced during receipt of CalAIM AHR community support. They suggested improvements to CalAIM AHR community support.

## Interpretation of the Findings

To explore the lived experiences of Spanish-speaking Latinos who received AHR services through the newly implemented CalAIM initiative, specific domains of the CFIR framework was used to help identify barriers and facilitators during the implementation of the CalAIM initiative. Specifically, the CFIR domains (intervention characteristics, outer setting, inner setting, characteristics of individuals, and the implementation process) provided a lens from which to explore the unique experiences of study participants.

**Consolidated Framework for Implementation Research**

The CFIR is a framework presented by Laura J Damschroder in 2009 that is often used to help identify barriers and facilitators during the implementation of a new program. CFIR identifies five domains: (a) intervention characteristics, (b) outer setting, (c) inner setting, (d) characteristics of individuals, and (e) the implementation process (Damschroder et al., 2009, 2022a, 2022b). CFIR was used to explore how factors like the program, organization, community, and individual characteristics affect Spanish-speaking Latinos' experiences who received AHR services through the CalAIM initiative. Using the CFIR framework to guide the study, nine GETs and 18 PETs were produced. Table 3 provides an overview of the alignment between CFIR domain and GETs.

**Table 3**

*Consolidated Framework for Implementation Research and Group Experiential Themes*

| CFIR Domain | GET |
|---|---|
| Inner Setting | • GET 8: Challenges experienced during receipt of CalAIM AHR community support *(indirectly captured)* |
| Outer Setting | • GET 1: Asthma diagnosis and severity<br>• GET 2: Frequency of asthma symptoms and attacks<br>• GET 3: Motivation to participate in the CalAIM AHR community support |
| Individuals Characteristics | • GET 3: Motivation to participate in the CalAIM AHR community support<br>• GET 7: Impact of managing child's asthma on caregivers' well-being and daily routines |
| Process of Implementation | • GET 8: Challenges experienced during receipt of CalAIM AHR community support<br>• GET 9: Suggested improvements to CalAIM AHR community support |
| Intervention Characteristics | • GET 4: Types of CalAIM AHR community support services received<br>• GET 5: Satisfaction with CalAIM AHR community support and experience<br>• GET 6: Changes in symptoms after receiving CalAIM AHR community support |

## Inner Setting

The inner setting domain focuses on the organizational characteristics that shape the implementation of a new program or initiative, including culture, readiness, leadership engagement, resource availability, and communication practices (Damschroder et al., 2009). Even though study participants could not directly observe KP or Vendor X's internal operations and workflows, their experiences revealed organizational challenges, as noted in GET 8: Challenges experienced during receipt of CalAIM AHR community support with service. Study participants shared their perceptions on the poor coordination of services and the lack of clarity around roles and responsibilities between KP and its vendors. These findings align with those of Faiz et al.

(2024) and Moore (2024), who highlighted similar organizational barriers for patients who received CalAIM AHR community support, particularly in terms of poor service coordination and communication between patients and providers. Faiz et al. and Moore also added that these challenges are common in the early implementation phase of programs, where coordination structures and workflows are new and evolving.

**Outer Setting**

The outer setting domain reflects the external conditions, including economic, political, and social contexts, in which an organization operates, as well as how social determinants shape how individuals experience and engage with a new program or intervention (Damschroder et al., 2009, 2022a, 2022b). These reflections were captured in GET 1, which focused on asthma diagnosis and severity; GET 2, which examined the frequency of asthma symptoms and attacks; and GET 3, which explored motivation to participate in the CalAIM AHR community support. In GET 1, study participants shared insights into their child's early asthma diagnosis, which was most often first diagnosed during an emergency room visit or severe asthma episode. Study participants also provided key insights into their child's most experienced asthma triggers and the severity of their symptoms. Most participants explained that their child's asthma symptoms or attacks were often brought on by strenuous physical activity like running, or environmental triggers like dust or weather changes. The environmental triggers noted by participants are precisely the CalAIM AHR community support seeks to address among vulnerable populations.

GET 3, motivation to participate in the CalAIM AHR community support, provides insights into the factors that drove study participants to engage in AHR. Participants expressed some form of distress and were "willing to try anything" to help manage their child's asthma. At the same time, participants were also hopeful that receiving AHR from KP, whom they seemed to trust, would alleviate their child's asthma, as well as their own stress. These findings align with previously published works that highlight that Latino communities are disproportionately exposed to environmental hazards, including poor housing conditions and exposure to indoor and outdoor pollutants (Banta et al., 2021), contributing to poor overall well-being. However, individuals who disproportionately experience asthma triggers are more likely to be motivated to participate in programs when they are easily accessible, culturally and linguistically inclusive (Chinchilla et al., 2022; Faiz et al., 2024; Heintzman et al., 2020; Lopez Vera et al., 2023; Pérez & Coutinho, 2021). Overall, the outer setting domain provides key insights into the primary facilitators for participants' uptake of AHR: sense of distress and urgency to address asthma triggers, and the family's willingness and readiness to engage in AHR.

**Individual Characteristics**

The individual characteristics domain explores the knowledge, beliefs, self-efficacy, and personal motivations of those involved in a program (Damschroder et al., 2009, 2022a, 2022b). Reflections on key individual characteristics were captured in GET 3, the motivation to participate in the CalAIM AHR community support, and in GET 7, the impact of managing a child's asthma on caregivers' wellbeing and daily routines.

In GET 3, study participants consistently demonstrated high motivation to participate in the CalAIM AHR community support and perceived AHR as a necessary support for their child's asthma, but also as a potential respite from constantly stressing over and monitoring their child's asthma. GET 7 provides insights into the emotional and physical toll that having a child with asthma has on caregivers. Study participants described managing their child's asthma as an all-consuming part of their daily lives. They shared that their sleep was often interrupted and poor, the daily cleaning of their home to decrease allergens, and feeling constant anxiety at the thought of their child experiencing a severe asthma episode. Participant 3 shared that they have two children with asthma who often simultaneously experience asthma attacks and described it as being "very difficult, really difficult…both kids get triggered around the same time. It is exhausting." Participant 5 noted that although her child's asthma symptoms had improved, she still experiences anxiety and "checks on her every night." This demonstrated the emotional and physical burden that caregivers often experience, despite demonstrating resilience and unwavering dedication to their children's well-being.

Findings from this study align with those of Lange et al. (2025), who found that despite caregivers facing systemic challenges when dealing with their child's asthma, paired with associated emotional burden, caregivers' motivation to help their child often outweighs and even overlooks these challenges. Caregivers are willing to endure emotional and physical stress to help improve their child's asthma.

**Process of Implementation**

The process of implementation domain captures the stages and actions involved in implementing a new program, including planning, engaging stakeholders, executing, reflecting, and evaluating (Damschroder et al., 2009, 2022a, 2022b). Feedback on experiences with the implementation process of AHR is captured in GET 8, which addresses challenges experienced during the receipt of CalAIM AHR community support, and GET 9, suggested improvements to CalAIM AHR community support. In GET 8, study participants described the challenges they experienced during receipt of AHR, including long waiting periods, limited communication, and confusion about which organization (KP or Vendor X) was responsible for each step of the process. Participant 2 shared that it "took about a month for someone to reach out, then another month for the home visit, and another two or three weeks after that to get the items." Participant 3 admitted that they "did not know who to call or where to reach out." This feedback highlights challenges KP and Vendor X encountered in implementing processes as intended.

Despite participants sharing these frustrations, they also provided suggestions to improve coordination and communication, captured in GET 9, suggested improvements to CalAIM AHR community support. Participants provided suggestions to improve the patients' experience and overall AHR coordination. Participant 3 emphasized the importance of improved communication, "reach out to check if the goal was actually met." Participant 1 suggested placing clear mailing labels on items sent to patients' homes to eliminate any confusion about the source: "Make sure the packaging is labeled

as coming from Kaiser, because at first I did not know where the package even came from."

These findings are similar to those reported by Faiz et al. (2024) and Moore (2024) regarding early CalAIM evaluation, where gaps in coordination and inconsistent outreach were linked to early implementation workflow challenges. Although participants highlighted early barriers, actionable feedback was provided that would only increase existing patient satisfaction with AHR, such as closing communication gaps, clarifying roles and responsibilities between organizations (KP and Vendor X), and building workflows and processes that are responsive to patient needs.

**Intervention Characteristics**

The intervention characteristics domain focuses on aspects of a program or intervention that may impact its implementation success, such as its complexity, adaptability, cost, and the perceived strength of the evidence. Particularly, how well stakeholders understand the intervention and how adaptable it is in different contexts (Damschroder et al., 2009). Feedback on the overall implementation success was captured in GET 4, which included the types of CalAIM AHR community support services received. GET 5 assessed satisfaction with CalAIM AHR community support and experience, while GET 6 examined changes in symptoms after receiving CalAIM AHR community support.

Participants shared the types of support they received in GET 4, specific CalAIM AHR community support services, and reported that it helped manage their child's asthma. More specifically, participants described receiving items including vacuums, air

purifiers, humidifiers, cleaning supplies, and bedding. To participants, these items were seen as important to their child's symptom improvement and as being responsive to their needs. However, the different experiences participants had leading up to the receipt of these items were reflected in GET 8, satisfaction with CalAIM AHR community support and experience. Participant 2 shared that it took close to three months from initial outreach to receiving the items, adding that "it was definitely slow and kind of challenging. They [Vendor X] just took a long time to reach out, no calls in between, nothing." Another participant noted that they "got a letter from Kaiser saying the items were approved and sent, but that wasn't true, I only got some of them." However, some participants experienced a smooth process and were very satisfied with their experience, stating, "The vendor [Vendor X] was really involved and caring, always checking to make sure I got everything." These experiences indicate an uneven implementation process that varied in terms of timing, coordination, and communication.

Despite the variability in how participants experience AHR, they also acknowledged and shared the benefits their children and families had from AHR. GET 6, changes in symptoms after receiving CalAIM AHR community support, provides insights into some of the benefits of AHR. Participants reported that once they received their items, they were able to make immediate home environmental improvements, which reduced asthma symptoms in their children. Participant 3 shared, "he's [child] been doing a bit better these past few months, and I think part of that is because I run the air purifier in his room." Participant 5 added:

The dehumidifier really helped. A couple of weeks ago, she was dealing with

> allergies, runny nose, congestion. I ran the dehumidifier and feel the difference. It helps me sleep better, and it helps her [child] too, she doesn't wake up in the night or seem tired in the morning.

Overall, the findings reveal that the CalAIM AHR community support was able to achieve its intended goal of providing support for patient needs to help alleviate and manage asthma symptoms at home. Participants were grateful and saw great value in the program; however, they also experienced variability in timeliness, coordination, and communication with KP and Vendor X, which led to frustration.

## Limitations of the Study

This study had some limitations. Firstly, the sample size is small. I had intended to complete five to eight semi-structured interviews with participants, but only five interviews were completed. The low sample size was driven by two factors: limited uptake of the AHR community support and the inability to reach all who had received AHR community support. Spanish-speaking Latino families are historically hard-to-reach. For this study, it was evident that there was a low uptake of the AHR community support, as well as from multiple attempts to contact those who received it. Although the small sample yielded rich, thick descriptions of patients' experiences, findings may not be generalizable, and therefore transferability may be limited.

Second, this study was not able to recruit individuals who were primarily Spanish-speaking. Although our study documents (e.g., information sheet, interview guide, and outreach script) were professionally translated into Spanish, none of the interviews were conducted in Spanish. Therefore, study findings may not be reflective of

families who navigate the CalAIM AHR community support in Spanish. This finding reflects a larger issue: engaging linguistically isolated populations in health and social support services.

Third, all study participants were mothers. Although it is more common for mothers to be primary caregivers, this homogeneity contributed to a limited understanding of how fathers or other caregivers may experience managing their child's asthma and the barriers and challenges of receiving CalAIM AHR community support. Fathers' perceptions of asthma management, decision-making, emotional stress, and caregiving roles would provide important insights into household dynamics and intervention engagement.

Lastly, as a researcher employed by KP, I am aware that power imbalances may have effect participants' engagement in the study, particularly in response to participants' sharing negative experiences with the services they received. Additionally, being a KP employee may have led participants to feel obligated to participate or not share negative experiences. To avoid these risks, participants were informed during the consent process that their participation was voluntary, confidential, and would not affect their access to services. Additionally, I did not recruit individuals with whom I have direct professional or supervisory relationships to reduce the risk of perceived coercion further (Patton, 2015). Lastly, I made an effort to remain neutral, focusing on the participant's voice, and avoided justifying any organizational challenges mentioned during the interviews.

Overall, these limitations highlight potential barriers to participation for Spanish-speaking Latino families. It also highlights the importance of reflexivity when conducting

research as an insider and actively considering how my personal experiences and biases could shape interpretation (Patton, 2015). Despite these limitations, the study offers new and valuable insights into an underexplored population and provides important information that can serve as a basis for future qualitative research on CalAIM.

## Recommendations

This qualitative study has provided important insights into how Spanish-speaking Latinos experience the CalAIM AHR community support during its early implementation. The study provides key insights into mothers' motivations for accepting support, perceived benefits, and barriers related to the overall coordination of AHR. However, additional research would expand understanding of the topic, both in terms of increasing the study sample and the types of caregivers (e.g., fathers and other caregivers). Additionally, it is crucial to acknowledge potential power imbalances and insider research biases to ensure the trustworthiness of study results.

Future research should expand the participant sample in a few ways. Future studies should increase the study sample to include more than five participants and also expand to other caregivers' roles, such as fathers and other family members. Doing so would not only strengthen the results and increase the transferability of findings. This may also expand insights into asthma management, decision-making, emotional stress, and caregiving roles, allowing for a more comprehensive understanding of how CalAIM AHR community support was experienced.

Despite efforts to identify and recruit monolingual, Spanish-speaking participants, this study was only able to recruit bilingual mothers. As such, future research should

make a strategic effort to prioritize recruiting monolingual Spanish-speaking participants, as this group is more commonly affected by persistent disparities in research engagement (Chinchilla et al., 2022; Escobedo et al., 2023; Heintzman et al., 2020). Engaging monolingual, Spanish-speaking caregivers captures the voices of those who most often experience the most access barriers and who are less often represented in research studies.

Lastly, future researchers who conduct studies within their own organizations should continue to implement practices that emphasize reflexivity by recognizing and documenting their own biases. In this study, reflexive journaling was crucial in maintaining the researcher's neutrality and avoiding defensiveness when participants shared negative experiences.

## Implications

Findings from this qualitative study offer key insights into the unique barriers and challenges that Spanish-speaking Latinos encounter when accessing CalAIM AHR community support. In addition, the findings from this study fill an existing gap in the literature, which currently only illustrates the experiences of healthcare providers and organizations that provide CalAIM AHR community support. Understanding patient perspectives is important for designing effective, culturally responsive interventions. Lastly, the findings from this study have positive implications for social change, as they inform the design or modification of current and future public health interventions to help reduce disparities and enhance equitable access to care for Spanish-speaking Latinos.

## Conclusion

This qualitative study examines the barriers and challenges faced by Spanish-speaking Latinos participating in CalAIM AHR community support. Using the IPA approach and guided by the CFIR, this study captures caregivers' perceptions on the implementation and delivery of AHR, including the coordination of early AHR implementation. Despite the sample being small, the semi-structured interviews provided rich and powerful insights into participants' experiences with AHR.

Findings reveal important insights about participants' motivation to participate in AHR, driven mainly by participants' desire to alleviate their child's asthma symptoms and prevent future asthma exacerbations, but also a sense of urgency and desperation to find "anything that could help." Participants view AHR as a trustworthy and valuable support. However, participants consistently mention barriers related to delays in communication, lengthy processes from referral to service receipt, lack of clarity around provider roles, and delayed follow-up. Although these barriers reflect the early implementation of AHR, such as evolving workflows and processes, participants remain optimistic and grateful for the support the AHR community support provided.

Limitations of this study include a small sample size, the inability to recruit participants who only spoke Spanish, the focus on mothers, and my dual role as a KP employee and researcher. Mitigation strategies include reflexive journaling and paying close attention to bias. Additionally, these limitations underscore the importance that future studies capture a broader perspective on the topic.

Overall, this study found that the CalAIM AHR community support is well-received and appreciated; however, its impact is limited by inconsistencies in communication and coordination. Participants make it clear that AHR is aligned with their unique needs; however, improvements to the workflows and service delivery processes are necessary to enhance the AHR recipient experience. This study gives voice to the unique experiences of Spanish-speaking Latinos, often underrepresented in research, and contributes to the large body of implementation research that seeks to understand how public health interventions work in the real world.

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Appendix A: Interview Guide

**CalAIM – Asthma Home Remediation**
**Member Interview Guide**

Introduction: Hello, this is [YOUR NAME] from Kaiser Permanente. May I please speak with [caregiver name]?"

"Hi. I'm calling from Kaiser Permanente and the Regional Asthma Care Management Team. We submitted a referral for your child, [child's name], to evaluate if there is something that can help with your child's asthma like avoiding asthma triggers at home because we feel that they would benefit from these services. We understand that you received asthma home remediation services and we would like to learn what that experience was like for you and your child. Would you be interested in participating in a 30-minute phone interview today to share your experiences with us?

Please know that if you choose to participate in this interview, or not, your medical care at Kaiser Permanente will not be affected. Your participation is voluntary, and you may skip any questions or choose to end the interview at any time. Please know that your responses are confidential and will be used only to improve services.

Would you be interested in participating in the interview today?

**If Yes**, proceed. Please know that I will record our interview to make sure I capture your feedback accurately. The recording will only be accessible to myself and the research team. Do you consent to be recorded today?

**If Yes**, proceed to record.
**If No**, proceed without recording.

**If No**, thank member for their time and end the call.

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**Section 1: Background Information**

Child's Asthma History

1. Can you tell me about your child's asthma—when they were diagnosed and how severe it is?

2. How often does your child experience asthma symptoms or attacks?

Living Environment

3. Could you describe your current housing situation (e.g., apartment, single-family home, rental)?

4. Are there any issues in the home that might affect asthma (e.g., mold, pests, moisture)?

**Section 2: Experience with CalAIM Services (10 minutes)**

*For those who received services:*

Awareness and Enrollment

5. How did you learn about the CalAIM asthma home remediation program?

6. What made you decide to participate?

Services Received

7. What specific services did you receive? (e.g., home repairs, education, supplies)

Satisfaction and Health Impacts

8. How satisfied are you with the services you received?
    - Very satisfied
    - Somewhat satisfied
    - Neither satisfied or dissatisfied
    - Somewhat dissatisfied
    - Very dissatisfied

9. Have you noticed any changes in your child's asthma symptoms or general health since then?

10. Have there been any changes in how often your child visits the emergency room or misses school?

Emotional and Social Impact

11. How has managing your child's asthma affected your emotional well-being or daily routines?

*For those who declined services:*

Awareness and Decision-Making

12. Were you aware of that your child was referred for asthma home remediation services?

13. Why did you choose not to participate? (Concerns about privacy, landlord permission, or uncertainty are common barriers noted in recent work)

Barriers and Suggestions

14. Did you have concerns about the safety, usefulness, or cost of the services?

15. What could make it easier or more appealing for you to participate in the future?

**Section 3: Barriers, Challenges, and Improvements (5 minutes)**
Challenges During the Process

16. Did you experience any challenges during the service delivery process?

17. Were there delays or communication issues?

Suggestions for Program Improvement

18. What could be done to improve the asthma home remediation services?

19. Are there other resources or supports you wish had been offered (by KP)?

**Section 4: Closing (2–3 minutes)**
Final Thoughts

20. Is there anything else you'd like to share about your child's asthma care or your experience with the asthma home remediation service you received?

Future Contact

Would you be willing to be contacted in the future for follow-up?

Appendix B: Information Sheet

Experience with CalAIM Asthma Home Remediation Services
**Informational Sheet**

**SPONSOR:** Kaiser Permanente Southern California

**INVESTIGATOR:** **Jessica D. Vallejo, MS**
[redacted]

**TELEPHONE:** **(XXX)XXX-XXXX**

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You are being asked to be in a voluntary research study to provide feedback on your experience with the CalAIM Asthma Home Remediations Services. This study is funded by Kaiser Permanente Southern California (KPSC). You are being asked to take part in this research because you are an adult over age 18, are a Kaiser Permanente member and were eligible for CalAIM Asthma Home Remediation Services.

Your decision to be in this study is completely voluntary and will not affect the care you receive from Kaiser Permanente. You do not have to participate in any research project offered by Kaiser Permanente.

**PURPOSE**
The purpose of the study is to gather feedback through phone interviews on members' experience with the CalAIM Asthma Home Remediations Services.

**DURATION**
If you decide to participate, you will be invited to participate in a 20-30 minute phone interview to provide additional feedback on the CalAIM Asthma Home Remediation Services.

**VOLUNTARY PARTICIPATION**
Taking part in this study is voluntary. You do not have to answer any questions that you do not want to answer, and this will in no way affect the care you receive from Kaiser Permanente. The questions you answer as part of this research project will be used to improve the CalAIM Asthma Home Remediation Services.

**STUDY PROCEDURE**
As part of the research study, you will be asked to participate in a phone interview. The interview will ask you questions about your experiences with the CalAIM Asthma Home Remediation Services.

**RISKS**
There are minimal risks if you take part in this study. Some interview questions asked may be considered sensitive, may be difficult to answer, or may cause you to feel uncomfortable. You may choose to skip any questions or stop the interview at any time. With your permission, we would like to record the interview. The recording helps us make sure we get your feedback right. It will be kept safe and only the research team will be able to hear it. Your name and personal details will not be included in any reports or publications. The main risk is a loss of confidentiality, but we have steps to minimize this risk.

**BENEFITS**
There is no guarantee that you will benefit from participating in this study.

**ALTERNATIVES**
You do not have to participate in this study and the medical care you receive will not be affected.

**CONFIDENTIALITY**
To maintain your confidentiality, we will use unique study identifiers. This same study number will be used to record your study information. No personal identifiers will be linked to your study data. Research staff are trained to keep your information private. Your information will be used for the purpose of this project only.

**COMPENSATION**
There is no compensation for taking part in the study.

**COSTS**
There is no cost to participate in the study.

**STUDY CONTACT INFORMATION**
If you have any questions about this research study or any study procedures, please call **Jessica Vallejo** at [redacted]**.**

**QUESTIONS ABOUT PARTICIPANT RIGHTS**
If you have any questions about your rights as a study participant, you may contact: Armida Ayala, PhD, Director, Human Research Subjects Protection Office, at [redacted] or [redacted] to discuss questions, concerns, problems or complaints about your participation in a study and/or to obtain information and offer input about any study.