

How Accessible is Health Care for Immigrants & Refugees in Greater Boston?

A QUALITATIVE APPROACH TO WHAT IS WORKING AND
NOT WORKING IN HEALTHCARE ACCESS FOR A
MARGINALIZED POPULATION

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*In cooperation with the Massachusetts Immigrant &
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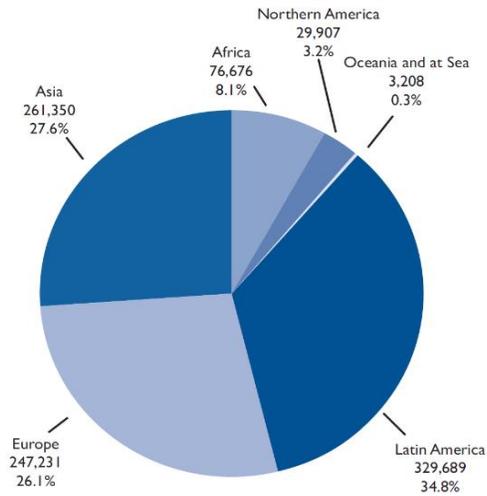
Introduction & Description of the Problem

In 2006, Massachusetts legislated healthcare policy reform, thereby increasing state-wide access to health insurance coverage through Medicaid. As a result, Massachusetts now enjoys one of the highest coverage rates in the country. However, despite high levels of health insurance coverage, immigrants have varying and disparate access to health insurance based on multiple factors, including length of residence in the U.S., language barriers, health literacy and immigration status (i.e. refugee, asylum applicant, legal permanent resident versus temporary protected status) which, in turn can also be influenced by country of origin. Research also shows that even in cases where availability of coverage is achieved, it “does not automatically lead to high-quality care” (Eisenberg & Power, 2000). The existence of hospitals and community health centers, as well as theoretical access to health insurance cannot obscure the disparities in unmet need (Arora, 2016). In addition to limitations in health insurance coverage, a socio-political shift in attitudes toward immigrants is occurring in both the United States as well as several European countries. Public opinion polls show one quarter (25%) of the U.S. population believes immigration is a “bad thing for the U.S.” (Newport & Brands, 2016), 39% would like to see immigration levels decrease (Dugan, 2015) and 36% support building a wall along the Mexico border (Newport, 2017). While this does not represent majority sentiment, it is not an insignificant segment of American. Researchers and healthcare providers are increasingly publishing on the impact of policy on health and health-seeking behavior (Hacker, Chu, Leung, et al., 2011; Hacker, Chu, Arsenault, et al., 2012; Mann, Siman, Downs, 2016; McEwan, Boyle, Hilfinger, et al., 2015; Menjivar, 2013; Capps, Hooker, Koball, et al., 2015; Rhodes, Mann, Siman, et al., 2015; Sabo & Lee, 2015; Toomey, Umana-Taylor, Williams, et al., 2014; Williams & Medlock, 2017). Despite living in a state with high levels of health insurance coverage, immigrants continue to face a variety of obstacles to equitable healthcare access.

Demographics in Massachusetts

Massachusetts was home to nearly 1.1 million immigrants (15.6%) in 2013 (AIC, 2015), over half (52.5%) of whom are naturalized citizens (AIC, 2015). This share is greater than the national average of 13.4%, representing 43.2 million immigrants nation-wide in 2015 (Lopez & Radford, 2017). Sixty-six percent of immigrants in the state had lived in the U.S. for at least 10 years and approximately 16% of households in MA are headed by immigrants (Clayton-Matthews, 2009). Immigrants tend to be younger, and more likely to be 25-44 years old (Clayton-Matthews, 2009). Cities with the greatest concentration of immigrants range from a high of 38% (Chelsea) to 25% in Quincy (26.7% in Boston) (Clayton-Matthews, 2009).

Region of Birth of Massachusetts Immigrants, 2009
 Source: American Community Survey, 2009 PUMS



(Clayton-Matthews & Watanabe, 2012)

Regionally, most immigrants in Massachusetts are from Latin America (34.8%), followed by Asia (27.6%) and Europe (16.1%) (Clayton-Matthews, 2009).

Population by Foreign-born Status, by Municipality, Massachusetts, 2009 <small>Source: American Community Survey, Multi-Year Estimates, 2005-2009, Table B05002</small>				
Geography	Total	Number of Foreign-born	% Foreign-born	Concentration Ratio
Chelsea City	36,166	13,747	38.0%	2.31
Malden City	55,684	20,612	37.0%	2.25
Lawrence City	70,273	23,985	34.1%	2.07
Vineyard Haven CDP	2,302	781	33.9%	2.06
Everett City	37,525	12,309	32.8%	1.99
Randolph CDP	30,391	8,852	29.1%	1.77
Somerville City	75,880	21,122	27.8%	1.69
Lynn City	87,196	23,901	27.4%	1.67
Revere City	50,555	13,738	27.2%	1.65
Boston City	625,304	167,157	26.7%	1.62

(Clayton-Matthews & Watanabe, 2012)

Immigrants in Massachusetts are very heterogeneous. The top ten countries of origin, in descending order, include: Brazil, China, Dominican Republic, Portugal, India, Haiti, Vietnam, Canada, El Salvador and Guatemala (Clayton-Matthews, 2009).

MA Rank	Country of Origin
1	Brazil
2	China
3	Dominican Republic
4	Portugal
5	India
6	Haiti
7	Vietnam
8	Canada
9	El Salvador
10	Guatemala

In 2013, approximately one in six people in Massachusetts are either Latino or Asian (AIC, 2015). Immigrants participate in the state’s labor force at a higher rate than US-born residents (71.7% vs 67.5%) (Clayton-Matthews, 2009). Half of immigrant-headed households are homeowners, and those who rent pay \$2.5 billion in gross rent (Clayton-Matthews). Immigrants’ share of tax filing is higher than their share of the state population, they pay \$1.36 billion in state income taxes, \$1.28 billion in local property taxes and \$338 million in sales/excise taxes) (Clayton-Matthews). Immigrants are institutionalized at lower rates across all age groups compared to US-born, and recent immigrants are significantly lower than established immigrants (Clayton-Matthews). Immigrants receive less public assistance than if their rates/amounts of receipt were the same as the US-born population (Clayton-Matthews).

Literature Review

Barriers to healthcare access among immigrant populations

Several studies have documented the numerous barriers to healthcare faced by immigrant communities. Fortuny & Chaudry (2011) at the Urban Institute identified barriers related to “program eligibility provisions, immigration enforcement initiatives, [and] family composition...” Hacker (2011) conducted focus groups in Everett, Massachusetts and participants reported fear of deportation, which contributed to high levels of stress and affected access to health services, as well as fear of collaboration between local law enforcement and Immigration and Customs Enforcement, “and concerns about not being able to furnish documentation required to apply for insurance and for health care” (Hacker, 2011).

A literature review by Hacker (2015), showed “barriers included bureaucratic obstacles, including paperwork and registration systems,” limited and overwhelmed safety net institutions, “discriminatory practices within the healthcare system itself,” deportation fear, stigma and insufficient social/financial capital to obtain services. Sethi (2013) found that “newcomers” reported insufficient “culturally appropriate services” as well as discrimination. In a study (Lindsay, 2016) of Brazilian immigrants in Massachusetts, “inconsistent quality of hospital interpreting services” contributed to negative experiences with the healthcare system.

Effects of immigration policies on immigrant health outcomes

In a study of three European countries (Ikram, 2015) it was found that “policy contexts may influence immigrants’ mortality.” Martinez (2015) found a “direct relationship between anti-immigration policies and their effects on access to health services.” The Migration Policy Institute (2015) notes that fear of deportation leads to stress which, in turn, leads to “poor physical and emotional health.” In a study on the perspectives of healthcare providers, Hacker (2012) finds that “health care providers are witnessing the negative effects of ICE activities on their immigrant patients’ psychological and physical health.” In a study (Rhodes, 2015) on the effect of section 298(g), Hispanic/Latina mothers “sought prenatal care later and had inadequate care” when compared with their counterparts, and participants reported mistrust in and avoidance of health services, as well as “sacrificing their health and the health of their family members.” Williams (2017) writes that “dramatic societal events” (such as the recent U.S. presidential campaign and election) “can have negative health effects on people who have been direct targets of what they perceive as hostility or discrimination and on individual communities who feel vulnerable because they belong to a stigmatized, marginalized or targeted group.”

Facilitators of healthcare for immigrants

In addition to identifying barriers to healthcare delivery and the health effects of immigration policies, it is important to also include a review of factors which facilitate healthcare for immigrant communities. Unsurprisingly, Fortuny (2011) finds “strategies and initiatives that appear to facilitate or improve immigrant families’ access to health and human services.” Focus group participants in Hacker’s (2011) study recommended improving relationship between law enforcement and ICE, education on rights and responsibilities as residents, and group sessions to improve civic engagement. In a literature review by Hacker (2015), recommendations identified included, “advocating for policy change to increase access to health care, providing novel insurance options, expanding safety net services, training providers to better care for immigrant populations and educating undocumented immigrants on navigating the system.” In a recent Canadian study (Na & Hample, 2016), finds that psychological functioning (“sense

of belonging, personal control and generalized trust”) is a mediator in the relationship between health and social integration, and that “visible minority immigrants were the least socially integrated. Rhodes (2015) recommends education on rights and eligibility to utilize health services. These findings and suggestions are important to keep in mind, as constructive suggestions for what can be done have already been made.

Conceptual Framework

In order to capture the complexity of multiple dynamic systems which cumulatively affect health, the ecosocial framework, first introduced by Krieger (1994) is most useful. Ecosocial theory refers to a multi-level framework, emphasizing the dynamic interplay between biological, ecological and social organization, in the production of disease (Krieger, 2001). Inherent to this theory is the degree to which individuals and the “environment” (traditionally conceptualized as entirely separate from the individual) are inter-connected. This model is highly adaptable to immigration-related contexts and rests on the concept of integration. Traditionally, integration of immigrant is thought of in terms of four spheres: 1) socio-economic; 2) cultural; 3) legal and political; and 4) the attitude of recipient societies toward immigrants (Entzinger, 2003). However, one can also conceptualize immigrant integration as the degree of interconnectedness between the individual, family/community, institutions and environment. At the broadest level, the environmental sphere encompasses large-scale population characteristics such as demographic shifts, immigration push/pull factors, anti-immigrant climates, the rise of nationalism/populism and racism/discrimination. The environment, in turn, impacts the nature of our institutions and systems. In response to the socio-political environment, immigration policies are shaped and enforced, limiting access to health insurance, the number and vitality of safety net institutions, and the degree to which quality of care is expected/enforced. Institutions and systems also influence socioeconomic status and capital. Communities and, at a smaller level, family units absorb the effects of both the environment and institutions, which can result in collective experiences/perceptions of fear, mistrust and uncertainty. Alternatively, community and family also contribute to the existence and strength of social networks. Community norms give rise to ranges of individual behaviors and perceptions. For example, the expectation of/need for migration may propel an individual to migrate, which can result in a host of immigration-related stressors and sequelae (i.e. unstable employment and poverty). In addition, community norms can also influence whether or not one seeks health care, where and which type of care. Individual biological factors contribute directly to one’s health and though while often considered the most proximal factor to one’s health, is also increasingly associated with social and environmental effects, in the field of epigenetics.

Central Research Aims

One of the primary research aims of this study was to include the voices of those both providing and receiving care. Secondly, given recent changes in the current political climate, it is important to describe how it may be affecting health-seeking behaviors. Thirdly, we aim to document examples of what is and is not working in our health care delivery to immigrant/refugee patients. Lastly, we aimed to explore different perceptions of what immigrant integration means, and how it might be related to health. From these findings, we propose best practices health care facilities may want to take into consideration.

Background of MIRA

The Massachusetts Immigrant & Refugee Advocacy Coalition (MIRA) was founded 30 years ago in 1987. Their establishment was borne out of the 1986 Immigration Reform and Control Act (IRCA), and they operated largely as a “policy shop” for the next nine years. As a result of the 1996 welfare reform and the Illegal Immigrant Reform and Immigrant Responsibility Act (IIRIRA), MIRA expanded their focus to include state-wide coalition building. Now the largest immigrant and refugee advocacy coalition in New England, MIRA has over 130 affiliate members including: “grassroots community organizations; refugee resettlement agencies; providers of social, legal and health services, faith-based organizations and civil and human rights advocates.” MIRA’s activities now expand beyond their initial efforts on legislation and policy research to include community organization, citizenship clinics and an Integration Institute, which focuses on civic, economic and social integration. MIRA’s vision is, “All immigrants and refugees are empowered to fully participate in their communities’ social, economic and civic life and advocate for themselves.”

Design & Methods

This study was conducted from May to September 2017 in Boston, Chelsea, Cambridge, Lynn, Lawrence, Lowell and Malden. A qualitative approach based on grounded theory was utilized. Initial exploratory questions were identified, data was collected in the form of interviews and participant observation, core theoretical concepts were developed and, finally, synthesized. Participant observation took place at MIRA’s Boston office, community events, public hearings at the State House, rallies and other local events. Interviews were all semi-structured and primarily individual. Two interviews were done in small groups of three individuals each, according the organizational preference and convenience. Interviews were conducted in either English or Spanish, lasted approximately 30-70 minutes, and while none were recorded, notes were taken throughout. Interviewees consisted of key informants (healthcare

providers, governmental and nonprofit agency leaders and MIRA staff) and beneficiaries (adult immigrants and refugees). Recruitment was through snowball sampling, beginning with MIRA's affiliate organizations working in the Greater-Boston area. In order to prevent interviewing beneficiaries already connected to healthcare services, recruitment was done through ESL classes. ESL service providers were operated by MIRA-affiliate organizations. This study was approved by the IRB at the Harvard T.H. Chan School of Public Health. Informed consent was obtained through verbal consent and no identifying information was collected. Data was analyzed thematically using NVivo software.

Description of the Sample

A total of 37 key informants were interviewed (31 individual interviews and two small groups of three individuals each). Key informant interviews represented nine different healthcare facilities (two safety net hospitals and six community health centers), five government-affiliated agencies, nine community-based organizations and 17 healthcare providers (including physicians, nurse practitioners, registered nurses, and behavioral health providers). Thirteen beneficiaries were individually interviewed: ten women and two men, all between the ages of 21-early 50s. Countries represented included the Colombia, Dominican Republic, El Salvador, Haiti, Ivory Coast, Morocco, Peru, Sudan and Togo. In all, 50 participants were interviewed.

Findings: Commonalities & Differences in Key Informants vs Beneficiaries

Changes in Trends

The majority of both key informants and beneficiaries described an environment of enormous amounts of change, particularly among the Spanish-speaking community. Participants noted an increase in racism and discrimination and less public support of immigrants/refugees. In general, fear, paranoia and "collective panic" were cited as major concerns. Importantly, individuals described subsequent significant changes in behaviors such as not taking public transit; restricting movement around their towns/neighborhoods; declining, and in some instances returning, benefits for which they are eligible; and lower turnout for educational opportunities such as ESL classes. Both groups also noted an increased need for and response from community organizations.

Beneficiaries in particular reported slower processing of applications for housing, work permits and health insurance, and wondered whether or not that had to do with the current political climate. One respondent observed a more punitive relationship with a social service agency, and assumed it was related

to general discrimination toward immigrants. Of note, some respondents reported no change or summarized group divisions as a normal aspect of society.

Similarly, some key informants stated that observation of changing trends depends on who one asks. Others stated that changes in utilization of services by immigrants is not known, because that level of specific data is not collected. There were conflicting reports of changes in school attendance and asylum applications. However, on the whole, most key informants reported increased lost-to-follow-up rates, and some directly attributed this to preventable hospital admissions. Several key informants observed an increase in requests from parents to document their parent-of-record status and increased visits for depression/anxiety. There were also observations of immigrant/refugee patients avoiding making necessary reports of domestic violence. In general, key informants reported an increased interest in advocacy among healthcare providers and the public at large.

Problems with Access

There was significant overlap among key informants and beneficiaries in observations of difficulty accessing care. Both groups commented on incongruent cultural expectations of care/treatment; lack of sufficient time with healthcare providers; enormous amounts of difficulty with and confusion about navigation of insurance and medical systems; lack of access to dental care; language barriers throughout all aspects of the healthcare system; and racial bias in the clinic. Beneficiaries overwhelmingly reported fear of medical bills/expenses, and described changes in their health-seeking behaviors to avoid any risk of incurring of bills. In addition, beneficiaries observed that receipt of quality of care is highly variable.

Key informants specifically noted that the degree of disenfranchisement of immigrants/refugees was a primary barrier to accessing care, and that access to health/social services in general is insufficient to impact social determinants of health. They also observed the effect of fear, mistrust and decreased sense of safety negatively impacts access to care/services, regardless of eligibility and despite legal vulnerability. In essence, key informants noted that immigrants/refugees in general, regardless of immigration status or ability to qualify for services/benefits, are experiencing fear, mistrust of institutions and a lack of safety. The majority of key informants also observed a lack of institutional capacity to meet the needs of their patients/clients, especially with regards to their legal needs. Lastly, some participants reported that institutional procedures/systems contribute to the disempowerment of both patients and providers. For example, health care providers stated patients applying for asylum are required to meet, report and repeatedly recount experiences of trauma that their sense of self-efficacy is reduced.

What Health Centers Do Well

Both key informants and beneficiaries commented on the high quality of clinical services, though key informants tended to report this more frequently than beneficiaries. Secondly, both groups observed the availability of language access in most locations. Some beneficiaries commented on the cleanliness of healthcare facilities and reported appreciating the feeling that it did not matter which countries they came from or their abilities to pay for services.

Key informants observed that clinical services are comprehensive and include important supports, such as patient navigators and community health workers. A few stated that certain health centers excelled at focusing on patients' social determinants of health. Others described the leadership exhibited by health centers, evidenced by letters written by clinical directors and increase in staff trainings. Some commented on the deep community engagement of certain health centers. Lastly, one key informant described their own innovative opportunity for meaningful medical-legal partnerships.

How Health Centers Can Improve

There was significant overlap among both key informants and beneficiaries in their suggestions for healthcare facilities to engage and participate more in their local communities. Both groups also stated that services could be more equitably accessible and clinics should do more to ensure consistent quality of care provided. Beneficiaries suggested health centers make improvements in the area of informing both patients and the general public. This group specifically observed the need to improve quality of care in general. Several beneficiaries requested that health centers create opportunities for patient support and interaction, consistently requesting informational sessions on how to cope with stress/anxiety, as well as racially/ethnically mixed groups in order to learn more about one another. Lastly, beneficiaries requested health centers do more to advocate on behalf of their patients/community.

Key informants stated health centers could do more to innovate upon existing needs (i.e. medical-legal partnerships) and learn more from one another. One healthcare provider observed certain clinics to have more expertise in caring for immigrant/refugee patients and expressed desire to better understand that clinic's approach. Other key informants suggested health centers could exercise more leadership, improve efforts to create a welcoming environment, and inform themselves. Lastly, many observed the need for health centers to increase their support of health care providers during this time.

The Meaning of Immigrant Integration

Both beneficiaries and key informants described integration as active community participation and mutual accountability (between both immigrants/refugees and the receiving community). Many also observed an inherent tension between balancing traditions/values from countries of origins with adapting to new rules and routines in the U.S. Both groups overwhelmingly equated integration with increased access to services, education and employment. There was also significant overlap in descriptions of how integration subsequently improves one's ability to achieve independence. Lastly, both groups described integration as the ability to feel safe and comfortable outside one's home.

Beneficiaries specifically described integration as a sense of unity and the ability to get along with one another. Key informants, in turn, described integration as social capital, political power, economic advantage, having protection from the government, the ability to trust in local authorities, having a sense of connection and development commonalities between disparate groups. Key informants also observed integration to imply a sense of welcome, inclusive and accessible services, feeling respected, valued and belonging. Lastly, key informants stated integration means accompaniment and collaboration.

Barriers to Immigrant Integration

Both key informants and beneficiaries described fear and lack of education as significant barriers to immigrant integration. Beneficiaries also reported that lack of information (i.e. uncertainty about immigration rules/regulations and about access to/availability of community resources) were significant barriers. Key informants observed numerous additional barriers to integration, including lack of equal access to resources (health insurance, in particular), and significant difficulty navigating complicated systems (educational, legal and medical). Many key informants also described the negative impact of poverty, racism, housing segregation and community tensions. This group overwhelmingly noted the difficulty of managing both acute and chronic stressors, leading to poor sleep and limited employability. Several key informants also noted that certain backgrounds (including limited work experience, education and histories of trauma) can limit integration. There were also consistent observations related to differences in communication styles (apart from language alone) and customs leading to cultural misunderstandings which, in turn, were barriers to integration. Lastly, several key informants reported that contradictory and confusing messages (i.e. "you are safe/welcome here" versus "you're at risk of deportation") as being a significant barrier.

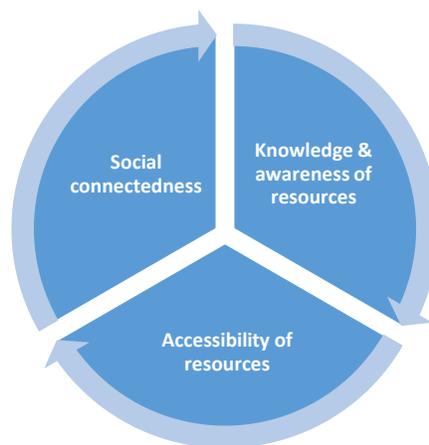
Facilitators of Immigrant Integration

The only commonality between both key informants and beneficiaries with regards to facilitators of integration was having opportunities to interact with people from different racial/ethnic groups. Otherwise, beneficiaries stated that language acquisition (notably by both immigrants and non-immigrants, alike) improved integration. Many beneficiaries also reported that feeling accepted and welcomed by the community increased their ability to integrate. A few commented that having the desire to learn and perhaps being of younger age are facilitators.

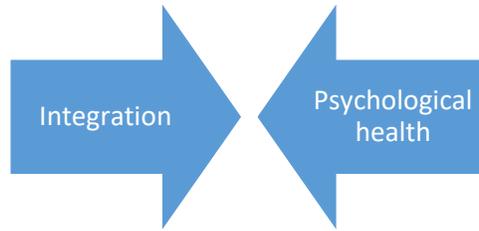
Again, key informants reported numerous additional facilitators of immigrant integration, including having opportunities leading to a sense of independence and empowerment. Importantly, several described the importance of psychosocial support such as feeling heard and good about one's self and not feeling isolated. Many key informants stated that health centers' engagement in the local community and their provision of comprehensive care, regardless of ability to pay, language, or medical issues were facilitators of integration. Several also observed that immigrants with both employment and educational experiences are more easily able to integrate, and conversely, local schools encouraging parent engagement facilitate integration. One key informant reported that living in a "sanctuary city" is an important facilitator of integration.

Relationship between Immigrant Integration & Health

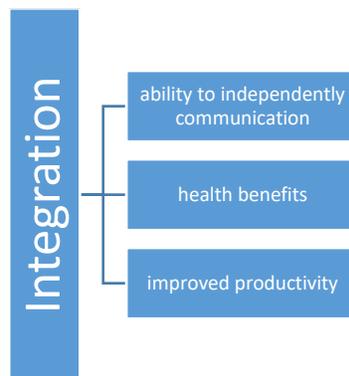
Both beneficiaries and key informants described an inherently interconnected relationship between integration and health. Nearly all participants observed social connectedness to improve knowledge about resources/options for care, thereby improving overall access.



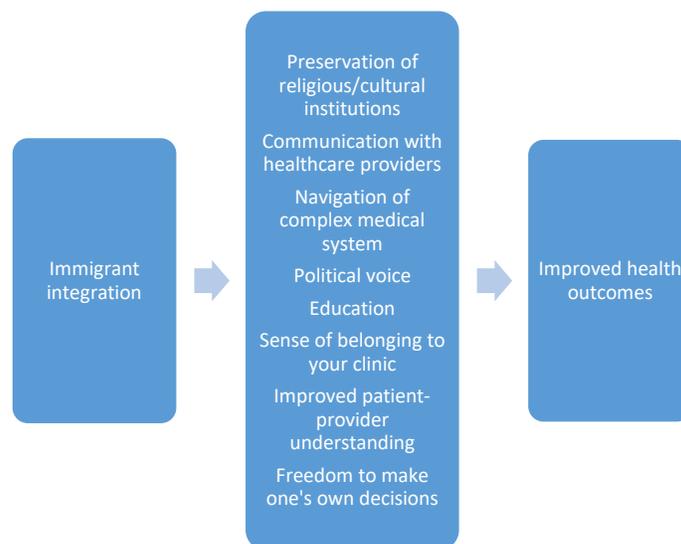
Secondly, both beneficiaries and key informants observed the dual interaction between having a sense of integration and one's psychological health (i.e. sadness, nervousness, depression, stress, and fear).



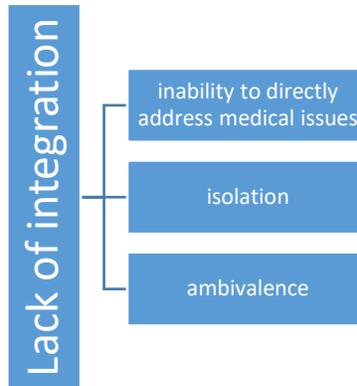
Beneficiaries stated that one’s sense of feeling integrated facilitated independent communication with others which, in turn decreases frustration; improved sleep, fewer headaches and less dizziness; and the ability to be productive, work and study.



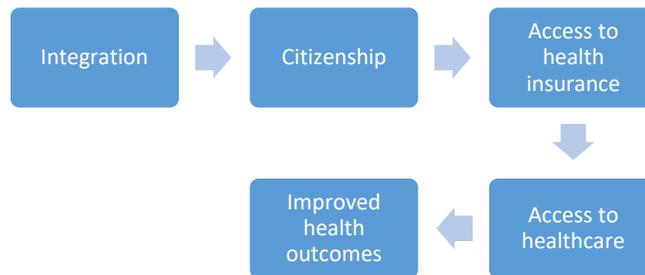
Key informants expressed numerous thoughts and observations about the relationship between immigrant integration and health. First and foremost, general questions and doubts were raised about the usefulness of the term “integration.” Secondly, key informants described multiple health-related outcomes of immigrant integration.



Conversely, key informants observed that a lack of immigrant integration prevents medical providers from being able to effectively address medical problems, promotes isolation and creates a sense of ambivalence among patients.



In addition, several key informants tied the concept of immigrant integration with U.S. citizenship, which is in turn connected with health insurance and subsequently access to health services.



The last relationship described by key informants associated integration with having an ethnically/racially diverse clinical staff (providers and non-providers, alike).



Summary

Interviews with both immigrant and refugee individuals, as well as key informants shed considerable light on what is working and not working with regards to healthcare delivery in greater Boston. While several participants noted healthcare at their sites was comprehensive and feeling accepted regardless of ability to pay or country of origin, there was considerable discussion about what is not working as well. Perhaps the most significant, among both groups was pervasive and persistent difficulty navigating complex medical and insurance systems. In addition, incongruent cultural expectations of care/treatment, insufficient time with providers, lack of dental care, language barriers at multiple points of care and racial bias were cited as problematic. Similarly, both participant groups generated a multitude of ideas for how access could be improved, principal among which was the necessity of community health centers engaging more actively with its surrounding community. Another prominent idea was the consistent suggestion from service providers that meaningful medical-legal partnerships be established and better utilized in health centers. Lastly, immigrants and refugees expressed explicit interest in learning how to manage stress in a climate a fear and anxiety.

Explanations of the meaning of immigrant integration were broad and far-reaching. Participants discussed ideas of community participation, mutual accountability, balancing inherent cultural tensions, access to services/resources, eventual achievement of independence, feeling safe/comfortable outside the home, a sense of unity, getting along with others, the ability to trust local authorities, and feeling welcome, included, belonging, respected and valued. Barriers to integration included fear, lack of education, insufficient information, lack of equal access to resources, difficulty navigating complex medical/insurance systems, poverty, racism, housing segregation and community tensions. On the other hand, facilitators of integration included the opportunity to interact with people different from oneself, language, acquisition, feeling accepted/welcome, opportunities leading to a sense of independence and empowerment, having psychosocial support, education and prior history of employment.

Despite differences in descriptions of immigrant integration, there was overwhelming support for the idea of a strong relationship between integration and health. Most commonly, participants associated a direct relationship between the two: the more one was integrated, the better the health outcomes. To a lesser extent, healthcare providers referred to evidence documenting declines in immigrant health outcomes the longer one lives in the U.S. Among those describing a positive relationship between the two, five models were identified: 1) social connectedness leads to knowledge/awareness of resources which, in turn leads to accessibility of resources; 2) integration and psychological health have a bidirectional impact on one another; 3) integration facilitates communication skills, decreasing frustration

and somatic symptoms, and improves health/productivity; 4) integration enables a multitude of pathways to improved health, including political voice, freedom to exercise decision, preservation of religious/cultural institutions, communication with healthcare providers, system navigation and a sense of belonging; and, 5) citizenship enables acquisition of health insurance, which improves access to health services.

Limitations

While this study has a number of strengths, it also is subject to several limitations. Firstly, interviews were conducted in a brief 10-week period by one graduate student. Additionally, ESL classes during summer months attract fewer English-learners than the academic year. These factors led to a small relatively number of participating beneficiaries. However, a benefit to the limited time and resources is consistency of interviews conducted and analyzed. Secondly, in order to protect privacy, data was not collected on immigration status. The analysis is not stratified by immigrants versus refugees, length of time spend in the U.S., race/ethnicity, country of origin or age. While stratification is important to consider, the absence of questions regarding status may encourage participants to be more transparent and forthcoming. Thirdly, some ESL programs preferred to select their own student-participants, whereas in other classes the graduate student gave a short introduction to the study and requested volunteers. ESL programs affiliated with MIRA tend to serve refugee resettlement agencies. This factor may bias participant selection. Fourthly, because the graduate student-researcher is fluent in only Spanish and English, interviews with beneficiaries more comfortable speaking another language were not interviewed. And, lastly, it is difficult to estimate impacts from the current political climate, and whether/how it affected willingness to participate or individual responses. These limitations may reduce generalizability of the findings. However, the inclusion of immigrant and service provider voices at the local level provides a degree of specificity that is easy to overlook.

Implications & Next Steps

To begin, inclusion of all immigrants (authorized and unauthorized, alike) into the formal healthcare system is imperative to improving access to services and health outcomes. Secondly, legislators and policy experts should bear in mind the “down-stream” health impacts of immigration policies on individual health outcomes. Thirdly, healthcare facilities may want to consider and adapt suggestions made by immigrants and key informants (Table 1. Best Practices). Lastly, additional research is warranted to investigate discordant perceptions of the accessibility of healthcare according to

immigrants versus healthcare providers; explore ways to create and fund meaningful medical-legal partnerships that benefit immigrant patients; leverage peer-peer networks, patient navigators and community health workers to demystify navigation of medical insurance and healthcare systems; and stratify participants by immigration status.

Acknowledgements

This effort was an entirely collaborative one, which could not have been done without the generous participation of individual immigrants and refugees. Sharing their stories, time, thoughtful suggestions and experiences afforded me the opportunity to do this work. The openness and willingness of community-based organizations, community health centers, public officials and healthcare providers provided a vantage point and context which greatly enriched this study. I am also indebted to the Massachusetts Immigrant & Refugee Advocacy Coalition (MIRA) and, in particular, Leah Muse-Orlinoff, whose guidance and advice were invaluable. Not least, the FXB Center for Health & Human Rights, the FXB Field Education Internship program and, especially, Myriam Zuber, who were the conveners, idea generators and mentors throughout the entire process. Thank you for supporting the process and providing encouragement along the way.

Table 1. Best Practices for Caring for Immigrant & Refugee Communities (per participants)

<i>Immigrants & refugees suggest health centers can</i>	
Get out into the community	
	Present/speak to local community organizations/groups about available services
	Provide informational brochures
	Attend local community celebrations and festivals: staff a medical table
	TV and/or radio ads about clinic services through culturally-appropriate mediums
Reassure and support	
	“In case you don’t have medical insurance, these are other supports/resources you have access to.”
	“If you’re worried about your privacy or the privacy of your information, we don’t share anything without your permission, or without a court order.”
	“How are you doing mentally/emotionally?” “How is your stress?” “How are you coping with things these days?”
	“How are you doing at work?” (instability, precarity and conditions of work)
Provide introductory trainings/talks in the community on:	
	Psychological effects of immigration on both adults and children
	Changes affecting health care/coverage
	Effects of stress on health
Take the time to explain	
	Exams, tests, treatments and prescriptions are managed differently in different countries. Explain what is being done, how and why.
	If payment is being requested, explain why and for what
Follow-up and be proactive	
	Available staff can call patients to confirm appointments (and reassure it’s safe to come to clinic).
	If calling to reschedule an appointment, ask what contributed to missing the appointment and help find a solution for next time.

	If a sick child was brought in, call the parent/guardian the next day to follow-up
Increase access to care through system changes	
	Make it easier to get walk-in or next-day appointments
	Increase availability of interpreters and insure their quality
	Improve accessibility of the healthcare provider (ease of reaching by phone and length of appointment time)
	Provide transportation to the clinic of a patient is afraid of immigration
	Only send written correspondence in the patient's preferred language
	Only leave messages in the patient's preferred language
	Extended hours and/or mobile clinics: many immigrants are unable to leave work during business hours or travel to obtain care
	Provide referrals to therapists/counselors, attorneys and dentists
	Improve navigation of insurance and healthcare systems
Advocate	
	Establish an agreement between the health facility and the local police that individuals will not be pursued while seeking health services
	Don't put patients in the position of having to choose between not being seen/long wait times or not having an interpreter
<i>Key Informants suggest health centers can</i>	
Make care more equitably accessible	
	Consider remote education/counseling (i.e. vizscripts) which may increase knowledge uptake in patients who are pressed for time or feel anxious in healthcare settings
Work toward language justice and cultural diversity	
	Staff diversity (front desk, medical assistants, psychiatrists and therapists) <ul style="list-style-type: none"> - Increase the language capacity of staff/healthcare providers - Hire more staff from the surrounding community
	Bilingual phone trees, automated messages and answering services

	Multi-lingual signage
	Incorporate cultural modalities of care (i.e. meditation room, natural therapies)
	People from different cultures communicate differently (i.e. linear vs circular, direct vs indirect, relational vs transactional). Language congruence is only one aspect of communication.
	Provide interpretation at specialty consults
Create a welcoming clinical environment	
	Make the clinic a more comfortable place to be in
	Take/make the time with your patients
	Include/post familiar art and imagery
	Craft, communicate and live up to your message: <ul style="list-style-type: none"> - We want to care for you - This is a health center that employs us and does outreach in our schools - We support you, we respect you and we're happy that you're here - We value and respect you - You have much to offer and teach us - You are safe in the health center
Consider your patients' safety and risks	
	Clinic name can appear in caller ID on phones (patients may avoid blocked calls/unknown numbers)
	Be a part of your local Rapid Response Network
	Proactively partner with local police <ul style="list-style-type: none"> - Social worker/community health worker can accompany police officers for appropriate calls (i.e. welfare checks, reports of overdose)
Facilitate better system navigation	
	Have (bicultural) community health workers and send them into the community to inform community members of available services. Consider going places where patients may be spending time (i.e. laundromats)
	Person-to-person handoffs (building a "human bridge" from one institution to another)
	Improve system alerts and automated ordering of routine screening tests
	Patient navigators who are integrated into the community they are serving
Address the large gaps in legal needs	
	Consider BIA accreditation

	Consider screening for legal/immigration needs
	Train providers to do medical exams for immigration/asylum
	Create “smartphrases” in different languages for electronic medical records about local legal resources
	Provide and/or link patients to reputable legal services <ul style="list-style-type: none"> - Hire an immigrant liaison - Embed legal representation - Advice and counsel sessions with paralegals and/or social workers
Get the word out, be consistently present and visible, build trust, convene, and demonstrate meaningful engagement with the community	
	Have a larger presence on mediums used by your clients (i.e. Facebook)
	Create short informational video content for the waiting room (i.e. what is a refill, what is HIPPA, how/when to renew your health insurance, how do I schedule/cancel or reschedule an appointment, how do I page my provider)
	Find ways to invest in the local community
	Connect with community/ethnic groups that reflect your patient population, and not only the groups that are the easiest to connect with (i.e. government funded, led by Westerners, etc.). <ul style="list-style-type: none"> - Reach out to groups where immigrants already feel comfortable going and trust (i.e. ESL classes, church). Blanket invitations aren’t as useful. - Get stakeholders around the table to create institutional policies (i.e. response to ICE coming onto campus). - Partner with a trusted group to minimize impact of un-enrollment from MassHealth with transition to Accountable Care Organizations (ACOs)
Innovate	
	Incorporate the skills of foreign-trained health professionals
	Roof garden for the clinic
	Social workers can lead teams (not only physicians)
	Positively frame support groups (i.e. social group, or coffee group), rather than “diabetes groups” or “depression groups”
Exercise leadership	
	Promote the good work being done by the health center so that the public/community has an opportunity to support it
	Foster a greater sense of advocacy among healthcare providers and trainees
	Demonstrate how your health center is a community resource
	Leverage the narrative of the “disempowered” to become empowered

	<ul style="list-style-type: none"> - As is being done for the opioid epidemic (and has been done for the HIV/AIDS community), advocate for those without a political voice - Collect data → pilot interventions → measure → iterate and build on what works - Demonstrate cost-benefit of having a medical-legal partnership
	Establish a community/family advisory board, even if your institution isn't mandated to do so
	Increase institutional leadership, rather than deflecting to/relying on the advocacy of smaller satellite clinics and individual providers
Inform clinical leadership as well as front-line staff	
	Increase the health/legal literacy of our own providers around immigrant health/legal matters
	Better understand the landscape of your population
	Run focus groups with your patients
	Educate providers about medical manifestations of trauma
	Ensure clinical guidelines are appropriate for immigrant patients
	Learn about how your health center may inadvertently contribute to racial bias and/or disempowerment of immigrant patients
Better support healthcare providers and staff	
	Find what needs to be done to retain mission-oriented staff
	Decrease the burden of interpretation on staff who are not designated as interpreters

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