COMMUNITY HEALTH NETWORK of Washington™

Immigrant Community Health Landscape Scan

Prepared for:

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Washington Health Benefit Exchange

Acknowledgments

Project Team

Erin Hafer, Hawa Elias, Dekker Dirksen, Connie Mom-Chhing, Ugbad Hassan, Theresa Hattori (Community Health Network of Washington) ● **Molly Firth** (MCG Consulting) ● **Tina Simpson & Alex Patton** (Atrómitos, LLC)

Immigrant and Refugee Health Alliance (IRHA)

Connie Mom-Chhing, Ugbad Hassan, Hawa Elias, Nkechi Agu-Ibe, Gerardo Perez-Guerrero, Theresa Hattori, Dekker Dirksen, Meg Olberding, Fathiya Abdi, Marisa Guevara, Erin Hafer, Kelli Houston, Kat Ferguson-Mahan Latet, Ganita Musa, Leanne Berge, Ismahan Ali, Joel Chavez, Deb Suelzle (Community Health Network of Washington) ● **Sami Bailey, Patricia Gepert, Courtney Smith** (Washington Association for Community Health)

IRHA Advisory Board

Claire Keeler (HealthPoint) ● **Liz Agi** (International Community Health Services) ● **Jesus Bervis** (Neighborcare Health) ● **Kristina Hoeschen** (Sea Mar Community Health Centers) ● **Lilliane Ballasteros** (Latino Community Fund) ● **Lisa Ritcher** Neighborcare Health) ● **Maria Benavides** (Yakima Valley Farm Workers Clinic) ● **Mary Bartolo** (Sea Mar Community Health Centers) ● **Mohamed Shidane** (Somali Health Board) ● **Ian Munar** (International Community Health Services) ● **Yesenia Moreno** (HealthPoint) ● **Giselle Zapata-Garcia** (Public Health Seattle & King County) ● **Shoshana Aleinikoff** (HealthPoint)

Contributors

Mary Bartolo, Claudia D'Allegri, Kristina Hoeschen, Ricardo Jimenez (Sea Mar Community Health Centers) ● **Scott Shurtleff & Molly James** (Project Access Northwest) ● **Annika Turner & Otto Matias Cruz** (Kitsap Immigrant Assistance Center) ● **Christine Lindquist** (Washington Healthcare Access Alliance) ● **Jesus Hernandez, Melodie White, Tawn Thompson** (Family Health Centers) ● **Kelli Nomura, Liz Agi, Sharissa Tjok, Tram Le** (International Community Health Services) ● **Elaine Ishihara** (APIC Advocating Together for Health) ● **Emma Catague** (Filipino Community of Seattle) ● **Thyda Ros** (Khmer Community of Seattle) ● **Mi-Yeoung Lee, Angela Lee, Hyunmi Hwang** (Korean Women's Association ● **Lupe Talamoni Anitema** (Pacific Islander Health Alliance NW) ● **Lika Smith & La'i King** (Pacific Islander Health Board) ● **Ming-Ming Tung-Edelman, Naoko Tsunoda** (Refugee Artisan Initiative) ● **Violet Lavatai** (Tenants Union of Washington)

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Executive Summary

This landscape scan on immigrant health relies on the perspectives of immigrants and individuals who interface with immigrant communities. Key informant interviews, focus groups, and surveys provided a breadth of information. This feedback confirmed what the literature identified as barriers to health insurance coverage and access to healthcare.

Cost, immigration status, cultural and language barriers, and social determinants of health make accessing healthcare services challenging for undocumented immigrants. These same barriers also impede health insurance enrollment. Some undocumented immigrants receive primary care in community health centers or free clinics, but many delay care until their conditions worsen and the emergency room is their only option. Individuals from different immigrant communities relayed anecdotes that align with findings in research studies included in the literature review regarding the use of healthcare services by undocumented immigrants.

Health insurance enrollment should lead to increased access to care and improved health outcomes. Extensive work is needed to convince immigrants to apply (and pay) for health insurance and to educate immigrant communities on how to use the U.S. healthcare system effectively. Some of that work must center on educating community-based organizations that serve these populations (and thus are trusted resources in their communities) on the opportunities presented by these new coverage options and recruiting those organizations to partner in outreach and enrollment efforts.

Informants shared many recommendations for the Washington Health Benefit Exchange (WAHBE) to consider as coverage becomes newly available to undocumented immigrants through *Washington Healthplanfinder*. These recommendations will help WAHBE to effectively facilitate immigrants’ access to insurance coverage and healthcare services.

Launch a Robust Education Campaign with Trusted Resources

- Community-based organizations serving and working with immigrant communities need funding.

Adapt Benefits to New Populations

- Transportation and interpretation will be more important for immigrant communities than currently enrolled individuals.

Educate Newly Covered Immigrants

- Newly covered immigrants will benefit from education about the health care system and how to navigate it, health literacy, preventive care, and insurance jargon.

Educate Providers and Healthcare Staff

- Providers and other healthcare personnel need cultural competency to better serve immigrants and cultivate their trust.

Tailor Outreach and Enrollment Support

- Many immigrants are new to *Washington Healthplanfinder* and will need additional support to enroll, but they need to hear more about the opportunity from various trusted sources. They will need more time and more information to alleviate fears about public charge.

Statement of Purpose

In May 2022, WAHBE submitted, at the direction of the Legislature, a first-of-its-kind State Innovation Waiver (1332 Waiver) to enable access to health and dental coverage through *Washington Healthplanfinder* for all Washington residents, regardless of immigration status, beginning in 2024. Additionally, through Cascade Care Savings, a state-funded premium assistance program, eligible individuals (i.e., individuals who do not meet citizenship or immigration status requirements to participate in Medicaid or federal premium subsidies) will have access to state subsidies to make coverage more affordable.

Recognizing the need for effective outreach and engagement with immigrant communities to ensure individuals and families are aware of coverage opportunities, WAHBE contracted with Community Health Network of Washington (CHNW) to conduct a landscape scan, including direct stakeholder engagement. The Landscape Scan informs WAHBE's understanding of the lived experience of individuals unable to obtain health coverage due to federal immigration status. It identifies practical and effective ways to connect with these individuals.

This focused engagement with undocumented immigrant communities is necessary because of their vulnerable positionality: community members (individually) and their families are subject to detention, deportation, and harassment. Due to this, their experiences and contribution to American society and economy have been described as effectively "invisible" in the context of avenues available for researchers while also occupying a position of "hypervisible identity."[1] This

means that there are limited avenues to accurately and reliably document this population's demographics, distribution, and experiences.

For this project, CHNW partnered with the Immigrant and Refugee Health Alliance (IRHA) to advise and assist in stakeholder engagement. IRHA is comprised of representatives from community health centers, community-based organizations, the Washington Association for Community Health, and CHNW, and is composed of bilingual and bicultural individuals with in-depth knowledge and experience working with immigrants and refugees.

Through this work, WAHBE seeks to assess and understand the following:

- The current awareness of health coverage options among immigrant communities, *specifically* across undocumented immigrants.
- The current level of awareness or trust in WAHBE and its partners within immigrant populations, *specifically* the undocumented immigrant communities.
- Areas where additional education or support for the eligible population may be needed and most impactful.
- Relevant opportunities for outreach and engagement to immigrant populations in Washington state, which WAHBE should prioritize, and feedback on how such outreach should be conducted.

As presented in this report, the information obtained through the Landscape Scan will allow WAHBE to tailor its insurance offerings better to address the population's needs, barriers, and preferences. It also will enable WAHBE to align its outreach strategy within the existing community networks to maximize engagement.

Figure 01: Objectives of the Landscape Scan

Identify knowledge gaps	Identify education opportunities	Identify where health care is being accessed	Engage potential outreach opportunities	Identify new partnerships for engagement
What is the current level of knowledge about health coverage options through *Washington Healthplanfinder* among immigrant communities	Where are additional education & community engagement needed in **each** immigrant community such as health coverage terminology, the value of having health insurance, where to access health coverage, or how to use health coverage?	Where are individuals without a federally recognized immigration status accessing health care services in WA State?	What are the community associations, college and university clubs, local festivals and events, and religious associations or churches that could provide support connecting individuals to health care affordability programs?	What organizations and groups would be appropriate for new partnerships for to reach immigrant populations in WA?

Methodology

Throughout this engagement, we worked closely with WAHBE to ensure that our approach aligned with WAHBE's prior research to the extent practicable, minimized duplication of effort, and ensured that the approach was closely tailored to the requirements and objectives of the engagement. We deployed a five-stage approach to this project, which began with creating a detailed strategy and tactical plan ("Action Plan") outlining the objectives, activities, and timelines for this engagement. This defined the domains for evaluation, including the parameters and terms of the literature review, identified data sources, outlined prospective community-based organizations (CBOs) and individuals for stakeholder engagement, and described the method by which CHNW would collect information from the Washington Association for Community Health (the Association). A copy of the Action Plan is included as Appendix A.

Following the approval of the Action Plan by WAHBE, CHNW conducted Background Research, including analysis of public data, evaluated aggregated data available through the community health centers (CHCs), and completed a Literature Review. The results of these analyses informed the development of surveys circulated to all CHCs statewide and the refinement of the stakeholder engagement plan, including the interview guides for Key Informants and Focus Groups.

A recurring barrier referenced throughout our research is difficulty engaging *directly* with community members. To address this, we developed and utilized a survey, eliciting feedback from community members on their perception of the prospective health coverage offering, the likelihood of enrolling, and identifying barriers and facilitators to enrollment. This was distributed to all 27 CHCs and across 17 partnered CBOs. **Figure 02** below illustrates the progression of our work plan and how each stage of the project was built upon and informed by the previous stages' results.

Figure 02: Landscape Scan Project Design

Research and Data Analysis

The Action Plan provided the parameters and primary sources for background research and data analysis. The primary sources used to inform our background research and methods for this report include the following:

- Pew Research Report – use of US Census data to extrapolate to the undocumented population
- U.S. Department of Health Resources and Services Administration Health Center Program Uniform Data System
- U.S. Department of Health Resources and Services Administration National Advisory Council on Migrant Health
- U.S. Department of Health Resources and Services Administration, Federal Office of Rural Health Policy
- Centers for Disease Control and Prevention, Immigrant, Refugee, and Migrant Health

The US Census (Census), completed every ten years, is a "direct count" of *all* U.S. residents and includes limited demographic data, including age, sex, and race.[2] Every year, the Census Bureau conducts the American Community Survey (ACS) which addresses a broad range of social, economic, housing, and demographic information.[3] The Census, ACS, and other Census-administered surveys represent a cornerstone in public health and sociological research across the United States. Consequently, each source listed above relies upon Census or Census Survey data as a foundation for its analysis. While the census counts all residents, including undocumented immigrants, there is a recognized "undercounting" of undocumented immigrants.[4] To address this, researchers generally rely on statistical methods (i.e., weighting) to estimate population demographics and information.

Literature Review

The main objectives of the literature review were to 1) inform the development of the stakeholder engagement plan, which includes the identification of stakeholders and crafting questions for the interview and focus group guides; and 2) to collate existing information on population experience with, perceptions of, and barriers to health services and insurance coverage.

The background research informed the literature review design. Both the background research and literature review informed our stakeholder engagement and survey development. While instructive, the background research and literature review clearly demonstrated a need for more information on the target population. This lack of information supports the need to conduct stakeholder engagement to fill these gaps, generally, but more importantly, with Washington-specific information.

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The literature review's domains were determined based on the Landscape Scan's objectives and the limitations identified during the background research. These domains were: (1) access to health services and where health services are received, (2) healthcare conditions and needs and what health services are most commonly delivered, (3) areas of highest unmet needs, (4) perceptions of healthcare services and accessibility, and (5) recognizing data lags in source materials and the impact of world events in recent years.

The Action Plan provided the domains, projected search terms, platform, and constraints for WAHBE for review and approval. The literature review was then conducted through PubMed. All searches were time and location bound only to include articles published between 2017 and 2022 and conducted in the United States. Relevant search terms were determined based on the findings from our background research. These search terms were later refined based on manual examination and scanned individually for relevancy. A total of 50 articles were included in the final literature review, which included primary research (quantitative and qualitative), secondary research, commentaries, and calls to action. A summary of the Literature Review results was shared with WAHBE on December 30, 2022.

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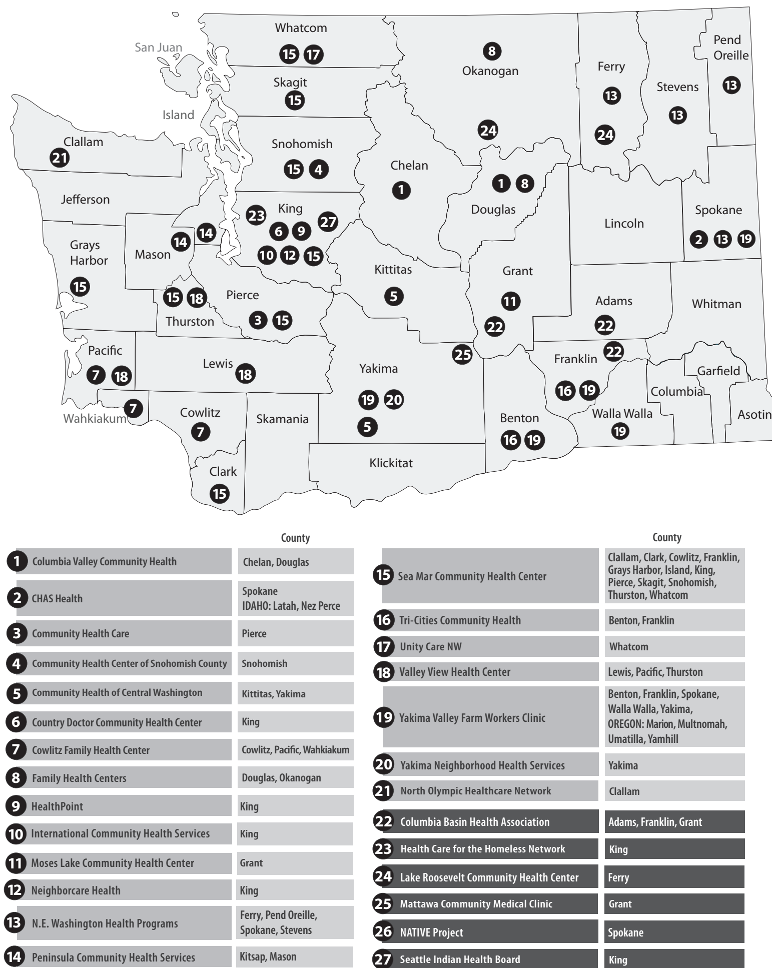
CHC Data Collection

The next stage was to collect clinical and demographic data from CHCs across Washington state. The Association) is comprised of 27 health center members, delivering services at over **300** sites across the state, with some CHCs having locations in Idaho (e.g., Community Health Association of Spokane) and Oregon (e.g., Yakima Valley Farm Workers Clinic). In 2021, these clinics served **1,195,483** patients, 16% of whom (190,292) were uninsured. Figure 03 below illustrates the distribution of the Association network across Washington.

Figure 03: Community Health Centers across Washington State



#	Health Center	County
1	Columbia Valley Community Health	Chelan, Douglas
2	CHAS Health	Spokane IDAHO: Latah, Nez Perce
3	Community Health Care	Pierce
4	Community Health Center of Snohomish County	Snohomish
5	Community Health of Central Washington	Kittitas, Yakima
6	Country Doctor Community Health Center	King
7	Cowlitz Family Health Center	Cowlitz, Pacific, Wahkiakum
8	Family Health Centers	Douglas, Okanogan
9	HealthPoint	King
10	International Community Health Services	King
11	Moses Lake Community Health Center	Grant
12	Neighborcare Health	King
13	N.E. Washington Health Programs	Ferry, Pend Oreille, Spokane, Stevens
14	Peninsula Community Health Services	Kitsap, Mason
15	Sea Mar Community Health Center	Clallam, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Pierce, Skagit, Snohomish, Thurston, Whatcom
16	Tri-Cities Community Health	Benton, Franklin
17	Unity Care NW	Whatcom
18	Valley View Health Center	Lewis, Pacific, Thurston
19	Yakima Valley Farm Workers Clinic	Benton, Franklin, Spokane, Walla Walla, Yakima, OREGON: Marion, Multnomah, Umatilla, Yamhill
20	Yakima Neighborhood Health Services	Yakima
21	North Olympic Healthcare Network	Clallam
22	Columbia Basin Health Association	Adams, Franklin, Grant
23	Health Care for the Homeless Network	King
24	Lake Roosevelt Community Health Center	Ferry
25	Mattawa Community Medical Clinic	Grant
26	NATIVE Project	Spokane
27	Seattle Indian Health Board	King

We next examined the relevance and availability of data reported across these CHCs. While the 27 association CHCs each have their own electronic health record and data platform(s), all CHC platforms must submit annual data consistent with Uniform Data System (UDS) requirements, as defined by the U.S. Health Resources and Service Administration (HRSA). This standardization enables improved quality reporting, monitoring, and comparisons across systems. However, CHCs do not track patients' legal status, and there is no close approximator based on the UDS fields.

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Furthermore, consistent with legal and ethical guidance across the industry, providers are actively encouraged to minimize documentation of immigration status due to the vulnerability of this population and uncertainty as to its use by enforcement agencies.[5] Consequently, although aggregate data was available and evaluated, this provided no direct insight into the distribution and experiences of the target population. More specifically, aggregate reporting of UDS data by CHCs to HRSA does not allow for the “cross-walking” of UDS tables against each other. For example, while we can identify the number of uninsured patients at a CHC, we cannot discern their race, ethnicity, age, and gender. Consequently, we had to rely on CHC-provided data from their EHRs, collected through a survey circulated to CHC Chief Executive Officers (“CHC CEO Survey”).

Through this survey, we collected information on two potential exceptions to this “data gap.” The first was a CHC’s documentation of Recipient Aid Category (RAC) Medicaid codes. These RAC codes represent programs with state-funded enrollment for undocumented immigrants. Three codes fall into this category: 1209 (Categorically needy, MAGI pregnancy, not lawfully present), and 1138 and 1139 (Children’s Health Program, non-citizen) as relevant to our inquiry. We asked CHCs to report the number of patients with these RAC codes were reported in ProviderOne through their clinics in 2021.

The second data point we identified was the rate of uninsured reported by CHCs and the demographics of the uninsured population. We hypothesized that a significant portion of the CHCs' uninsured population is undocumented. This hypothesis was supported by background research and feedback shared during stakeholder engagement, including by one community health center director, who noted that while immigration status is not tracked, most community health centers can estimate their undocumented patient population. Through the CHC CEO survey, we asked CHCs to estimate what portion of their uninsured population was undocumented and to explain the basis for this estimate. Respondents were also asked to provide demographic information on their uninsured patient population: including languages spoken, country of origin, and the number of times a year care is sought through the CHC.

This survey was distributed to the CEOs or Executive Directors of all 27 CHCs by email in early November 2022 and remained open to responses through the end of December 2022.

Stakeholder Engagement

All Stakeholder engagement materials, including a stakeholder engagement plan, surveys, Key Informant Interview (KII) guides, and Focus Group discussion guides, were shared with IRHA and WAHBE for feedback. Feedback provided was incorporated into the final version of the materials. For example, IRHA recommended not using the U.S. Census Bureau’s 42-group classification of the language spoken at home, as immigrants prefer to see their languages without broad groupings. Stakeholder engagement tools were used after WAHBE approval.

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CHC Surveys

In addition to the EHR data collected from CHCs through the CHC CEO survey described above, feedback was solicited from the state's 27 CHCs about their *perspectives* on undocumented immigrants and their access to care. The CHC's perspective was sought because they treat patients regardless of their ability to pay and are located across the state. Their feedback was intended to provide quantitative data about where immigrant populations are located and where they receive care and qualitative data about their perception of population needs, barriers, and recommendations to address those barriers.

Two different surveys were designed by CHNW and deployed by the Association in early November 2022: one was distributed to the CEOs and one to the Chief Medical Officers (CMOs); these are referred to as the "CHC CEO Survey" and the "CHC CMO Survey" in this report. Respondents were given an initial deadline of November 23, 2022, but the deadline was extended to encourage participation. The survey was closed in late December 2022.

Key Informant Interviews

CHNW conducted six key informant interviews. A copy of the Interview Guide for these interviews and a table of participants is appended as Appendix C and D. Three community health centers (CHCs) serving large immigrant populations in urban and rural areas in different areas of the state were included:

1. Sea Mar Community Health Center serves a variety of immigrant populations in different locations throughout Western Washington.
2. International Community Health Services primarily serves Asian and Pacific Islander populations in King County.
3. Family Health Centers has locations throughout Okanogan County, with a high farmworker population.

Other KIIs included representatives from organizations serving and working closely with undocumented immigrants.

4. Washington Health Access Alliance is an association of free clinics
5. Kitsap Immigrant Assistance Center provides immigrant-centric family, immigration, and tax and business services in Kitsap County.
6. Project Access Northwest connects uninsured individuals in King, Snohomish, and Kitsap counties to specialty and hospital care.

The literature review identified gaps in available information related to undocumented immigrants, access to care, health insurance, and barriers, *mainly* regarding Washington State-specific data. A central objective of these key informant interviews was to "fill in" those gaps. We wanted to understand the variation between immigrant groups and how insurance coverage may impact access to healthcare. Questions focused on health needs and behaviors relating to healthcare and barriers to care and coverage for undocumented immigrants; their health literacy, digital literacy, and access to digital resources; and what undocumented immigrants need to feel safe applying for coverage or accessing care.

Semi-structured interviews were conducted via Zoom with one or more key informants from the same organization in November and December 2022. Informed consent was sought for participation and recording of the interviews. The same two project team members participated in all the key informant interviews. One of the project team members inductively coded each interview and conducted a thematic analysis.

Focus Groups

A discussion guide was developed to assist the facilitators with consistent questions or themes by section and variation as appropriate by the audience and is included as Appendix E. Each discussion sought to understand the health needs of immigrant communities, where care is received, barriers to obtaining care, familiarity with current coverage options and enrollment challenges, awareness of healthcare terminology, strategies and solutions, outreach methods, and trusted sources of information.

Three one-hour focus groups were conducted via Microsoft Teams with CHC staff working in outreach and enrollment, health equity, or as community health workers. Forty individuals representing 12 community health centers and three other healthcare or social service organizations participated in these sessions. A table outlining participants is included in Appendix F. Before the focus groups, participants received an overview of the current landscape and proposed coverage expansions. This presentation is included in Appendix B.

A fourth focus group was conducted via Zoom with three coalition members from the Asian Pacific Islander Coalition Advocating Together for Health. The three participants represented various immigrant communities statewide, including those from the Pacific Islands, the Philippines, Cambodia, and Vietnam.

The focus groups occurred in November and December 2022. After the focus groups, one of the project team members inductively coded each interview and conducted a thematic analysis.

Immigrant Health Community Survey

Due to the challenges of securing focus groups from within immigrant communities, a survey was developed to elicit direct feedback from community members on key research questions. The survey was designed to be as simple as possible to maximize engagement and completion. We defined the following survey requirements: it must

(1) take no more than five minutes to complete,
(2) identify respondents by immigration status, and
(3) be easy to read and accessible in multiple languages.

The English version of the survey is provided in Appendix J for reference. The survey collected demographic information, including country of origin and preferred language, and asked questions about the likelihood of participation if free or low-cost health coverage was available, barriers, and supports for enrollment. At the end of the survey, participants were asked if they were U.S. citizens. If the respondent answered "no," they were then asked if they were a "lawful permanent resident." If both questions were answered in the negative, they were assumed to come from undocumented immigrants. While this is not a perfect delineation and omits refugee statuses, it is considered a reliable proxy.

The survey was translated into nine languages: Arabic, Chinese, French, Korean, Spanish, Swahili, Tagalog, Turkish, and Vietnamese. These languages were selected based on background research (e.g., the proportion of undocumented and uninsured Washington residents reported to speak these languages) and feedback from CBOs.

A webpage was added to the IRHA's website with links to each translated survey, Frequently Asked Questions, and printable surveys in each language. A survey toolkit was developed and distributed to 21 CBOs serving immigrant populations and 27 CHCs. A copy of this toolkit is included as Appendix I. CHCs were asked to share the survey in-person, via social media, or email. Community health centers were asked to post the survey in their clinics and on social media. Appendix K details the CBOs included in this outreach and their respective engagement. We contacted a total of 45 CBOs to assist with stakeholder engagement. Of the 45 CBOs contacted, 24 failed to respond or declined to participate. To encourage greater engagement and participation among this key group of CBOs, and in recognition of the time involved in promoting the survey during a hectic time, CHNW extended the survey deadline by two weeks and offered grants ranging from $600 to $1500 to participating CBOs based on their self-reported level of engagement.

In addition to the targeted outreach through CBOs expressly serving immigrant populations, CHNW and IRHA also emailed survey toolkits and an explanation of the project to 56 additional CBOs between December 13th and December 15th, 2022. A list of these organizations is provided in Appendix L.

Limitations

Recognizing the importance of trust when engaging with this population, we predicated our stakeholder engagement strategy on the partnership of CBOs serving these populations. This strategy included engaging with CBOs as key informants and focus group members, but also, initially, partnering with CBOs to conduct focus groups with community members. Given the initial timeline for this project (deadline of December 15th), CBOs could not facilitate focus groups with community members. Consequently, our focus groups and key informant interview groups reflect the perspective of informed front-line service providers. While this is an integral component of understanding the landscape, the absence of direct community member engagement in focus groups is a significant limitation that should be addressed through further engagement.

We developed and deployed the Immigrant Health Community Survey in recognition of this limitation; however, CBOs needed more capacity to partner in distributing this survey and marketing campaign. Many CBOs contacted about survey deployment needed to familiarize themselves with the coverage expansions proposed for undocumented immigrants. Significant time was spent engaging with identified CBOs to “bring them up to speed” on the opportunity and to recruit their participation. The uncertainty of coverage expansions, competing priorities, and the end of the year's business may have minimized CBO participation at the survey launch. The timing of the survey, occurring as it did in the run up to Christmas holidays, also likely impacted CBOs availability.

No compensation was offered for immigrants filling out the survey. While it is a best practice to compensate community members for sharing their time and opinions, we did not want to collect personal information that could create discomfort among immigrant communities. Our response rate may have been lower as a result. The offer of compensation to CBOs and survey extension were distributed immediately before Christmas when organizations may have had limited staffing, which may explain the limited response.

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Findings

Background Research

Immigrant Populations in Washington State

In 2018, there were approximately 1.1 million immigrants in Washington, encompassing 15% of the state population.[11] The majority of immigrants were from Mexico (23%), with the remaining population comprised of individuals from India (8%), China (7%), the Philippines (6%), and Vietnam (6%).[11] Additionally, most adult immigrants (38%) had a college degree or higher education, while more than 22% had less than a high school diploma. [1] Immigrants comprised 18% of the state's labor force, with the most significant shares of immigrant workers among farming, fishing, and forestry (53%), computer and mechanical (33%), building and grounds cleaning & maintenance (30%), healthcare support (23%), and production (22%). Furthermore, the majority of immigrants (79%) reported speaking English "well" or "very well." [11] Approximately half of all Immigrants in Washington state are naturalized U.S. citizens. [11]

Undocumented Immigrant Populations in Washington State

In 2019, there were an estimated 246,000 *undocumented* immigrants in Washington state.[12] This constitutes approximately 3.3% of the state's total population.[1] The top countries of birth include Mexico (57%), India (7%), the Philippines (6%), China/Hong Kong (5%), and Guatemala (4%).[12] Approximately 87% of undocumented immigrants are from Latin America (Mexico and Central America) or Asia.[12] The majority (61%) of Undocumented Immigrants have resided in Washington for more than ten years. [12] Nearly 71% of the Undocumented Population are between the ages of 25 and 54.[12] Approximately 6% of undocumented immigrants are under the age of 16, 15% are aged 16 to 24, 29% are aged 25 to 34, 27% are aged 35 to 44, 15% are aged 45 to 54, and only 7% are ages 55 and over.[12] Roughly 18,000 undocumented youth are DACA recipients, with approximately one-third to one-half living in Seattle-King County.[13]

In 2017 undocumented immigrants encompassed nearly 5% of the state's workforce.[14] The top industries of employment include agriculture (18%), accommodation and food services, arts, entertainment, and recreation (14%), professional, scientific, management, administrative, and waste management services (14%), construction (14%), and retail trade (8%).[12] The majority of undocumented immigrants are males (55%).[12] At least 40% of the population report difficulty speaking English or as not speaking English. [12] Additionally, approximately 7% of the undocumented immigrant population speaks only English, with 29% reporting speaking English "very well" and 23% reporting speaking English "well. [12] The top languages spoken at home include: Spanish (64%), English (8%), Tagalog (4%), Chinese (4%), and Korean (2%).[12]

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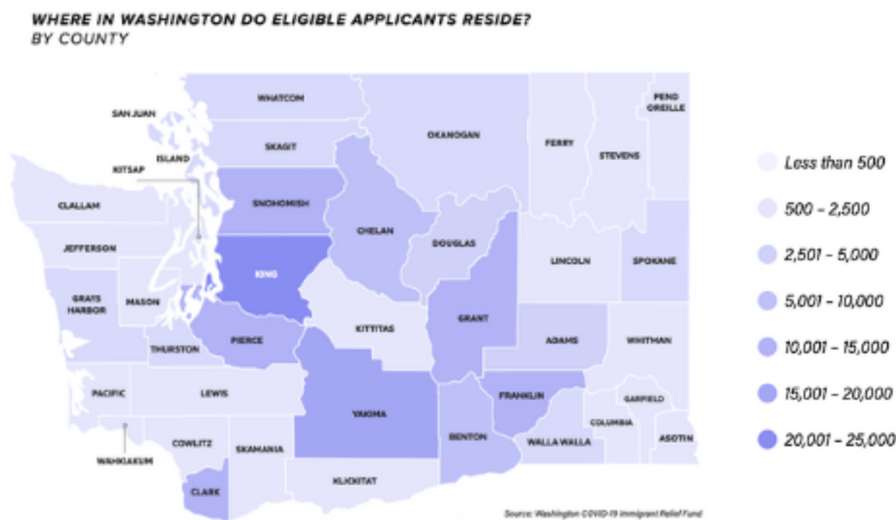
The COVID-19 Pandemic, and more specifically, the efforts to respond to community needs, presented an opportunity to systematically collect further information on this population. The Washington State Department of Social and Health Services, Office of Immigrant and Refugee Assistance (DSHS OIRA) created the COVID-19 Immigrant Relief Fund to distribute emergency relief in the form of cash assistance to immigrants who were ineligible for other forms of government assistance during this time. Between 2020 and 2021, **120,853 individuals** received direct assistance through this program.[6] DSHS OIRA relied upon the coalitions of community organizations and advocacy groups to implement the initiative. The Washington Dream Coalition ("Dream Coalition") used the data generated by the distribution of these funds to "map" the distribution and demographics of this population across the state. The Dream Coalition also conducted a series of key informant interviews and focus groups with relief recipients, further enhancing the information available, publishing their results and analysis of the data from the state-funded COVID-19 Immigrant Relief Fund in the report: Community Provides: Undocumented Communities in Washington State During the COVID-19 Pandemic.[7] Figure 03 below, taken from that report, illustrates the distribution of relief to 78,275 recipients over the course of 2020. While this is not exclusive to or comprehensive of Washington's undocumented population, the mapping of relief recipients provides insight into the likely distribution and concentration of undocumented communities across the state. As illustrated by this analysis conducted by the Dream Coalition, there is a high concentration of eligible recipients in King County (20,599), followed by Yakima County (12,027). There were 5,001 – 10,000 recipients in each of Clark, Franklin, Grant, Snohomish, and Pierce counties. This distribution broadly aligns with existing demographic data.

Figure 04: Distribution of COVID-19 Immigrant Relief Benefits by County
Source: Washington Dream Coalition (2021), *The Community Provides*.



Experience with and Access to Healthcare Services

Affordability of services and language differences are often barriers to health services for immigrant populations, especially for preventive, hospital, emergency, and dental care.[16,17] Immigrants are significantly less likely than citizens to have health insurance, compounding the challenge of affordability of healthcare services. [18,19] An analysis of 2020 Census Data (Current Population Survey Annual Social and Economic Supplement) by the Kaiser Family Foundation concluded that **42% of non-elderly, adult undocumented immigrants were uninsured**, compared to 26% of the documented immigrant population and 8% of U.S. citizens.[18] This gap in healthcare coverage also exists across undocumented children, with 28% of undocumented children lacking insurance coverage. [18] This disparity can be explained, in part, by the fact that undocumented immigrants are ineligible for the majority of public benefits (i.e., Medicaid and the ability to purchase subsidized coverage through the Affordable Care Act marketplaces) and have greater difficulty obtaining private benefits (i.e., due to employment, under-employment, or where an employer does not offer employer-subsidized insurance).[16,18]

Undocumented immigrants often forego or delay healthcare services due to various factors, including affordability, lack of health insurance, fear of interaction with public entities, language barriers, transportation barriers, and inability to take time off work.[16,17] *When* care is sought, it tends to be in response to an acute or emergency need.[15, 18] Undocumented immigrants rely heavily on safety net providers, including hospital emergency departments, Federally Qualified Health Centers, and look-alikes (i.e., CHCs).[23] CHCs provide services, regardless of ability to pay, and operate with a sliding scale fee; as such, they are frequently the primary, routine provider of health services for some of the most vulnerable members of society, including undocumented individuals.[23]

While undocumented immigrants utilize fewer health services than the general population, they frequently have more significant unmet health needs than the general population.[9] Hospitalization admission rates for preventable conditions are higher among undocumented individuals than the general population.[10] Studies have found that stressors related to an individual's undocumented status (i.e., discrimination and stigma) may negatively affect physical and emotional health outcomes. [15,16] These stressors have increased in recent years. COVID-19 and changes in federal immigration policies in recent years (including the public charge rule) contributed to increased regulatory and environmental barriers to healthcare among immigrant populations and the need for health services.[17]

Literature Review

A total of 50 articles were included in the final literature review, which included primary research (quantitative and qualitative), secondary research, commentaries, and calls to action. Appendix N provides a summary table detailing the search terms, results, distribution by study design, and themes and conclusions for each domain. While the small sample size of relevant articles for each domain limits the generalizability of results, four key themes occurred across all domains, which should be considered when addressing immigrant health.

(1) Immigrants generally, and undocumented immigrants *specifically*, face unique and pervasive barriers to receiving healthcare. Consequently, healthcare for undocumented immigrants is frequently delayed, and there is a reliance upon hospitals (specifically the Emergency Room) and public health infrastructure (community health clinics).
(2) Disparities experienced across immigrant populations in social determinants of health exacerbate health conditions. There is a high need for primary care services, including chronic disease management and behavioral health services.
(3) Perceptions of the availability, accessibility, and *suitability or adaptiveness* of healthcare services can be improved. Studies surveying community members and providers serving community members note, overall, a generally negative perception of healthcare infrastructure not only as it relates to its affordability but also the ability of healthcare providers to provide care in a linguistically accessible manner and wariness as to the safety (particularly as it relates to risking disclosure or exposure to immigration enforcement) of healthcare facilities and the degree to which they are "welcomed" and accommodated.
(4) The health needs of immigrants, specifically undocumented immigrants, and refugees, must also be considered in the context of the local and global political and social environment. Recent world events, including the hostility of the Trump Administration, COVID-19, and international conflicts, including but not limited to the invasion of Ukraine, impact community members' perceptions of the availability of healthcare services and directly impact physical and mental health needs and outcomes for this population. This is particularly acute as it relates to unmet behavioral health needs.

The most important conclusion from this literature review is recognizing the barriers to engaging with and studying this population. This is a consequence of the population's unique vulnerability within the U.S. legal and social system. There is no systemic, consistent quantitative data on undocumented people and their experience with the U.S. healthcare system.[24] This is further compounded by the fragmentation of the U.S. health system, data sources, and the laudable accommodations healthcare providers have made to minimize the legal exposure undocumented patients may face when seeking health services.[5]

Consequently, there needs to be more research in this area. What research does exist relies on qualitative survey design and mixed methods. Studies tend to be specific to a given geographic location and community group (e.g., Latinx women population in Atlanta) and often further restricted to a particular venue for health delivery (e.g., a hospital system, community health center network, or to a specific health condition (e.g., end-stage renal disease and pre- and ante-natal care). These limitations, and the small sample sizes of the studies included in the review, decrease the generalizability of the results.

This limitation presents two crucial data points that merit recognition. First, it underscores the difficulty of engaging with and collecting information on this population. Most studies relied upon stakeholder engagement, often with front-line service providers serving this population instead of the community members. With few exceptions where focus groups elicited direct feedback from community members, studies were restricted to very small sample sizes (<40). In some instances, surveys were utilized to collect input from a larger population, such as the study by Sudinaraset et al. (2022) that examined the associations between immigrant enforcement tactics and delays in COVID-19 testing and healthcare services among 326 Asian and Latinx undocumented immigrants in California.[47] Surveys limit the scope of data collected across a larger population.

Secondly, the limitations of these studies in the aggregate also consistently emphasize how ill-equipped the U.S. health system is to collect information on this population. This is reflected by the legacy of fragmentation of data exchange across health systems, its reliance upon claims data for shared data exchange across populations, the technical limitation of electronic health platforms (which generally do not track immigration status), and the need by providers to actively *avoid* documenting documentation status when providing or coordinating care out of concern for the risk presented to the patient and their family.[5]

Analysis of Each Domain

Where Health Services are Received

Immigrants in the U.S. face a disproportionate number of barriers related to engaging in and receiving care; these barriers are compounded for undocumented populations. While barriers to health services are discussed in the following section, obstacles to access and delivery impact where (and when) health services are sought by and provided to this population. As noted above, most healthcare services are received in emergency departments. One example is a commentary written by Welles & Cervantes (2020), which discusses the disparities among undocumented immigrants with end-stage renal disease (ESRD) and the barriers to treatment for ESRD. The authors indicate that this condition is often treated under emergency-only conditions. While the Call to Action does not represent original research, it does provide a thorough examination of the discrepancies related

to access and coverage of healthcare services among undocumented Immigrants and confirms that care is often received through emergency or hospital services.[25]

Barriers to Care

Immigrants in the U.S. face a disproportionate number of barriers related to engaging in and receiving care, which can adversely affect health outcomes among this population. These barriers are compounded for undocumented people. Current literature supports top barriers to healthcare, including cultural insensitivity among providers, increased language barriers, and geographic and structural barriers such as transportation. [26-34] Lack of insurance coverage, adequate healthcare infrastructure, proper medical documentation, and trust can also present themselves as barriers to engagement in care.[27-28,32-33, 35] A study conducted by Larson et al. (2017) conducted key informant interviews and focus groups with Latino and non-Latino community members and service providers in rural, eastern North Carolina and found that there were unmet health needs among immigrant populations, especially in regards to chronic and work-related conditions.[26] Another study by Sangarmoorthy et al. (2017) conducted key informant interviews with providers and immigrants in rural Maryland with similar findings.[27] At a structural level, limited clinic service hours and cost can inhibit immigrants from seeking care.[15,26,30,32-34] Additionally, system-level barriers such as an increase in restrictive immigration policies (i.e., public charge rule) and the enforcement of immigration laws amplified by anti-immigrant rhetoric, can perpetuate feelings of fear of discovery and deportation, which could prevent immigrants from seeking care, and ultimately decrease positive physical and mental health outcomes among this population.[36-40]Individuals with non-citizenship status are also less likely to engage in care.[27]

What Health Services are most commonly delivered / Prevalent Health Conditions and Areas of Highest Unmet Needs

Disparities among the social determinants of health (SDOH) have disproportionately impacted the health outcomes of Immigrants in the U.S. Current research suggests that financial resources, transportation, and food assistance are the most frequently reported structural inequalities among this population.[26,33-34] Additionally, there are discrepancies related to healthcare, including prenatal risk information and mental health services among adult immigrants.[42-44] A study by Garza et al. (2020) used semi-structured interviews to examine the perceptions and experiences of Latina immigrants.[42] They found that this population needs more prenatal risk information that is culturally sensitive to meet their healthcare needs better and limit stressors.[42] Additionally, researchers conducting a cross-sectional survey of Immigrants across the U.S. found a significant need for mental health services among this population, which the COVID-19 pandemic has exacerbated.[44] The incongruities among the SDOH create more significant challenges for Immigrants to receive quality, adequate care especially related to prevalent health conditions, including chronic and work-related conditions, diabetes, heart disease, hypertension, high cholesterol, arthritis, musculoskeletal problems, mood and anxiety disorders, and kidney

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disease.[26,43, 45-46] Emergency care is also prevalent among this population, with hemodialysis often being treated under “emergency-only” conditions in emergency departments.[25]

Community Member Perceptions of Healthcare Services and Accessibility

Perceptions of healthcare services and accessibility are limited among immigrants in the U.S. A cross-sectional study by Barwise et al. (2019) used data from the 2018 Health Information National Trends Survey and found that perceived knowledge of palliative care among Immigrants in the U.S. is poor.[47] Researchers also found that levels of knowledge of palliative care were significantly lower among women when compared to men.[40] Moreover, a scoping review by Puli et al. (2019) described the gaps in physician screening education regarding colorectal cancer screenings.[35] Additionally, Evola et al. (2022) found that patient perceptions varied among English language preference and non-English language preference individuals in regards to trust in government, symptom identification, preferred sources for information, and perceptions that cultural needs are met which could be indicative of the cultural contexts and differences that exist among Immigrants in the U.S.[48] Perceptions related to COVID-19 services and eligibility also vary among Immigrants, with LatinX Immigrants expressing concerns related to fear that providers will provide information to Immigrant authorities, and the perception that they are ineligible for COVID-19 testing and services.[49] Furthermore, there is a perceived knowledge of limited healthcare resources available at school-based health centers among Immigrants.[50]

Impact of COVID-19 and other world events

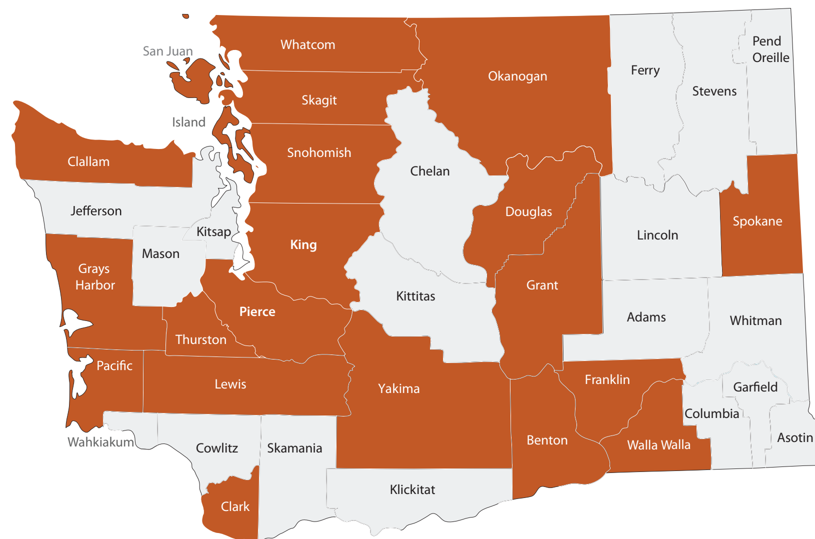
The effects of COVID-19 have disproportionately affected immigrant populations causing increased rates of stress, anxiety, and depression; increased risks of COVID-19 -related death; and decreased access to healthcare.[38,51] This population also faces lower rates of COVID-19 vaccine uptake due to vaccine hesitancy and fear of contact tracing – worsening physical and mental health outcomes.[30,37, 44] New U.S. immigration policies (e.g., public charge rule) at the state and federal levels and increased anti-immigrant rhetoric have also exacerbated poor health effects by serving as barriers to seeking healthcare services.[38-39, 41, 51-54] A qualitative study by Hoekstra (2021) found that healthcare advocacy is essential in combating the impacts of these policies, especially for undocumented immigrants who may experience exclusion and criminalization.[55] Another study by Yu et al. (2020) examined how these policies might affect the experiences of Undocumented Immigrants seeking healthcare services in Los Angeles county and found that these policies negatively impacted community support programs that aim to provide more affordable care, thus decreasing availability and accessibility to care among this population.[39] Finally, insurance coverage and eligibility changes over the years have impacted Immigrants’ access and quality of care. Recent calls to action have stated that Medicare coverage needs to be expanded to all US residents regardless of immigration status. Additionally, that cash-benefit policy eligibility must be increased to enhance access to quality healthcare among undocumented immigrants. [56-57]

Data Collection from CHCs

CHC CEO Survey Results

Eleven out of 27 CHCs responded to the survey, resulting in a response rate of 40.7%. Respondent CHCs are listed under Figure 06 below. These CHCs served a population of 830,201 patients (182,292 of which were uninsured) in 2021 and served over a catchment area of 21 counties in Washington. The map below illustrates the catchment area or "reach" of these 11 CHCs.

Figure 05: Map of Service Area of Responding CHCs



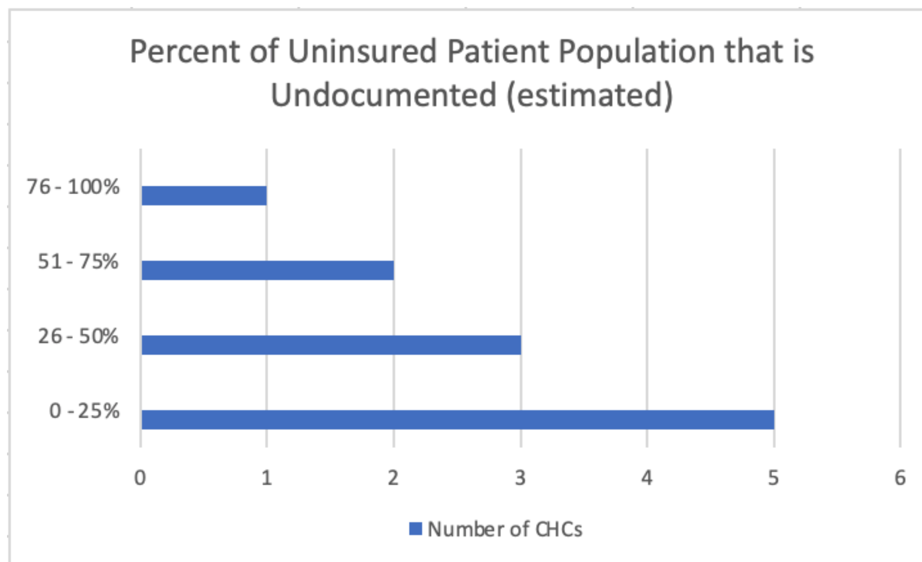
a. Yakima Neighborhood Health Services (Yakima County)
b. CHAS Health (Spokane)
c. Yakima Valley Farm Workers Clinic (Benton, Franklin, Spokane, Walla Walla, Yakima)
d. HealthPoint (King)
e. Community Healthcare (Pierce)
f. Moses Lake & Quincy Community Health Center (Grant)
g. International Community Health Services (King)
h. Sea Mar Community Health Centers (Clallam, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Pierce, Skagit, Snohomish, Thurston, Whatcom)
i. Neighborcare Health (King)
j. Family Health Centers (Douglas, Okanogan)
k. Valley View Health Center (Lewis, Pacific, Thurston)

None of the 27 CHCs collect information or document the immigration status of patients. This is consistent with circulated best practices to protect vulnerable patients, given ambiguity around the "discoverability" of protected health information or the utilization of aggregated data by U.S. Immigration and Customs Enforcement (ICE) and other government entities. As explained in the

Methodology section of this report, we hypothesized a high correlation between uninsured status and the undocumented population. Overall, respondents validated this hypothesis: 73% agreed there is a high correlation between the clinic's undocumented and uninsured patient population.

Given the lack of data available on patient demographics regarding legal immigration status, CHCs were asked to estimate the representation of undocumented individuals within the uninsured population. There is a wide variation (0% to 100%) across respondents, as reflected in the graph below but reflecting an average of 39% across all respondents.

Figure 06: Estimate of Uninsured Population that is Undocumented by CHC Respondents



Each CHC described the rationale used to reach this estimate. Most CHCs referenced a combination of their reliance on the "thoroughness" of their insurance screening process (and the fact that this population is not eligible for most benefits) combined with an estimate from clinical or administrative staff. Examples are provided below.

"Our organization is the only healthcare provider for the uninsured in the County. I believe the estimate is conservative based upon information gained from a survey of CHC staff that works with the patient population."

- ***CHC estimating 50% of the uninsured population are also undocumented***

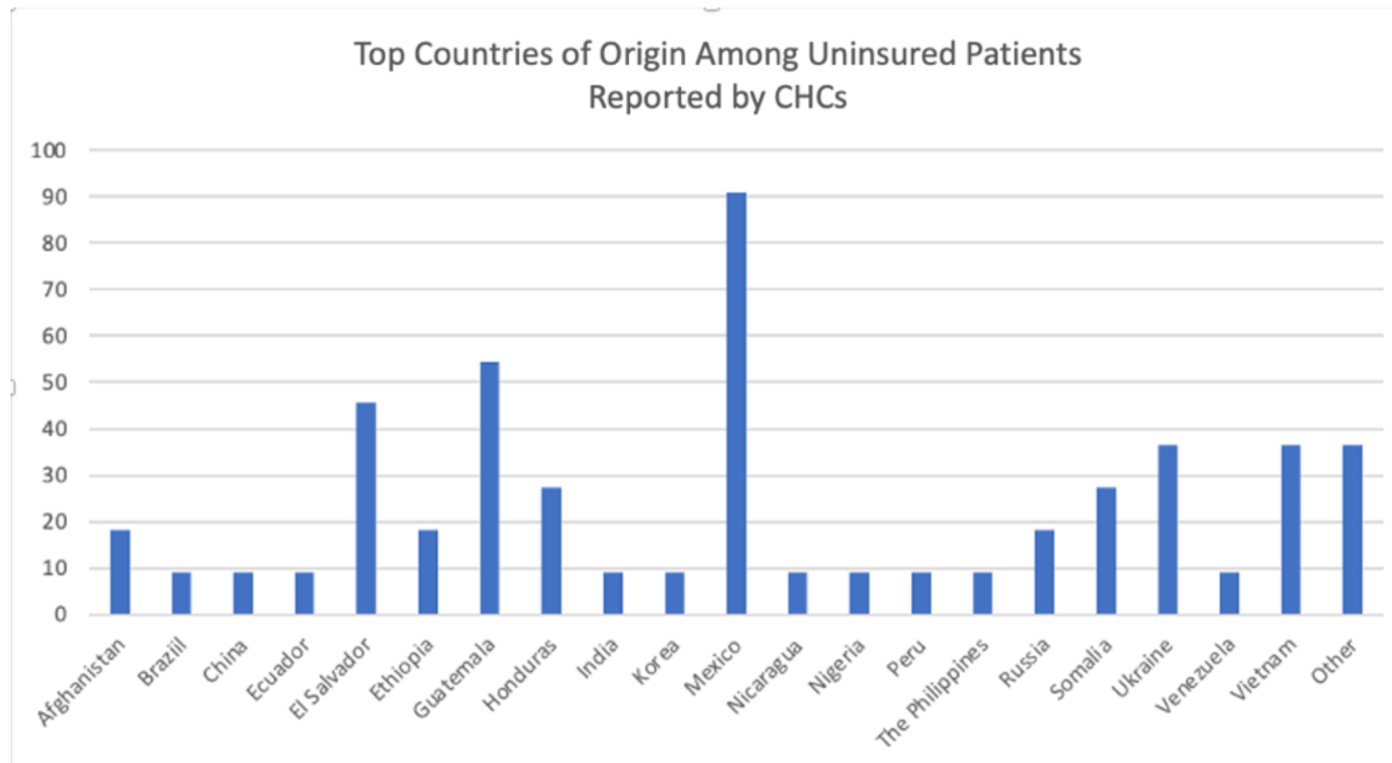
"We track payer mix and most of our sliding feel patients are ag(agricultural)/migrant workers who are mostly uninsured."

- ***CHC estimating 23% of the uninsured population are also undocumented***

Demographics of Undocumented Patient Population

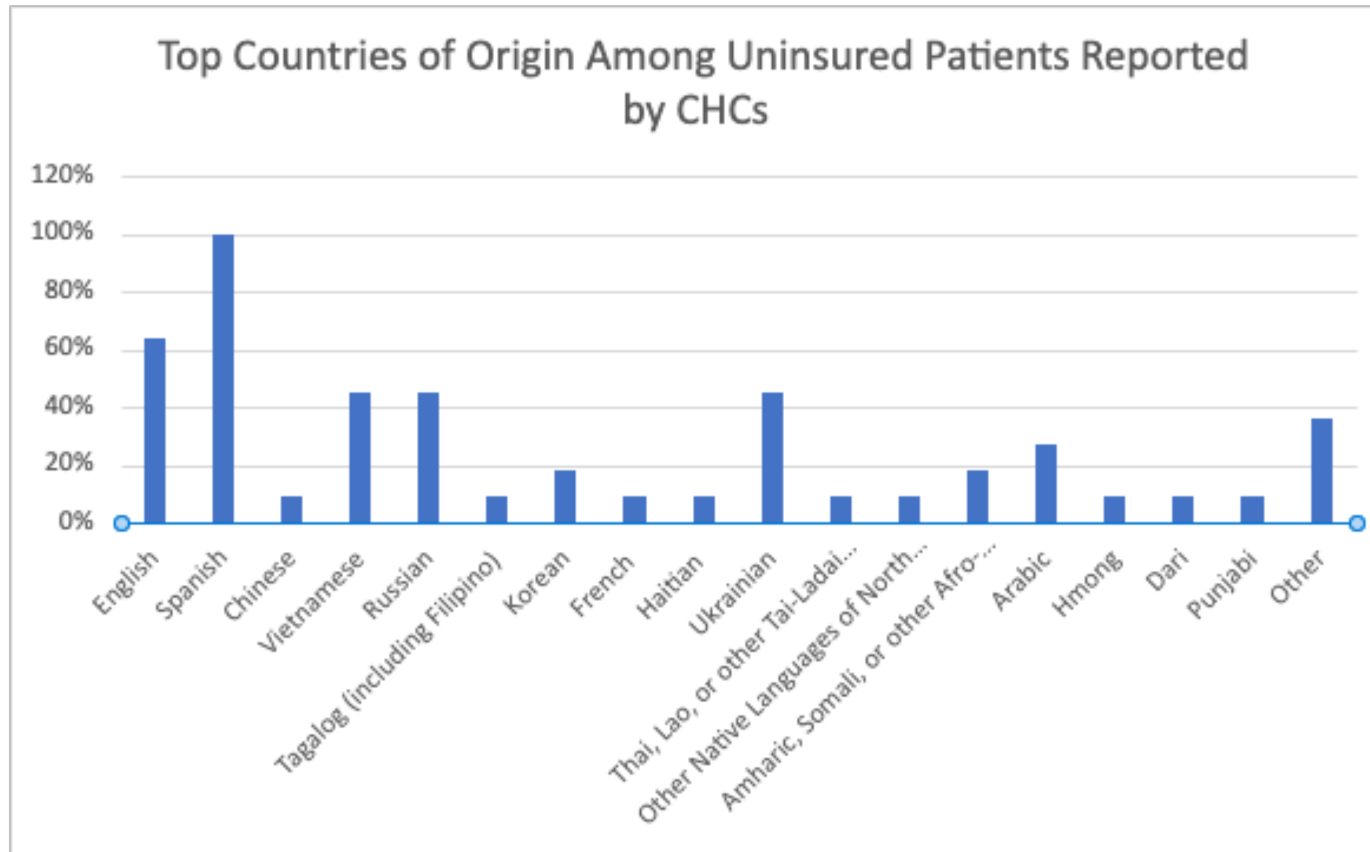
Overall, the top five largest immigrant communities among uninsured patient populations reported across CHCs are Mexico (cited by 90.9% of participating CHCs), Guatemala (54.6%), El Salvador (45.5%), Ukraine (36.4%) and Vietnam (36.4%). Countries specified in the “other” category include Iraq, South America, Thai, Lao or other Tai-Ladai, and Jamaica.

Figure 07: Top Countries of Origin Among Uninsured Patients



The top five languages most spoken by uninsured patients reported *across* CHCs include Spanish (cited by all respondents), English (63.6%), Vietnamese (45.5%), Russian (45.5%), and Ukrainian (45.5%). Languages specified in the “other” category include Marshallese, Trique, Mixtec, and Jamaican Patois.

Figure 08: Most Often Spoken Languages Among Uninsured Patients



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Observed Healthcare Patterns of Population

CHCs estimated that an uninsured patient receives care from their CHC 2-3 times a year, on average. This is slightly less often than the undocumented population, reflected below.

Figure 09

In your best estimate, how many times per year does an uninsured adult patient receive care at your community health center, on average?

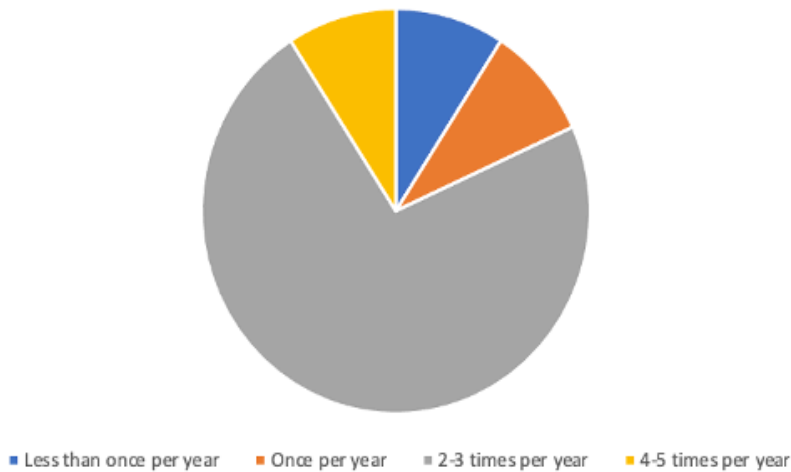
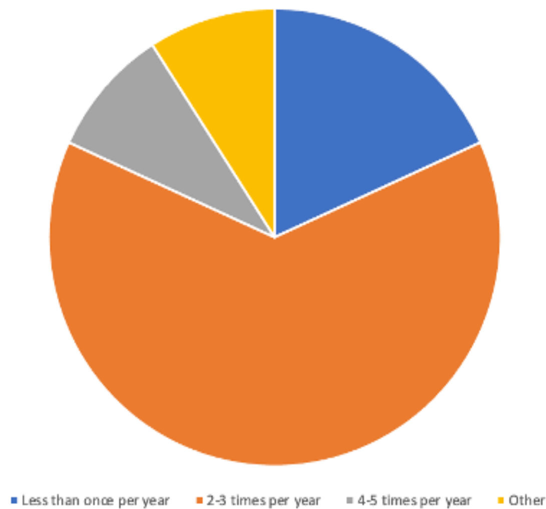


Figure 10

In your best estimate, how many times per year does an undocumented adult patient receive care at your community health center, on average?



Respondents underscored the **centrality** of the CHC as a primary source of healthcare for this population in their community. Two respondents cited that their CHC (or another CHC in the area)

was the only other source of routine care for this population. According to various respondents, the sliding fee scale and the reliable availability of services in the patient's language are determining factors. One CHC serving King County noted that there is a high degree of avoidance of the US healthcare infrastructure in general, with care being delayed as long as possible:

> ***"From staff's experience working with undocumented families, a lot of them who have a health problem don't actually seek medical care and avoid the US healthcare system altogether. These are usually older patients who live here part of the year and wait to get treatment in their home country. If they do get services, some would rather schedule appointments at hospitals. Some families trust hospitals more than their local clinic… A lot of the time, families just wait until things are really bad and they have to use the ER, because they just don't want to pay for a medical visit that won't solve their needs."***

Most respondents (81.8%) referenced the Emergency Room (ER) as a primary venue for care delivery. Five respondents referenced the ER as the *only* other venue utilized by this population, apart from their CHC. Extracted quotes are provided below:

> ***"Staff report that the ER is the only other place where undocumented patients seek care when we are not open."***
>
> ***"The only other provider of health services for this population is the ER. This is based upon patient interactions with patients."***
>
> ***"Staff/community members report undocumented patients primarily use the local ER or go without care."***
>
> ***"Emergency dept, other CHCs. We see this in our data systems for seeing where assigned patients go, and also hearing from patients about their own or family's experiences."***

Other venues for healthcare delivery that were identified include free clinics (18.2%), health fairs and mobile clinics (9.1%), and urgent care (9.1%).

Six CHCs (54.5%) responded to the free response question, which allowed respondents to provide any additional information they believe is important for us to understand about this patient population. Most of these responses provided further insight into the limitations of the data available to the respondent. Excerpted replies are listed below:

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It is very hard to track country of origin and directly coordinate with other organizations without shared systems or communications. Some information above is based on language rather than known country of origin.
We do not track citizenship status for any of our patients and this is why the data submitted is highly estimated. We do not track Provider One RAC codes since it is not needed for sending a claim. In our area we have significant number of patients that are not immigrants and are un-insured. It is also impossible to estimate the number of patients that are uninsured from the various countries of origin.
An insurance program for the undocumented should include the same interpreter reimbursement benefit as existing Medicaid programs, keeping in mind that the current Medicaid interpreter broker program needs improvement.
Most of this population comes from rural parts of Mexico and Central America where formal education is limited. Therefore, many are illiterate or limited in their own language.

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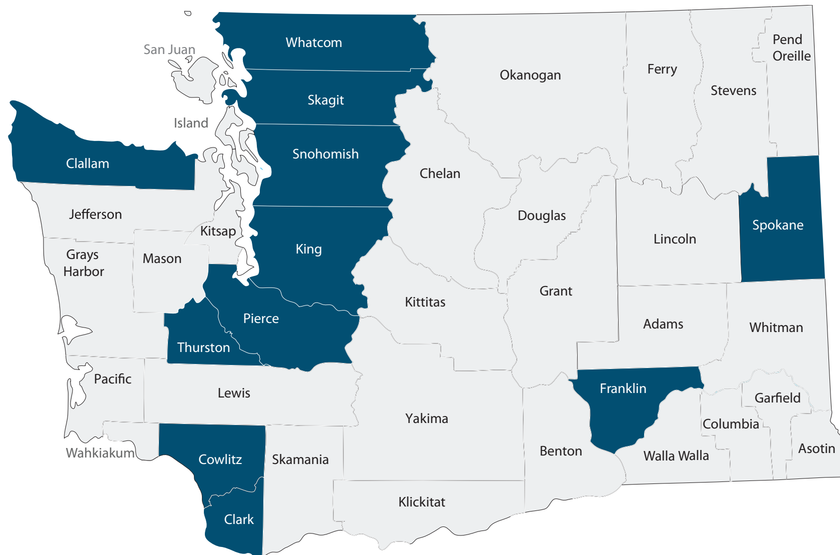
CHC CMO Survey Results

Five CHCs responded to the CMO survey, resulting in a response rate of 18.5%. Respondent CHCs are listed under Figure 11 below. These CHCs served a population of 400,995 patients (63,201 of which were uninsured) in 2021 and served over a catchment area of 13 counties. Three of the responding CHCs also responded to the CEO survey.

Figure 11: Map of Service Area of Responding CHCs (CMO Survey)



a. CHAS Health (Spokane)
b. HealthPoint (King)
c. International Community Health Services (King)
d. Sea Mar Community Health Centers (Clallam, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Pierce, Skagit, Snohomish, Thurston, Whatcom)
e. Carolyn Downs and Country Doctor (King)

In this survey, we asked the CMOs to identify the primary health needs of their clinics' undocumented (adult) populations. The majority (60%) cited chronic care management as the *primary* need of this population (with one specifying the specific condition of hypertension), with the remaining two respondents referencing the related category of (1) preventative care; and (2) medication. Individual responses are provided below, in descending order of importance.

Figure 12: "What are the top five health needs of undocumented adults served by your CHC?"

CHC 1	CHC 2	CHC 3	CHC 4	CHC 5
1. Chronic medical care 2. Acute medical care 3. Preventative medical care (routine) 4. Dental care 5. Behavioral health care	1. Hypertension 2. Diabetes 3. Chronic Pain 4. Dental 5. Counseling	1. Medications 2. Diagnostic testing (screening and evaluation, labs and imaging) Preventative medical care (routine) 3. Behavioral health beyond what primary care can 4. Dental care - procedures become costly even on sliding scale 5. Hospital care - rare, but can be financially crushing when occur	1. Chronic care evaluation and treatment 2. Primary care preventative interventions: immunizations, screening of chronic conditions and communicable diseases 3. Access to mental and behavioral health primary care evaluation and treatment, including PTSD. anxiety and depression 4. Dental care: acute (complicated caries, abscesses), and hygiene services 5. Optometry/refractory evaluation and treatment (glasses)	1. Preventative care 2. Pediatric wellness and vaccination 3. Behavioral Health 4. Dental care 5. Vision

Respondents were also asked to identify the primary barriers undocumented adult patients face accessing healthcare services. Affordability of care (including *but not limited to* insurance coverage), reliable transportation, the availability of services in their language, and fear of immigration enforcement or impact on immigration status through the public charge were cited by all respondents. Notable excerpts are included below:

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Table 01: Identified Barriers to Care as Reported by CHC CMOs

CHC 1	1. Cost of appointments (even with sliding scale) 2. Cost of medications (even with sliding scale) 3. Transportation to appointments 4. Access to specialists 5. Safe working conditions 6. Access to nutritious foods 7. Medical bills from ER visits
CHC 2	1. Access to health insurance similar to Medicaid 2. Clinics not accessible during nontraditional work hours and weekends 3. Transportation 4. There is no policy that would keep migration & Customs Enforcement agents out of medical clinics 5. Community education about services
CHC 3	1. Fear of being unable to afford care, of the public charge process, of inability to navigate even the best-intentioned parts of the byzantine US Healthcare system (such as CHCs)
CHC 4	1. Language 2. Transportation
CHC 5	1. Lack of access 2. Lack of knowledge about the services available 3. Unfamiliarity with the system 4. Linguistic challenges 5. Transportation issues

Respondents universally confirmed that undocumented patients generally lacked insurance. The following are excerpted feedback from respondents in response to this question that merits additional reference:

> ***"…in fact, sometime things will be diagnosed in pregnancy (i.e, dental treatment needs, depression, or diabetes) and it becomes more difficult to manage after pregnancy due to the loss of health insurance. Lack of health insurance often means less access to medical care for chronic conditions, delays in seeking care or diagnosis for acute conditions."***
>
> ***"Without insurance, our patients are reluctant to access care, because even if the visit is free or has a nominal charge, there may be labs or other tests advised that have an associated cost, or prescriptions, or referrals or follow-ups. Any/all of those may have their own financial assistance programs available, but each one is unique, creating its own additional barrier in time, knowledge, and trust in order to access affordable care. There are too many flaming hoops to jump through, and patients are therefore even further discouraged from actively participating in their healthcare, exacerbating disparities."***

Finally, in response to the question regarding where else this population routinely receives health services, 80% of respondents cited the Emergency Room (ER).[1] Most respondents (50%) cited the ER and other CHCs as the ***only*** other source of care for this patient demographic.

[1] It is notable that the only CHC that did not reference the ER as a source of care seems to have misread the question, and referenced other practical needs of this population, citing "Food, clothing, shelter" in their response.

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When asked about barriers to *enrolling* undocumented patients in available coverage, respondents referenced distrust of government, fear of deportation, literacy, and ability to navigate the enrollment process. Excerpted responses are listed below:

> ***Making sure that they are aware when they qualify! reducing fear that receiving benefits would affect their immigration status in the future***
>
> ***Historical mistrust/relationship building, outreach, lack of understanding of volume of undocumented adults in our community.***
>
> ***English literacy. Many will need one on one support with the paperwork. The more eligibility and application documents can be kept simple and streamlined, the better.***

Key Informant Interviews

Six key informant interviews were conducted. A total of 16 key informants from six organizations participated in these conversations (see Appendix H). Key informants were primarily asked about undocumented immigrants. Themes emerged about health needs and where undocumented immigrants are currently receiving care. Many themes emerged about barriers, facilitators, and recommendations for healthcare access and health insurance coverage enrollment.

Health Needs

While not asked directly about the healthcare needs of undocumented immigrants, key informants suggested that the population likely has serious health needs. The conditions mentioned included hypertension, heart disease, diabetes, and undiagnosed mental health conditions. One key informant shared, "Patient complexity [of undocumented immigrants] is much higher post-COVID – we have received triple the number of referrals. A sicker population may come in – even if a low number, they may have a much higher need than the average Medicaid patient."

> ***There's a variety of mental health issues. It's why sometimes you find alcoholism. Sometimes you see domestic abuse. It's a lot of things that come as a result of being away from loved ones for a long time, because once you get across the border, it's so dangerous to cross the border that you don't get to go back every year to visit your loved ones. You're stuck here until you're ready to go back for good, you know. So there's a lot going on in that population that is unattended to. – Key Informant from a Community Health Center***

Locations Currently Accessing Care

Key informants primarily assessed that undocumented immigrants are currently accessing services at community health centers, free clinics, or hospital emergency rooms if they are receiving any healthcare services. Most key informants agreed that undocumented immigrants tend to avoid care until it becomes emergent, which often results in emergency room visits. Key informants from community health centers assumed most of their uninsured population comprises undocumented immigrants or legal permanent residents in the five-year bar. Two other key informants thought most of their patients or clients were undocumented immigrants. Key informants also pointed out that many immigrants rely on traditional healers and home remedies.

Barriers to Accessing Healthcare Services

Many barriers emerged in conversations with key informants about undocumented immigrants' access to healthcare services. The barriers were grouped into four themes: cost, immigration status, cultural and language, and social determinants of health. These barriers result in delayed care, resulting in a sicker population, death, disabilities, living with injuries, or obesity. These barriers result in trips to the emergency room and the need for more expensive specialty care.

Cost

Cost is a barrier for these immigrants because they typically lack access to health insurance coverage. All costs are perceived as a substantial barrier precluding them from accessing care. The costs of specialty care, hospital emergency room visits, and paying for care on the sliding fee scale at community health centers or for prescription drugs were highlighted by key informants. One key informant pointed out that undocumented immigrants are not eligible for most pharmaceutical company drug assistance programs due to a social security number requirement. This can make it harder for undocumented immigrants to access high-cost medications.

Immigration Status

The second barrier is their immigration status. Their lack of legal documentation makes them fearful of deportation, a powerful barrier for immigrants who have resided here for an extended time and have started families. They want to keep their personal information private in healthcare settings. The impacts of public charge go beyond enrolling in benefits. The proposed changes to the "public charge" rules in 2017 instilled concern among undocumented immigrants that accessing healthcare would result in them being labeled a "public charge." Being labeled a public charge would negatively affect their immigration status. The recently implemented public charge rules remove many of the threats of the initial proposal. Still, it may take time for immigrants to feel more comfortable taking risks that may impede their future legal status.

Cultural and Language Differences

Key informants mentioned a lack of trust in healthcare settings, systems, and providers as a reason immigrants may avoid care. One reason for the lack of trust in healthcare settings is a need for more communication about what to expect from the visit or related costs, resulting in surprises and a long-term lack of trust. Immigrants tend to rely on home remedies, herbs, elders, and traditional medicine, typically not reflected in their experience with the U.S. medical system. Some immigrant groups have a high distrust of government agencies that "creates an immediate red flag," according to one key informant. This is particularly evident for immigrants from countries undergoing recent unrest, including Afghanistan, Ukraine, Russia, and certain Central and South American countries.

Another cultural barrier cited by many key informants is stigma related to mental healthcare. One key informant shared that mental health is highly underdiagnosed in their immigrant communities. Many immigrant women in their community use their priest as their counselor instead of engaging with mental health or behavioral health providers. Another key informant mentioned that cultural barriers had been particularly challenging for female Afghan refugees who have been through trauma and need mental health support. An Afghan psychiatrist shared that it would take two to three years for the family to adjust and build trust with the system, particularly the male head of households, as they make decisions regarding the women reaching out for services.

Language remains a significant barrier that impacts health literacy. English language proficiency varies among immigrant populations. One key informant shared, "it varies widely; in the older populations, our more senior members, [English proficiency] is maybe 5th or 6th grade. And when we're looking at younger generations, especially those who came to the U.S. when they were young, they're pretty proficient. There is vast variation depending on when somebody came to the U.S., their age, and where they live." Guatemalan immigrants in Mason and Kitsap counties speak Mam, an indigenous Mayan language, and tend to have less English than native Spanish speakers. Multiple key informants shared that undocumented immigrants in their communities have some work-related English and may be able to schedule appointments. However, one key informant pointed out that conversational English does not mean they are medically proficient.

Immigrants will want interpreter support during medical appointments even if their English skills are moderate. Multiple key informants also highlighted the challenges of limited English proficiency and filling out forms for financial assistance at the hospital. One key informant mentioned how time-consuming it is to wait for an interpreter at a specialist appointment. Another said that the current interpreter service broker through the Healthcare Authority is unavailable for urgent care visits and indigenous languages are unavailable. Unfortunately, one key informant shared, "immigrants depend on their little kids. So, a lot of times you'll have a family bringing an 8-year-old to interpret in a clinical visit, because they're used to using that 8-year-old at the post office, at the grocery store, at the school...Coming in [to the clinic] is a bit of a challenge sometimes." Translated

documents may provide some language assistance, but materials are often not translated into multiple languages. Key informants cautioned that some immigrants might have low literacy in their native language.

Low health literacy presents in various ways as barriers to care. The U.S. healthcare system is complicated, and patients often need more awareness about navigating between providers, particularly at unfamiliar hospitals or medical centers that lack language support in community health centers and free clinics. They may not know what to expect during a doctor visit or be familiar with what we consider “preventive care.” If immigrants lack primary care, they may go directly to the emergency room to meet their needs because they are unaware of other options.

Obesity spells success. That means you have enough money to have an overweight child, so you must be doing pretty well. From a food scarcity standpoint, skinny means you are starving. The non-English speaking caretaker may be responsible for all of the nutrition for the whole family, and we’re not even getting to them. Those Grandmas are not coming in for their wellness checks. – Key Informant from a Community Health Center

I heard a story today about a patient who is undocumented. He’s got a condition where he is probably going to die but because he didn’t understand how to navigate the healthcare system and big complex hospital systems, he was marked as being non-compliant. He is not an English speaker, and he needs a lung transplant. – Key Informant from a Community Health Center

Many immigrants use smartphones to connect with family in their native country via WhatsApp or other apps but typically have limited digital access or literacy. They may have digital access but have not been taught to fill out forms on a website or to search for information on their phone. One key informant said that, like English language proficiency, digital literacy varies depending on age, where they live, and the period they arrived in the U.S. Another key informant pointed out that some areas in their community experience poor cell phone access and have limited high-speed internet. Telehealth is harder for immigrants because of these barriers. One CHC found that audio-only telehealth visits are easier for the patients (though not preferred by providers). They reported, “we have staff who…have to call patients and walk-through step by step, where to click so that they can launch the virtual appointment.” Related to this same challenge, one key informant mentioned, "People could do a phone call…but anytime there needed to be logging into MyChart or looking at a screen, it never once worked.”

Social Determinants of Health

Many immigrants live in poverty and are experiencing housing and food insecurity, often placing healthcare lower on their priority list.

> ***The social determinants of health are so high, that a parent would rather spend money on something they need that is basic and important, than think about taking their child for mental health. On their scale of needs, it might be on the bottom. – Key Informant from a Community Health Center***

Transportation to a healthcare provider may be challenging because many immigrants do not have a car. If they have a car, they may not have a driver's license and fear driving more than necessary. Or the car may be used by the primary driver for work, leaving the rest of the household without transportation for that time. Many undocumented immigrants in some communities are agricultural workers "who don't have permission to take off work. This is not an employee pool who has 10 sick days to use, and they're not getting a dime to send back home if they're not working." Arranging childcare is also a barrier recognized by key informants.

Supports for Accessing Healthcare Services

Throughout the interviews, supports for accessing healthcare services were shared. The facilitators were grouped into three main themes.

Building Trust

A key theme is building trust. All the key informants referenced trust as critical to making people feel safe and comfortable accessing healthcare. Having multicultural staff and providers and language assistance in healthcare settings was perceived as a significant facilitator among the key informants. Other ways to build trust were by providing naturopathic medicine or physicians having the cultural competency to respect their culture's preferred remedies. Community health center key informants referenced community health workers as being extremely helpful in helping to build trust with immigrants. One key informant shared that "community health workers know at what level to talk to the person" because they are a peer.

Initiating Care at Primary Care Clinic

CHC key informants also perceived patients initiating care at a primary care clinic as a critical enabler for accessing healthcare services more regularly. In one CHC, Worker's Compensation claims provide an entry point for undocumented agricultural workers. Another entry point is positive experiences in a clinic setting being shared within the community. The sliding fee scale facilitates ongoing care in community health clinics.

Community-based Organizations Partnering to Increase Access to Care

Some key informants create unique partnerships to increase access to care. Project Access Northwest connects uninsured individuals to specialty care. This requires partnerships within the healthcare system and the ability to work well with uninsured individuals, many of whom are undocumented immigrants. Kitsap Immigrant Assistance Center partners with West Sound Free Clinic to host free clinics and refer immigrants to Peninsula Community Health Services (the local community health center) and Project Access Northwest, as appropriate. Sea Mar Community Health Centers has partnered with legal assistance organizations to bring immigration services to select clinics.

Recommendations for Increasing Access to Healthcare Services

Key informants shared recommendations to facilitate immigrants accessing healthcare. Recommendations are divided into system-level and provider-level because some recommendations are more appropriate for WAHBE, and others are more appropriate in the clinical setting.

System-Level Recommendations

Ensure Health Insurance Program Name is Not Linked to Immigration Status

At the system level, multiple key informants suggested that program enrollment should not be linked to an individual's immigration status. Concerns were shared about potential discrimination from clinic front-desk staff if new coverage options for undocumented immigrants referred to "alien assistance" or otherwise identified the patient as being undocumented.

Provide Initial and Ongoing Education on Preventive Care, Terminology, Costs, and Health System Literacy

Initial and ongoing education on preventive care, health system literacy, and health insurance terminology will help immigrants to understand and better navigate our healthcare system. These efforts should happen at a system level because they are needed by all immigrants who may be interfacing with different healthcare systems and clinics. Specifically, costs will likely remain a significant barrier to care even with new coverage options for undocumented immigrants. Key informants recommend ensuring immigrants understand their out-of-pocket costs for care upfront.

Ensure Workforce Supply Meets Demand

One key informant expressed serious concerns about system capacity constraints and if undocumented immigrants would be able to access care. They fear inadequate provider networks, long wait times, and delayed care.

> ***Who is going to take this coverage? Who is going to be accepting this coverage? Who are the Medicaid providers and what's their capacity and interest in taking on more patients, especially if they are inadequately compensated? – Key Informant Who Indirectly Supports Immigrant Access to Care***

This issue needs to be addressed. Much work in our state is happening to increase workforce supply, but it will remain a serious issue to address as more populations receive insurance coverage.

Provider-level Recommendations

Create Visual Documents

One key informant recommended that providers use documents with graphics or pictures to help with literacy challenges. Some organizations have had better luck with infographics with more images and less text. Ensuring font size is no smaller than 12-point will help immigrants with poor eyesight.

Make Immigrants Feel Safe

The most prominent recommendations at the provider level are grouped as "make immigrants feel safe." Recommendations in this area include ensuring immigrants receive language assistance and cultural competency during their healthcare setting experience and using community ambassadors to increase access to healthcare services.

Language assistance is not limited to interpreter services during the physician visit. It also includes language assistance for the non-medical elements of their healthcare visit to help them with follow-up and referral services. Hiring multicultural staff with multiple languages will help immigrants feel more comfortable getting through their visit to a healthcare setting without depending on their children or other family members. Another way to make immigrants feel safe is by ensuring there is an available trusted resource – someone who can be reached directly in a clinic (via text, direct phone, or in-person) who speaks their language. Multiple key informants provided this recommendation. One key informant mentioned knowing of such a person in one clinic because many of their clients refer to her by name. This individual can be found in the waiting room of the local community clinic, and the immigrants in the community rely on her for their needs.

Other key informants mentioned that once comfortable, immigrants will bring in non-healthcare-related letters for clinic staff to help translate. This demonstrates the need and demand for trusted resources in the community. In some cases, a community health worker can fulfill this role. Immigrants rely on community health workers because they come from their communities and understand their barriers to healthcare services. Key informants recommend increasing the number

of community health workers in healthcare settings to help facilitate immigrants' access to healthcare services.

Respecting the cultural values and traditional medicine of immigrants is another way to make them feel safe. Few immigrants were raised to rely on Western medicine; their cultural values or reliance on traditional medicine may need to be better understood and respected by physicians. But key informants encourage physicians to take a "both/and" approach to these cultural differences. Both traditional and Western medicine approaches may have value, and the patient and their provider have a right to their own experiences and preferences. Both can be used to treat the patient if one is not contraindicated.

Key informants recommend using community ambassadors to help make immigrants feel safe utilizing healthcare services. One key informant who indirectly supports immigrant access to care said, "There is always a hesitancy about if they should go to a place or not. When they hear it from trusted sources, and people in their communities attend, they attend, they are reassured." Community ambassadors could be religious leaders or leaders within their community. Healthcare settings should consider how they can utilize community ambassadors to increase access to care.

Provide In-Person Support for Referrals

Another recommendation at the provider level is to provide in-person support for referrals. Several key informants referenced the challenges immigrants have navigating the healthcare system when they leave the primary care clinic setting. Often, a referral is made, resulting in a back-and-forth phone tag to schedule a specialist visit. This may result in a specialist visit not being scheduled, which can be perceived as noncompliance and result in adverse health outcomes. One key informant referenced hearing immigrants say they did not need a referral and had already seen a doctor, failing to understand that they had seen a primary care doctor but also needed a specialist. In-person referral assistance will minimize disruptions in care and help get immigrants the follow-up care they need.

Simplify Access to Care

Simplifying access to care is a critical way to facilitate access to care for immigrant populations. Mobile units, digital navigators, and telehealth were all mentioned by key informants. Clinics should deploy mobile units to reach immigrants where they are instead of expecting immigrants to be able to come to healthcare settings. Mobile clinics are critical to reaching farmworkers who cannot take time off to seek healthcare during their workday. Another way to simplify access to care is to use digital navigators. At this time, key informants mentioned that it is easier for many of the immigrants they serve to only engage in audio-only telehealth visits with their providers, even though providers typically want to see the patient visually. Digital navigators are expected to help

build digital literacy and digital access over time. However, telehealth should be relied upon as much as possible (audio-only or otherwise) to increase access to care best.

> ***Perhaps we need to think outside the box here, we have new Afghan and Ukraine refugees in our areas. When the community got here, everyone was pitching in to provide them needed services and we saw quickly that medical care was a big need. We decided to go to the place where they are. It is very difficult to bring the services to the site, but it is the only thing that works as far as having the patient be seen by a clinician. Just having the services available is not enough. – Key Informant from a Community Health Center***

Barriers to Health Insurance Coverage

Key informants shared that several barriers prevent undocumented immigrants from enrolling in health insurance coverage.

Distrust in Government

Distrust in, or fear of, the government is particularly challenging following the public charge changes proposed by the Trump Administration. It takes time for accurate information to spread and for individuals to rebuild trust. Many key informants mentioned this as a barrier to insurance coverage. One key informant also said that some immigrant communities perceive some Americans' stigma toward receiving state assistance, which may make them more reluctant to accept it.

Cost

Cost remains one of the most significant barriers to health insurance coverage. The out-of-pocket cost of premiums, deductibles, and co-pays is a substantial barrier for individuals and families with limited resources. A fluctuating income or lack of documentation of income may also present a barrier for many undocumented immigrants to enroll in health insurance coverage. What may be affordable one month may not remain affordable next month.

Digital Limitations

Digital limitations present another obstacle to health insurance coverage. Many immigrants use digital technology solely for communication and need help navigating websites. Many key informants felt that even if immigrants have a cell phone or other digital technology, they are unlikely to have the digital literacy to fill out forms or navigate a complex online application process without in-person assistance. Most key informants said navigating a website like *Washington Healthplanfinder* would be challenging, with limited English proficiency. One key informant shared, "*Washington Healthplanfinder* is really hard to navigate for people with all the privileges and

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abilities; questions aren't always clear." The complexity of any insurance product compounds this limitation. All respondents stressed that understanding and comparing insurance terms is challenging, including navigating a platform in one's native language. That difficulty is exponentially compounded when navigating a platform in another language or where the navigation is not intuitive. One key informant said, knowing the challenges native-English speakers have, "I cannot imagine the barriers that would go into undocumented people buying off the Exchange."

Another informant gave an example of her staff's assistance when helping patients with their health insurance coverage information and accessing *Washington Healthplanfinder*. Staff had to explain to a patient that "a password is like a key; if you want me to fix the light in your house, you have to give me the key." Navigators regularly encounter digital limitations.

Not Perceiving Value of Coverage

The value of coverage is not perceived by all people equally. Key informants worry that undocumented immigrants familiar with going without coverage will continue to do so because they may not perceive the value of paying a monthly premium when they may not need healthcare monthly. The concept of health insurance is likely a foreign concept to some immigrants, including the jargon used with it (e.g., deductible, premium, co-pay, cost-sharing). The complexity of health insurance products (including deductibles, co-pays, etc.) can also impede their perceived value.

Supports for Health Insurance Coverage

Immigrant Children Eligible for Apple Health for Kids

One of the strongest supports for health insurance coverage mentioned by key informants was that many immigrant children are already enrolled in Apple Health through the Children's Health Program. Their parents have some awareness of *Washington Healthplanfinder* and the Washington State Healthcare Authority.

Enrollment Assistance to Help Individuals Enroll in Coverage

Other key informants cited enrollment assistance to help enroll in coverage as a significant facilitator for coverage. Many key informants referenced navigators; some specifically pointed to bilingual or multilingual navigators working in community health centers. One key informant mentioned that hospital financial assistance staff have been particularly helpful in enrolling immigrants in coverage in their community.

Social Service Agencies

Multiple key informants mentioned that social service agencies already play a significant role in helping to connect immigrants to community resources. Kitsap Immigrant Assistance Center was contracted to help immigrants apply for the Washington COVID-19 Immigrant Relief Fund.

Contracting with organizations with deep ties and relationships in their community is a meaningful way to facilitate enrollment in health coverage. Kitsap Immigrant Assistance Center lacks the capacity to become a navigator, but they would welcome navigators to come onsite and help enroll their clients into health insurance.

Covered Benefits

The covered benefits available from health insurance may facilitate enrollment. Individuals may need to be more familiar with the typical benefits covered by health insurance and are often more interested once they know more about the covered benefits. One key informant mentioned that immigrants need to understand mental health and counseling benefits better, and "they may be happy to be able to get counseling from a mental health professional instead of their priest."

Outreach Via Trusted Resources

Outreach via trusted resources is vital in facilitating enrollment in coverage. In the past, schools were particularly helpful in enrolling children into Apple Health coverage. Community clinics have a long history of working with patients to assess program eligibility and enroll families into coverage. The key is that they had a relationship of trust with immigrants, making immigrants willing to share their personal information.

Recommendations to Increase Health Insurance Enrollment

Key informants made extensive recommendations in our conversations about ways to increase health insurance enrollment among undocumented immigrants.

Provide Clear Information and Messages

Most key informants referenced public charge and a need to provide clear information and messages about the impacts of obtaining health insurance on their public charge status. One key informant pointed out having experienced inconsistency between immigration attorneys and public benefits attorneys, which will require coordination to develop appropriate and accurate messaging for undocumented immigrants.

Additional information on data privacy, proof of income when paid in cash, and benefits and costs will be needed. Key informants expect some of these issues to need to be better understood or worth explicit explanations for immigrants to feel safe applying for coverage.

Create Education Tools and Training Opportunities for Immigrant Communities

Key informants recognize that immigrant communities would benefit from more education and training about our healthcare system and other topics to build health literacy. Key informants identified the following issues for ongoing education: healthcare system navigation, what

communications to expect from which entity related to health coverage, the responsibilities of different state agencies, the enrollment systems used by state agencies, preventive care, and insurance jargon. One key informant mentioned how confusing it is for their immigrant patients when they get communications from *Washington Healthplanfinder*, their Qualified Health Plan (QHP), and their provider. Their clinic staff finds "it is helpful to have staff let folks know that they will receive a letter after they enroll or see the doctor. That way, they will know what to expect. And this helps build comfort on the whole process/system." This comfort cannot solely be put upon individual providers and should be considered a system-level intervention.

Immigrant communities would also benefit from enrollment training videos in different languages. WAHBE should consider creating enrollment training videos in various languages to better communicate the enrollment process with immigrant communities. In-person training designed by WAHBE but facilitated by CBOs could also help to increase understanding and awareness and help newly eligible individuals feel more comfortable using *Washington Healthplanfinder* to enroll in health insurance.

Enhance Enrollment Opportunities for Initial Years

Two new coverage options may be available to low-income undocumented immigrants in 2024. The potential exists for undocumented immigrants to flood the system to enroll. Key informants made two recommendations for WAHBE consideration. First, consider extending the length of open enrollment for the first year. While eligibility in a Medicaid-like offering will be open year-round, enrollment in a QHP is time-limited to the open enrollment period. Key informants expressed concern that it will take time to build trust and convince immigrants of the value of coverage.

Along with this, key informants suggested that more navigators will be needed to help enroll immigrant communities into coverage. Particular attention should go to diversifying navigators from within immigrant communities. If they use an appointment-based model, navigators should plan for longer appointment times to complete the application process.

Conduct Broad Outreach to All Immigrant Communities

Key informants pointed out that the WAHBE should reach all immigrants, not just undocumented immigrants. Many legal immigrants remain uninsured despite being eligible to purchase coverage on *Washington Healthplanfinder*.

The Department of Social and Health Services (DSHS) recently completed outreach for the Washington COVID-19 Immigrant Relief Fund. Our understanding from key informants is that the Washington Immigrant Solidarity Network contracted with various immigrant service organizations throughout the state to help immigrants apply for funding. The model has been quite successful.

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The WAHBE should consider replicating this model to outreach to immigrants about new health coverage options.

The WAHBE should use trusted resources for outreach, including foreign language-sponsored Facebook ads, radio channels through Facebook Live, English language media, private forums used by immigrant communities, DSHS Community Service Offices, English Language Learning programs, schools, employers, churches, immigrant assistance organizations, and community clinics. Key informants worried that employers would be overlooked. WAHBE should work to identify employers who may be motivated to encourage their employees to enroll in health coverage through *Washington Healthplanfinder*. Community ambassadors and community leaders should be sought for additional outreach assistance.

Outreach materials should be translated into various languages, and flyers should be placed in grocery stores and ethnic markets. Materials should be distributed to moms through local Parent Advisory Councils, organized through the *Office of Superintendent of Public Instruction's Migrant Education Program*. The WAHBE should print translated flyers and distribute them to CBOs and CHCs or provide grants for self-printing. Key informants suggested that immigrants likely need to receive printed information and process it before hopefully coming back to take the next steps.

> ***Mam and Q'anjob'al aren't languages people read, so don't spend waste your money translating written materials into those languages.***
>
> ***– Key Informant Working with Immigrants in Kitsap County***

Ensure Health Insurance Program Name is Not Clearly Linked to an Individual's Immigration Status

A repeat recommendation from the recommendations to increase access to healthcare services is to ensure the health insurance program name is not clearly linked to an individual's immigration status. Immigrants live in fear and face stigma and bias regularly. Key informants expressed concern that any program name identifying immigrants as undocumented would be problematic and impede insurance enrollment.

Simplify Enrollment Process

The current *Washington Healthplanfinder* application and enrollment process needs to be simplified. Any efforts to streamline the process, especially for undocumented immigrants for whom English is not their first language, would be most appreciated. Key informants referenced having to troubleshoot often on behalf of their clients and patients. Sometimes this requires one quick phone call to the right person, but other times it requires more extensive follow-up over a longer time. Additional WAHBE and Healthcare Authority resources would help to troubleshoot these issues quickly when they arise.

Limitations

One person conducted all the coding and theming of the interviews due to capacity constraints. While this led to consistency in the inductive coding process, qualitative research is more defensible when multiple coders are used and when high inter- and intra-coder reliability is obtained.

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Table 03. Themes from Key Informant Interviews and Focus Groups

<table>
<tr><th colspan="2">Key Informant Interview Themes</th><th colspan="2">Focus Group Themes</th></tr>
<tr><td colspan="2">Barriers to Accessing Healthcare Services</td><td colspan="2">Barriers to Accessing Healthcare Services</td></tr>
<tr><td>Cost</td><td>Cultural & language differences</td><td>Cost</td><td>Cultural & language differences</td></tr>
<tr><td>Immigration status</td><td>Social determinants of health</td><td>Lack of legal status</td><td>Social determinants of health</td></tr>
<tr><td colspan="2">Facilitators to Accessing Healthcare Services</td><td colspan="2">Facilitators to Accessing Healthcare Services</td></tr>
<tr><td>Trust</td><td>Initiating primary care</td><td colspan="2" rowspan="2">Language and interpretation</td></tr>
<tr><td>CBOs partnering to increase access to care</td><td></td></tr>
<tr><td colspan="2">Recommendations to Increase Access to Care</td><td colspan="2">Recommendations to Increase Access to Care</td></tr>
<tr><td rowspan="3">System-Level</td><td>Ensure immigrants have an upfront understanding of out-of-pocket costs for care</td><td colspan="2" rowspan="7">Make immigrants feel safe</td></tr>
<tr><td>Provide ongoing education</td></tr>
<tr><td>Ensure workforce supply meets demand</td></tr>
<tr><td rowspan="4">Provider-Level</td><td>Create visual documents</td></tr>
<tr><td>Make immigrants feel safe</td></tr>
<tr><td>Provide in-person support for referrals</td></tr>
<tr><td>Simplify access</td></tr>
<tr><td colspan="2">Barriers to Health Insurance Coverage</td><td colspan="2">Barriers to Health Insurance Coverage</td></tr>
<tr><td>Distrust in government</td><td>Cost</td><td>Complicated online application process</td><td>Health insurance jargon is confusing</td></tr>
<tr><td>Digital limitations</td><td>Not perceiving value of coverage</td><td>Swiftly changing immigration policies</td><td></td></tr>
<tr><td colspan="2">Facilitators to Health Insurance Coverage</td><td colspan="2">Facilitators to Health Insurance Coverage</td></tr>
<tr><td>Immigrant children eligible for Apple Health for Kids</td><td>Covered benefits</td><td>Trusted resources</td><td>General awareness of coverage opportunities or lack thereof</td></tr>
<tr><td>Enrollment assistance to help individuals enroll in coverage</td><td>Social service agencies</td><td>Immigrant children eligible for Apple Health for Kids</td><td>Language assistance</td></tr>
<tr><td>Outreach via trusted resources</td><td colspan="3"></td></tr>
<tr><td colspan="2">Recommendations to Increase Enrollment in Insurance Coverage</td><td colspan="2">Recommendations to Increase Enrollment in Insurance Coverage</td></tr>
<tr><td colspan="2">Ensure clear information and messages</td><td colspan="2">Expand outreach model and appropriately fund trusted resources for immigrant communities</td></tr>
<tr><td colspan="2">Create education tools and training opportunities for immigrant communities</td><td colspan="2">Ensure clear information and messages</td></tr>
<tr><td colspan="2">Enhance enrollment opportunities in initial years</td><td colspan="2">Simplify application process and resources, and translate materials into different languages</td></tr>
<tr><td colspan="2">Simplify enrollment process</td><td colspan="2" rowspan="3"></td></tr>
<tr><td colspan="2">Conduct broad outreach to all immigrant communities</td></tr>
<tr><td colspan="2">Ensure health insurance program name is not linked to immigration status</td></tr>
</table>

Focus Groups

We conducted four focus groups with 47 total participants. The focus group themes were aligned with the key informant interview themes related to healthcare access and coverage. They also provided more information about specific themes.

Qualities and Strengths of Immigrant Communities

When asked about the qualities and strengths of immigrant communities, focus group participants shared that they have willpower and are hard-working, resilient, and generous. They were described as "cooperative," having relationships within the community and being united as a group. They have strong family ties and seek to assimilate into the Western culture while maintaining their cultural traditions. Above all, they want legal status.

Health Needs

The focus groups shared that immigrant communities need broad access to healthcare services. Participants broadly mentioned chronic disease management, dental care, cancer treatment, behavioral healthcare, and preventive care as immigrant communities' most prominent health needs. One focus group participant pointed out the climate change-related health issues becoming more evident for outdoor workers, such as exposure to wildfire smoke.

Locations Where Immigrants Currently Access Care

Focus group participants seemed to agree that most undocumented immigrants were currently accessing care from clinics (community health centers or free clinics) and hospital emergency rooms. Of course, most of the focus group participants worked in community health centers. One focus group participant reported that many undocumented immigrants rely on the Union Gospel Mission's free clinic in Yakima; another participant noted that some undocumented immigrants feel unsafe going there because of the homeless population in and around it.

Accessing Healthcare Services

The focus group themes of barriers and facilitators to healthcare access mirror the themes found in the key informant interviews. Focus group participants noted that a specific transportation barrier to healthcare services is not being able to take the driving test in their native language in their community (instead, having to travel to Yakima or Seattle).

Recommendations were primarily about building trust and making immigrants feel safe. One recommendation to increase healthcare access to care is to keep Immigration and Customs Enforcement (ICE) officials out of healthcare settings. Another is extending hours to meet better the needs of immigrants who work weekdays.

Enrolling in Health Insurance Coverage

Many focus group participants were CHC enrollment workers who help their communities through the *Washington Healthplanfinder* application process*.* The themes collected from these conversations largely mirrored those of the key informants. Focus group participants found that

lack of digital resources, digital access, low digital literacy, and limited English proficiency compounded *Washington Healthplanfinder's* complicated online application process. One focus group participant mentioned having to call the Healthcare Authority for each applicant without a Social Security Number, which adds time and complexity. Other focus group participants said that health insurance jargon is consuming for the people they work with. Facilitators of coverage include trusted resources, such as navigators from their community, trusted community members, family members, and community health workers. Having Apple Health for Kids cover undocumented children was mentioned as an additional facilitator of coverage.

Recommendations for increasing enrollment in health insurance were like those of key informants. However, they wanted to ensure that the outreach model was expanded and appropriately funded with trusted resources for immigrant communities. CBOs already serve immigrant communities and can help with outreach. They may not have the desire or capacity to be navigators, but they should be funded to engage in the outreach effort. This is particularly important given the recent success of the Washington COVID-19 Immigrant Relief Fund outreach effort. Navigators remain critical to helping enroll the community, and the WAHBE should ensure they are well-trained, in-person, and speak the language of their community's immigrants as much as possible. Digital navigators were also referenced as an important resource to bolster in advance of coverage expansions.

Other recommendations to enhance coverage were consistent with the key informants, such as clear information and messages on public charge and data privacy and providing flyers in multiple languages.

Limitations

The focus group discussion guide was ambitious in length. Facilitators opted to prioritize discussion. As a result, not all focus groups completed the list of questions for focus groups.

Additional Feedback from Other Stakeholder Engagements

Throughout conversations with CBOs, other important points were raised. One CBO representative expressed doubt that providing or subsidizing insurance would effectively address the healthcare needs of undocumented immigrants. Other CBO representatives pointed out the practical barriers to care that remain even if coverage is easier to obtain, including limited in-network providers and language barriers. Questions were raised about how health plan provider networks would be adjusted to accommodate more diverse providers. Many immigrants may want to receive care from providers from within their community. These providers may not currently be "in-network," with many health plans offering coverage through planned expansions. This should be addressed in expectation-setting by the WAHBE, the Washington State Office of the Insurance Commissioner, and the Washington State Healthcare Authority. Key informants questioned how the Healthcare Authority's spoken language access provider program for interpreters might be used to expand

access to care for immigrants. While not perfect, interpretation is necessary for immigrant populations.

Skepticism was expressed that outreach would be successful without real and continuous investment in CBOs working with and supporting immigrants. Recommendations were made for direct investment in CBOs could help provide appropriate navigation and assistance.

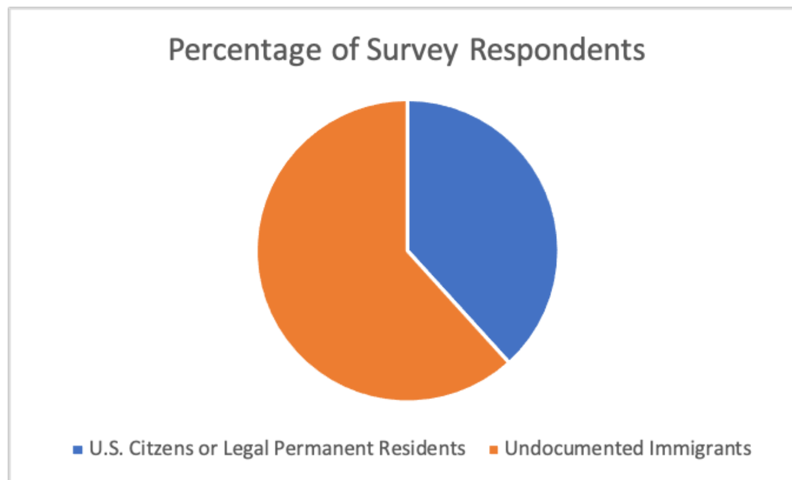
Immigrant Community Health Survey

The Immigrant Community Health Survey was distributed throughout the state by various CBOs and translated into nine different languages. Among the 45 CBOs targeted as engagement partners, 17 confirmed participation and distribution of the survey, reflecting an engagement rate of 22.7%.

For this analysis and understanding that some people are not comfortable disclosing their documentation status, we counted individuals who answered "no" to being a U.S. citizen and "no" to being a legal permanent resident or having a green card as being undocumented.

There were 131 responses across the English, Korean, Spanish, Tagalog, and Vietnamese surveys. Of this number, 49 respondents (37.4%) reported being U.S. citizens or legal permanent residents, while 79 respondents (60.3%) were undocumented.

Figure 12: Distribution of Survey Respondents



Across the surveys, the majority of U.S. citizens or legal permanent residents (55.1%, 27) (cited as "US or LPR") reported being likely or very likely to enroll in free or low-cost health insurance if available. Undocumented immigrants (cited as "UI") had higher rates, with 94.9% (75) respondents reporting being likely or very likely to enroll in free or low-cost health insurance.

Among *all* respondents, the cost was the most frequently reported factor for preventing individuals from getting free or low-cost health insurance ([26.5%, US] and [49.4%, UI], respectively). Difficulty understanding insurance plans and what is covered without assistance (24.5%) was the next most commonly cited barrier among U.S. citizens or legal permanent residents. Not feeling comfortable providing information to a government entity because of deportation concerns was the next most frequently cited factor among undocumented immigrants (34.2%). Additional text responses included: no free insurance, already having insurance through their employer, difficulties filling out insurance information online due to inaccessibility, and not qualifying due to immigration status.

Respondents indicated that having in-person assistance in their language (US: 32.7%] and [UI: 35.4%]) and in-person help from someone in their community ([US: 24.5%] and [UI: 22.8%]) would be the most helpful resources when enrolling in health insurance. Top reported barriers among U.S. citizens or legal permanent residents included: cost (38.8%, 19), lack of insurance (32.7%, 16), lack of a usual healthcare provider (16.3%, 8), and language barriers (18.4%, 9). Undocumented immigrants indicated similar barriers, with lack of insurance (64.6%) leading, followed by cost (62.0%) and language barriers (30.4%).

Among all respondents, the majority indicated receiving care at community clinics ([US: 34.7%] and [UI: 40.5%]). U.S. citizens or legal permanent residents reported receiving care at a private provider's office (28.6%), and undocumented immigrants reported receiving care at free clinics (22.8%).

The majority of U.S. citizens or legal permanent residents who participated in the survey stated their country of origin as Korea (39.6%), Mexico (33.3%), Cambodia (6.3%), and Guatemala (6.3%). Respondents who were classified as undocumented immigrants reported their country of origin as Mexico (74.4%), Honduras (5.1%), and Guatemala (5.1%). The primary preferred languages among respondents include English ([US: 45.8%,] and [UI: 12.8%]), Korean (US: 27.1%), and Spanish ([US: 29.2%] and [UI: 74.4%,). Additional preferred languages reported included: Arabic, Khmer, Tagalog, Ukrainian, and Vietnamese.

There was notable variation in responses to the Korean language survey that merit additional attention and are listed below:

- Approximately 75% of Korean survey respondents reported being unlikely or very unlikely to enroll in free or low-cost health insurance if available. Only 5% of respondents reported being likely to enroll, while the remaining 20% reported being uncertain.

- Most Korean respondents reported currently receiving care at private practices.[2]
- Additionally, the top resources reported that would be most helpful when enrolling in health insurance include: assistance selecting a plan suited to my needs (40.0%), in-person assistance in my language (35.0%), and easy-to-understand descriptions of what is covered by the health insurance plan (15.0%). Other helpful resources include in-person assistance from someone in my community (5.0%) and help to navigate the website and submit their application (5.0%).

[2] Some of this variation may be partly explained by the participation of the Korean Women's Association in distributing the survey, which is a healthcare provider.

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Analysis and Discussion

Throughout this work, we explored how immigrant communities currently access healthcare and health insurance coverage and important considerations once new coverage options become available.

Across all these engagements and interactions, we noted repeated themes and recommendations. These are broadly organized into five key themes and recommendations.

1. WAHBE needs to immediately engage in a robust education campaign for the people who will be trusted resources of those eligible to enroll. The trusted resources for immigrants are mainly unaware of the future benefit and are the people who will be informing and educating immigrants about coverage options. Includes funding and supporting them as they educate their communities.
2. The target population has critical areas of need related to primary care (acute and chronic care management), behavioral health, medication management, transportation, SDOH, language access, and telehealth. The benefits may need to be structured accordingly to meet their needs best.
3. Patient education on how to access and use appropriate care, along with health literacy, will be essential once coverage becomes available.
4. Providers and clinic staff need significant education on how to best work with immigrant populations to gain trust.
5. Outreach and enrollment will need to be tailored for immigrants to ensure coverage.

Each of these findings is discussed in greater detail in the following subsections.

Launch a Robust Education Campaign with Trusted Resources

Key informants and focus group participants mentioned various trusted resources among immigrant communities, including schools, community clinics, DSHS Community Service Offices, English Language Learning programs, employers, churches, and immigrant assistance organizations. With federal 1332 waiver approval, education of trusted resources needs to begin now.

Most CBOs outreached to during this project needed to be made aware of the proposed coverage expansions for undocumented immigrants. These are the organizations whom immigrants trust and who will be critical for pushing out messages about coverage opportunities. Many were involved in the outreach for the COVID-19 Immigrant Relief Fund and already demonstrated effective reach within their local communities.

Reaching out to all immigrant communities, not just those undocumented, may result in more legal immigrants obtaining health insurance coverage. One CBO we connected with works with female artisan immigrants. Their artisans have legal status but lack health insurance – and were surprised to hear that coverage opportunities exist for immigrants with legal status. The welcome mat effect is likely to be significant, as demonstrated by the vast enrollment gains of children into Apple Health when Apple Health for Adults became available for their parents.

Trust was raised by most key informants and focus group participants as the key to making undocumented immigrants feel comfortable accessing healthcare services. Immigrants face many barriers to care, but trust helps to break down many of them. Undocumented immigrants are unlikely to trust our healthcare system much – it's complex, confusing, and hard to navigate. Instead, immigrants typically trust the CBOs that provide immigration assistance or other direct services to their immigrant community. Without a robust education campaign with these trusted resources, immigrant communities are less likely to hear about new and existing coverage options or be willing to enroll.

Adapt Covered Benefits to New Populations

Immediately following the pandemic, key informants, focus group participants, and others all agree that undocumented immigrants likely have high health needs. This is likely due to a combination of factors, including the COVID pandemic and the initial proposed public charge rules invoking fear.

A majority of CMO responses indicated chronic care management as the primary need of their undocumented patients. All the CMOs indicated a high need for dental and behavioral healthcare. Most CMOs highlighted preventive medical care, and two responding CMOs mentioned vision. Most key informants pointed to hypertension, heart disease, diabetes, and undiagnosed mental health conditions as likely conditions. Focus group participants were in large agreement with the CMO responses. Their responses comport with the feedback from other informants: undocumented immigrants likely have pent-up health needs.

According to historical trends, researchers have concluded that undocumented immigrants would be low care utilizers. WAHBE responded to a question from federal agencies during the 1332 waiver application review, pointing to the "considerable evidence that individuals without a federally recognized immigration status tend to be healthier and have lower claims costs on average than U.S. citizens and legal residents." The feedback gathered from various perspectives during this project indicates that longstanding expectations may be inaccurate. Undocumented immigrants may benefit from education, trust, and coverage to help them appropriately utilize the U.S. healthcare system.

The likely health needs of immigrants indicate a corresponding need to adapt covered benefits to ensure alignment. The benefits should incentivize preventive and primary care and provide entry points in primary care clinics with services to meet their needs. Transportation and interpretation will be more critical for this population than for commercially insured populations because they are more likely to be challenged by social determinants of health and cultural and language barriers to care. The interpreter services provided for Apple Health enrollees should be available (and enhanced) for immigrants enrolling in QHP coverage.

Educate Newly Covered Immigrants

Feedback from key informants supports literature findings that care is often received by undocumented immigrants through hospital emergency rooms (ERs). Unless already connected to a CHC for primary care, most key informants believe that undocumented immigrants primarily use the ER, but only when conditions have become too severe to continue delaying care. Most CHC CEO survey respondents believe the ER is a primary venue for care delivery for their patients.

The use of ERs is not surprising. The U.S. healthcare system is complex and hard to navigate. When immigrants first arrive in the U.S., the ER makes sense as a first point of care. Newly covered individuals will benefit from education about the healthcare system and how to navigate it, health literacy, preventive care, and the jargon used with insurance.

One key informant shared that undocumented immigrants in her community are “resilient. They don’t complain. They are tough, and they’re used to working sick. They’re used to working no matter what, and they suck it up, and they don’t complain.” However, insurance coverage goals are improved health outcomes, requiring access to care. Education will help immigrants understand when and where to access care, what preventive care is recommended, and how to navigate between different providers.

Educate Providers and Healthcare Staff

Healthcare providers and personnel should develop cultural competency to better serve immigrants from their communities. Many immigrants struggle with cultural and language barriers. Providers could better understand their cultural and healing traditions while working with them to identify the best paths forward to optimize health. Meeting immigrants where they are without judgment and working to break down language barriers will help engender trust in immigrant communities. Some community and free clinics have already cultivated trust with undocumented immigrant populations. Many are likely accounted for in the community health centers’ annual uninsured patient count. But a vast majority of undocumented immigrants go without any regular primary or preventive care.

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Key informants and focus group participants elucidated how vital trust is when helping or caring for immigrants. Immigrants who lack legal status often have limited English proficiency. If they do speak English, it may be limited to functional English for their work or not extend into healthcare terminology and complexity. Depending on which country they immigrated from, they may have low literacy in their native language. Beyond the language barriers, their fear of deportation is constant, and they measure every decision against their risks. Trust allows these immigrants to feel comfortable and safe asking for help.

Tailor Outreach and Enrollment Support

The landscape scan indicates that immigrants struggle to understand our healthcare system and how to navigate it. Understanding what insurance coverage is and how to use it are other barriers, especially if the coverage will include out-of-pocket costs for accessing care. Immigrants will need to be persuaded to apply for coverage, make an informed insurance choice, and continue through the enrollment process despite out-of-pocket expenses. Decision fatigue may delay enrollment, even with the support of an interpreter. Additional one-on-one conversations with immigrants may be needed, in addition to community-led training to increase education. Following are some recommendations for where WAHBE could place additional resources.

Add More (and Different) Navigator Support

Navigators are familiar with *Washington Healthplanfinder* and have experience helping people through enrollment. Immigrants responded to the Immigrant Health Community Survey indicating that in-person assistance in their language and in-person assistance from someone in their community would be the most helpful resources for enrolling in health insurance. Navigators may need to be diversified to reach immigrant communities truly. The challenge for the WAHBE will be ensuring sufficient navigators with language capabilities to assist immigrants with enrollment.

Additionally, navigator support may require more partnerships with the CBOs serving immigrants. Some CBOs we spoke with are not currently navigators and did not express interest or have the organizational capacity to become navigators. They may be able to host or partner with navigators to help get their communities enrolled. This may require the WAHBE to adjust community engagement expectations for the navigators.

An organization contracted for COVID-19 Immigrant Relief Fund outreach recommended that navigators plan longer appointment times to walk undocumented immigrants through the enrollment process. This may be more important for two reasons. First, it may also take longer for navigators to work with individuals with language barriers, requiring longer appointment times and potentially additional follow-up. Second, only some undocumented immigrants have familiarity with the concept of health insurance and may have encountered little of the U.S. health system.

More people may be interested in enrolling in coverage if a free coverage option becomes available (Medicaid-like coverage). Cost and complexity may otherwise be barriers to a "low-cost" QHP.

One key informant shared that the longer it takes to get to WAHBE to troubleshoot an issue in the application, the more likely the enrollee will want to stop their application process. Additional time creates additional anxiety and lost trust.

Despite being able to purchase coverage through *WA Healthplanfinder*, the out-of-pocket costs of QHPs may continue to put coverage out of reach for many immigrants. One key informant from a rural agricultural area expressed doubts about undocumented immigrants enrolling in QHP because of high deductibles or out-of-pocket costs. Even if Cascade Care Savings may cover their monthly premiums, healthcare costs may remain out of reach. This may comport with the Wakely Consulting Group projecting a low take-up rate in their Actuarial and Economic Analysis for the Section 1332 State Innovation Waiver application.

Work with Immigrant-facing Community-Based Organizations

Not all CBOs want to become navigators, but they may hold trust within immigrant communities. Partnering with them to conduct effective education and outreach will be a practical step toward reaching immigrant communities. Pursuing the model used by the Department of Social and Health Services and the Washington Immigrant Solidarity Network may provide an appropriate path. It will be essential to balance the critical role CBOs play in having trusting relationships in the community and the need to track performance metrics while not making the requirements overly restrictive.

Translate to Break Down Language Barriers

Washington Healthplanfinder presents application challenges for most people but quickly becomes impossible for people with limited English proficiency. The website is currently only available in English and Spanish. Most of Washington's undocumented immigrants are Spanish-speaking, but many other languages are also common in the undocumented immigrant population. Translation of the website into additional languages will be necessary as the WAHBE seeks to reach new populations.

WAHBE must translate information and patient-facing materials and distribute them to CBOs and navigator organizations. If providing flyers for distribution, printed copies should be disseminated, or printing copies should be compensated.

Provide Key Information

Key informants and focus group participants highlighted the need for more information about specific topics. WAHBE can provide critical information to help immigrants feel comfortable that their decision to enroll in health coverage will not impact their immigration status. More

information needs to be documented about potential risks related to the new public charge rules and shared widely with trusted resources.

Extend Open Enrollment Periods

One key informant mentioned how long it could take the immigrants they serve to become comfortable with the information they provide. It can often be weeks before an immigrant returns to follow up on a flyer shared at their prior clinic visit. This example indicates that it may take time to work through the education and outreach steps, plus the actual application and enrollment process.

Outreach events before open enrollment are likely to conflict with the schedules of seasonal farmworkers. Compensate for this with outreach to agricultural employers.

WAHBE should extend future open enrollment periods to allow more time for undocumented immigrants to enroll in coverage. This extension should be at least until the end of January for the duration of the waiver period, a timeline that would align with other state-based marketplaces.

Enhance Digital Access

Key informants highlighted that undocumented immigrants are not one unique group but many different groups with their characteristics. They consistently reported that only some undocumented immigrants would have the digital literacy to fill out online forms or applications. As previously highlighted, Immigrant Community Health Survey respondents indicated that in-person assistance in their language and in-person assistance from someone in their community would be the most helpful resources for enrolling in health insurance.

Digital resources vary though most immigrants have smartphones. Key informants believe the older generations use their phones primarily for communication, while younger generations may engage more in online spaces. Targeting online marketing toward the younger generation may help to reach the older generation. Digital access varies with disparities between urban and rural areas. Internet access and cell phone signal are different across the state.

Community Health Network of Washington is increasing digital literacy among CHC patients with *Link to Care WA*. This Department of Commerce-funded program is connecting with people via telephone statewide and in person in Yakima and King County. In-person assistance is rolling out into other communities in 2023. Digital navigators will play an essential role in helping immigrants better access healthcare services, allowing them to manage their care online and participate in virtual telehealth visits.

Additional funding should be considered for digital navigation as health insurance coverage expansions require more immigrants to use their digital resources to access healthcare. Accessing lab reports, filling out forms, and accessing telehealth can happen through technology if people become comfortable using it. One CBO mentioned having trained the elders in their community about how to use their phones. More CBOs might have the capacity for similar training in their immigrant communities if funding were available.

Recommended Next Steps

The landscape scan timeline was truncated into a short period to collect extensive information. More time was needed for an exhaustive outreach effort. Each conversation with CBOs required ten minutes to explain the proposed coverage expansions and answer questions. The project period also overlapped with open enrollment, numerous holidays, end-of-year fundraising, and other close-out by CBOs. It takes time to cultivate relationships with CBOs serving immigrant communities. More than one 30-minute conversation is required. **They are rightly protective of their time, resources, and communities.**

To continue the work outlined in this landscape scan report, WAHBE should follow the three-part strategy outlined below:

1. Connect with other state agencies to learn best practices for working with and outreaching immigrant communities.
2. Explore new community partnerships beyond the navigator model. Reach out to the organizations engaged in COVID-19 Immigrant Relief Fund outreach.
3. Outreach to trusted resources for immigrant communities since they have trust and may have appropriate openings to inform the population about coverage opportunities.

More about these steps are outlined below.

Connect with Other State Agencies for Best Practices

Multiple Washington State agencies have worked with immigrants in recent years. WAHBE should connect with them to learn more about best practices.

Consideration should be given to the COVID-19 Immigrant Relief Fund's outreach model because it would be an excellent way to leverage relationships and potentially lead to greater health insurance enrollment. The Washington State Department of Social and Health Services could provide more information about the project from the state agency's perspective and how they partnered with the Washington Immigrant Solidarity Network.

The Washington State Department of Health (DOH) worked to distribute COVID-19 vaccines throughout the state equitably. They supported a Community Media Outreach program to connect with priority communities disproportionately affected by the pandemic and experiencing access

barriers to COVID-19 information, resources, and vaccines. Their community dashboards highlight the various ways they reached out to these communities. This may be instructive for the WAHBE to understand which outreach methods were most effective or may have provided the best return on investment. Of note, the Community Media Outreach program strategies included prioritizing allocation and support to providers effectively serving disproportionately impacted communities and investing in trusted leaders, messengers, and organizations.

The Washington State Department of Commerce's Digital Navigator Program operates statewide through the Washington State Broadband Office and community partners: Community Health Network of Washington, Equity in Education Coalition, Goodwill of the Olympics & Rainier Region, and the Seattle Housing Authority. These organizations provide free digital navigation, free digital literacy skills training, affordable internet access assistance, and connected device acquisition assistance for residents or households at or below 135% of the Federal Poverty Level. Services are available in multiple languages. The WAHBE should learn more from the Department of Commerce to gauge opportunities to partner on digital literacy related to *WA Healthplanfinder* enrollment.

Finally, WAHBE should follow the Washington State Office of Equity's Community Compensation Guidelines when considering how to engage immigrant communities and the organizations serving them.

Explore New Community Partnerships

As mentioned, it will take time to cultivate relationships to partner with CBOs effectively, but these organizations are critical for education and outreach support. Washington Health Benefit Exchange should consider building upon the work done during this landscape scan (See Appendix K) to reach more immigrant-focused CBOs.

Community partnerships would be highly regional and immigrant population specific. We recommend starting with the list of organizations we reached out to and incorporating the community organizations engaged in the COVID-19 Immigrant Relief Fund outreach efforts. The Washington Immigrant Solidarity Network may want to pivot its work on the COVID-19 Immigrant Relief Fund outreach to focus on health coverage outreach. Offer to fund education and outreach work so CBOs can begin socializing the coverage opportunities with their communities long before open enrollment begins.

CBOs already working with immigrant communities should be appropriately resourced to educate and outreach to the community. Funding would need to extend beyond the first year of open enrollment since it will take time to increase understanding of the value of insurance coverage.

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Outreach to Trusted Resources for Immigrant Communities

Trusted resources for immigrant communities already have something WAHBE lacks – trust. Simple outreach and partnerships can help to increase awareness and coverage. Promoting COVID vaccination is an excellent example of how some faith-based communities turned their places of worship into COVID vaccination sites to target specific communities of color. Introducing health insurance coverage and health literacy early in English language classes at community colleges, high schools, or English Language Learning programs can effectively reach new immigrants. CBOs assisting with the resettlement of immigrants and refugee populations are another place for WAHBE to engage. WAHBE should also take advantage of various cultural/ethnic community events to increase immigrants' awareness of healthcare resources within the state.

WAHBE should gather data on the intersectionality of communities or CBOs that work with intersectional identities (e.g., individuals who are undocumented and have disabilities, individuals who are undocumented and need gender-affirming care, etc.) to best ensure that populations with the highest risk for disparities are not missed.

Conclusion

Over four months, CHNW and IRHA engaged in an intensive data collection and stakeholder engagement process. Throughout this process, key themes were forcefully and repeatedly emphasized as critical for effective engagement with this population.

First and most importantly, outreach and engagement with this population can best be accomplished through partnerships with CBOs that are embedded within and serve these populations. Trust is critical. Trust is also built over time. Consequently, when partnering with CBOs to raise awareness of insurance offerings or to assist in enrollment, WAHBE should approach these engagements in a way **that recognizes CBO leadership**. This *also* includes identifying and planning for the operational limitations of CBO partners. Often the most impactful and essential CBO resources have the narrowest “margins” regarding functional capacity. This means planning for more extended time horizons for engagements (as CBOs may need to plan further in advance or over a longer time horizon given staffing constraints) and minimizing (insofar as possible) unnecessary administrative burden associated with contracting with a State agency which may otherwise prevent the participation of smaller, regionally based CBOs.

Secondly, social networks and trusted community resources are intensely localized by geography and demographic groups (i.e., ethnic and age groups).

Thirdly, while CBOs will be a linchpin and the foundation of an effective outreach strategy, there remains a lot of work in getting potential partners “up to speed” with the opportunities presented by these expanded insurance offerings.

Finally, effective outreach to these populations, as measured by enrollment in health insurance coverage, will require a great deal of time and effort. It would be a mistake to think that the outreach models and navigation assistance provided to the general population will sufficiently engage and enroll this population. The barriers that individuals across these populations encounter regarding their willingness (i.e., trust) and ability to evaluate and enroll in insurance offering online should not be underestimated. In-person and *continued* navigational assistance in an individual’s language is critical. One respondent explained that a “Navigator on steroids” is needed, meaning not only that the type of navigational services that may be required is expanded for this population but also the requirements of the navigators themselves. They must speak the languages of the individuals they serve and reflect and be knowledgeable of the cultures of their constituents.

Our work over the past months has reinforced our appreciation for the scale and scope of the critical work WAHBE has taken on. We encourage WAHBE to regard this landscape scan as the first step in a more intensive engagement process with CBOs serving these populations, and community

members, to develop tailored outreach plans and implementation networks across regions and demographic groups. Successful engagement will depend upon the degree to which the State is able and willing to invest in the necessary support for this population throughout enrollment and the CBOs tasked with outreach and deployment.

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