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Screening for Immigration-Related Health Concerns in a Federally Qualified Health Center Serving a Diverse Latinx Community: A Mixed Methods Study

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Abstract

Background: Immigration-related concerns can impact health and are an important consideration while caring for a multinational Latinx immigrant community.

Methods: Patients and caregivers waiting for a non-urgent clinic appointment were randomly screened with one of two social risk screening tools. One tool included a question about “any health or stability concerns related to immigration status.” The other tool did not include an immigration health question. Immediately following, respondents were invited to participate in a semi-structured interview regarding their social risk screening experience.

Results: 201 screens were completed, and 20 patients agreed to an interview. There were no significant sociodemographic differences between groups. Of those screened for immigration, 11% reported a concern. In both arms, interviewees felt that social risk screening was acceptable in a clinic setting.

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Discussion: Questions about immigration are timely, important, and relevant, and can be considered when implementing social assessments in communities where there are high levels of trust in providers.

Keywords

Screening; Social Determinants of Health; Immigrants; Community Health Center

Background

Immigration status impacts health and access to care at least as significantly as other social determinants.[1, 2] However, none of the publicly-available evidence-based screening tools include questions about immigration status.[3–7] The Supreme Court has recently upheld proposed changes in the public charge rule - receipt of public benefits, including public insurance and food benefits, can make people ineligible for obtaining or renewing legal permanent resident status.[8–13] Such changes will directly negatively impact health by increasing food insecurity, financial hardship, stress, and exclusion from health care.[14–16] Immigration and Customs Enforcement raids are stoking fear across immigrant communities, contributing also to indirect exclusions from health care and social services based on fear of detainment or deportation.[16–18] Sensitivity to documentation status is foundational to providing high quality care to immigrants. Yet we are not aware of any data on how patients feel about being screened for immigration-related concerns in the context of health care delivery.

We conducted a mixed-methods study to determine feasibility and acceptability of including immigration-related health concerns in a social risk screening tool. While evidence suggests that social risk screening in clinical environments is generally acceptable to patients and providers,[3, 19–25] we sought to understand if a screening tool tailored for a diverse Caribbean and Central American Latinx immigrant population affected acceptability and how it would be perceived in today's political climate. This inquiry was grounded in a modified social-ecological model, to understand how personal, community, and political environments determine behaviors related to health.[26]

Methods

Study Design, Participants and Setting

This study employed a convergent mixed-methods approach.[27] Participants were randomly assigned to complete one of two 10-item social risk screening assessments. Each respondent was then invited to complete a semi-structured interview. The screening tool responses and interview findings were designed to be the basis for any changes to the screening tool, and to guide implementation processes for social risk screening.

The study took place in a Federally Qualified Health Center (FQHC) serving a predominantly immigrant (Central America and the Caribbean, with the largest populations from the Dominican Republic and Puerto Rico) Latinx population. Federally reported 2018 data show 93% of patients served by the FQHC identified as a racial or ethnic minority, 88%

were Hispanic/Latinx, 24% were black, and 97% lived at ≤200% of the Federal Poverty Level.[28]

Data Collection

Patients or patient caregivers aged ≥18 waiting for a non-urgent primary care visit were approached to participate. We collected data on age, gender, and caregiver status. All study activities were conducted in either English or Spanish by a bilingual member of the research team (SHG).

Patients or caregivers in the waiting room completed one of two different social risk screening tools, randomly assigned based on day of the week. Which tool was assigned to which day varied over the course of the study (i.e. screener one was used on Monday during week 1, Tuesday week 2, etc). The first screener was developed by the Centers for Medicare and Medicaid Services (CMS) for the Accountable Health Communities (AHC) project.[29] The second screener was developed by providers at the local FQHC using available evidence-based social screening questions from the published literature.[3, 30, 31] The FQHC survey was piloted to a representative sample of patients in summer 2017; reviewed with FQHC providers and support staff for feedback, and with patients in preliminary semi-structured interviews before final approval by FQHC leadership. Both screening tools included comparable questions about housing quality and stability, food security, financial hardship, and transportation. The exact wording and response choices for the screeners are available in Appendix 1. The AHC tool included 4 questions on interpersonal violence, which were not assessed by the FHQC tool. The FQHC tool included a question on literacy and a question asking about “any health or stability concerns related to immigration status”, which were not included in the AHC tool. All screeners were read aloud to patients to ensure low literacy was not a limiting factor. Response rates between screening tools and for comparable domains and respondent demographics were compared using Student’s t-test for significance

After completing the assessment, respondents were invited to participate in a 30-minute in person semi-structured interview focused on their understanding of the screening questions, acceptability of the questions, comprehensiveness of the screening tool, and the participant’s perception about the appropriateness of social risk screening in the health care setting. The interview guide was developed with input from the research team and FQHC staff. Outside experts gave feedback on the interview guide after initial pilot testing before the guide was finalized. Participants were given a $20 incentive for completing the interview. Participants were recruited from June – September 2018, until thematic saturation was reached. All surveys and interviews were audio recorded, transcribed, and forward and back-translated.

Data Analysis

Two researchers (E.B. and A.L.) used a comparison and consensus process to code transcripts.[32] Team members independently analyzed 5 transcripts line-by-line, generating common codes to summarize key ideas. The transcripts were then re-evaluated to group codes in conceptual categories using thematic analysis.[33] Both coders reviewed all transcripts, iteratively updating the codebook by adding and combining new codes. Analysis

progressed from description to explanation and/or interpretation of the patterns and their broader meanings and implications. All final codes and themes were agreed upon and applied systematically across transcripts. Final codes and themes were presented to FQHC staff. Coding and analysis was performed using Dedoose coding software version 8.2.14. This study was deemed exempt by the Tufts Medical Center Institutional Review Board.

Results

A total of 201 screenings were completed, 100 with the FQHC tool that included the immigration-related health question. Only two of the approached patients or caregivers declined to be screened (99% response rate). Twenty respondents (10 in each survey arm) consented to participate in the interview, which was the a priori recruitment goal and the point at which thematic saturation had been reached. There were no significant demographic differences between screening groups in age, gender, language, number of identified social risks, or patient vs. caregiver status. Of the 100 screened for immigration, 12% reported an immigration-related health or stability concern, with no skipped responses (Table 1).

Interviews provided insights on how a diverse Latinx population saw immigration status as relevant to health and acceptable to include as a component of routine social risk screening. They also highlighted explicit concerns. Three key themes emerged: (1) Immigration as a health and social issue; (2) Social risk screening as a reflection of lived experiences; and (3) Community-specific factors contribute to social risk screening acceptability.

1. Immigration as a health and social issue

Regardless of screening tool used, respondents highlighted immigration status as a serious concern. Those that were screened using the FQHC tool highlighted the immigration question as the most important question. Per one respondent: *“For me, the best question of all these … is the one that doesn’t apply to me: immigration. Because it is a problem that is affecting a lot of people nowadays.”* Respondents who were not asked about immigration because they had been screened with the AHC tool suggested adding screening for immigration because of its relevance. One respondent, after discussing his own pending immigration case, mentioned that it should be added as an important question: *“I have had worries and all that, but [this] is more [important] than everything because, as I am in the middle of an immigration case, then all this makes me nervous, it stresses me. [Immigration] …does not appear here, but yes, [it makes me worried].”*

Interviewees described immigration concerns as pervasive. Interviews included discussions about the government and current politics, and detailed descriptions of family separations and concerns related to receipt of benefits, a consequence of changes to the public charge rule.[34] Fear was frequently mentioned as coming from undocumented community members, not necessarily on behalf of the respondents themselves. Many respondents were American citizens from Puerto Rico, or who naturalized to the US, but recognized the stress this caused their community: *“[Undocumented people] … [are]… constantly scared. I’m not [undocumented] because I’ve been here for 50 years. I am a [citizen], but I do know about a lot of people who have many, many problems.”* The respondent discussing his current immigration case described how the stress was a contributor to his overall health: *“It is right*

that the doctor apart from diseases or what happens physically, [your doctor must] know emotionally [what happens].” Respondents also highlighted connections between undocumented status and potential exclusion from the health care system, underscoring how immigration status can result in worsening physical health because people are afraid to seek care. Per one respondent, “*The things that are going on right now scare me because everyone has the right to live a good life.”*

2. Social risk screening as a reflection of lived experiences

Despite stated fears regarding the changing political climate related to immigration, respondents were universally in favor of including immigration along with the other domains in social risk screeners. Many drew on lived experiences within the community of high rates of poverty, low wages, and prevalent housing problems. Asking about social risk was acceptable to participants, in large part because they described social risks as real concerns faced by everyone. When asked about how they felt while completing their screener, one respondent described the questions as if they were written about her specifically: *“As if they knew me or as if they were waiting for me … they made that questionnaire based on me. Because of the questions that are there, my financial… situation and the eviction and the housing and how I pay [for it], it’s [me]!”* While not all respondents endorsed unmet social needs at the time of the interview, all were able to describe friends, family, or neighbors who were facing social obstacles. Respondents felt the screening questions acknowledged struggles faced by the community. By reflecting these realities through the screening questions, respondents felt their doctors and the FQHC were providing whole-person care.

> “Interviewer: Do you wish these [questions] would have been asked before? Interviewee: Of course… if you were my doctor and you had asked me that, I would feel like, “Oh, they are asking about my life. This is good”. Because sometimes you have problems and come here and your doctor doesn’t ask you about any of that. He…doesn’t ask you anything like, “Do you have food in your home? They don’t ask you about that. That’s why I said, “Wow”.”

Screening was acceptable to many respondents because not only were they or their friends facing social challenges, but many did not know where to go or how to navigate the social services delivery system. There was gratitude on behalf of respondents for opening the door to discuss available resources, or to identify the clinic as a place where community members could go if they did not know where else to turn for help. Per one respondent*, “Clinics and churches here tend to help people a lot. There are people who don’t have any food but there’s a lot of help for the community in [the clinic]. I don’t know about [food stamps] because I don’t use them…but yes, there’s a lot of help here.”*

3. Community-specific factors contribute to social risk screening acceptability

The study was conducted at an FQHC with a strong social mission and deep ties to the community it serves. All respondents described high levels of trust in their providers, and how the clinic is a known and trusted entity within the community. *“My doctor is like my best friend. My doctor, from this clinic…I trust in him. I tell him about my state of health, my state of mind, my fears, my worries, because he is the only one who has been concerned about [me].”* The majority of providers and staff at the clinic are bilingual. Respondents

recognized that language and cultural competency contributed to how and why they felt comfortable discussing social needs with their health care team. Per one respondent, *"The doctor of mine is excellent. She has gone to my country and everything."*

Respondents also described a tight-knit community. When asked about where respondents have gone or would go for assistance, friends, families and neighbors were on the top of the list. Per one respondent, *"[I have had] friends that said, look, I need a hundred dollars…I've always [helped] friends with this."* Family and community were an important, continuous source of support. Many participants stated they were not facing social needs at the time of the interview, but had in the past, thought they might in the future, or knew someone who was experiencing social barriers. Community resilience, in particular strong family ties, buffered the pervasive social needs described by participants. Per one participant, *"I don't get worried if I run out of food, because, I have 7 kids…So if I don't have food, they'll simply bring me some or invite me over.…That doesn't worry me at all."*

Discussion

This study found that screening for social risks in an FQHC that serves a diverse Caribbean and Central American Latinx immigrant community is acceptable, and patients agree that they should be asked about immigration status as it related to their health and stability. In a community faced with high rates of poverty and associated adverse social conditions, screening for social risks was seen as recognition and acknowledgement of the patients' lived experience. Trust in their providers and confidence about family and community supports enabled patients and caregivers to express comfort when discussing these topics with their health care team.

This study complements and expands on other work suggesting that patients believe screening for social risks is acceptable in clinical settings.[3, 24, 25, 35] This is the first study to compare perceptions of a screening tool endorsed by CMS that has been implemented across a diversity of practice sites[29] to perceptions of a screening tool developed locally based on community-specific needs. In designing the screener, FQHC providers felt that adding a question about "immigration related health and stability" was necessary given the high prevalence of documented and undocumented immigrant patients they served. The FQHC providers also found this question preferable to a more direct question about current documented status. This study provided important feedback on how patients and caregivers might react to questions related to documentation status, and if asking about immigration would impact the perceptions of social risk screening generally. Literature on clinician perspectives of social risk screening suggests that providers would be hesitant to ask sensitive information out of concern that it could undermine the doctor-patient relationship.[36, 37] Our findings are consistent with other work suggesting that trust is a pre-requisite for social risk screening.[3, 24, 25, 35, 38] By designing the screening tool based on prevalent community needs, patients and caregivers felt that the screening tool reflected their reality, touched on common experiences, and demonstrated provider validation of their experiences. This extended to screening for immigration-related health concerns. Our study highlights the value of understanding patients' lives outside of the

clinic. FQHC providers were able to successfully tailor a social risk screening tool that patients felt accurately reflected their lived experiences.

Despite the positive feedback from the patients and caregivers in this study, questions remain about how best to implement social risk screening, in particular when considering documentation of social risks. Documenting immigration-related health concerns in the medical record could have significant consequences.[39] Bioethicists argue that immigration status should be considered Protected Health Information under the Health Insurance Portability and Accountability Act Privacy (HIPAA) Rule,[40] yet concerns regarding court ordered release of medical records by state or federal governments could result in status disclosure. Our study did not distinguish between how respondents felt about being asked questions and how they felt about their responses being kept as part of their medical record. A multi-site survey of patient and caregivers who had been screened with the AHC tool found that two thirds of patients felt comfortable including social screening information in electronic medical records.[3]

Immigration status is a known barrier to seeking and accessing health care.[41–43] Medical-legal partnerships (MLP) are an evidence-based health care delivery innovation that improves health by addressing upstream structural and legal needs.[44] Clinics serving patients facing immigration concerns may benefit from including MLP. Critics of social risk screening have cited concerns about inability to meaningfully address social needs when they are identified.[36] MLPs can serve as an important partner to define clear pathways to address identified immigration concerns once they are identified.[45]

This study has several limitations. First, it was conducted at a single site that serves as the primary care provider for 85% of the community and is located in a high profile sanctuary city. Findings may not be generalizable to other primary care sites, or other FQHCs, especially those that lack linguistic and cultural congruency between the providers and the community they serve. Second, the study is subject to response bias. While we randomized which screener participants received to control for unmeasured potential differences between respondents, and we had a high response rate to the survey, it is possible that those who agreed to participate in the interviews were more likely to have viewed the screening favorably. Third, this study was not powered to compare differences between screening tools. Both tools, while asking similar questions about food, housing, and financial difficulties, included additional and unique questions in each tool (Appendix 1). Instead, we were hoping to understand if differences in the surveys used resulted in differences in screening tool acceptability. We also used the data to provide feedback on screening questions used at the FQHC. Finally, we did not include patients on the research team; patient participation in reviewing and analyzing transcripts could have improved our ability to ensure codes matched lived experience.

New contribution to the Literature

There is no universal recommendation on what domains to include in social risk screening tools. In this study, respondents reported that asking about immigration-related health and stability in an FQHC that serves a diverse Latinx immigrant community was relevant and

valuable. Trust and knowledge of the community are essential to implement effective social risk screening in all settings. Physicians were considered important allies, despite current political trends that otherwise influence undocumented immigrants away from care.

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Appendix 1:: AHC screener & FQHC screener

AHC HRSN Screening Tool Core Questions: If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?
   - I have a steady place to live
   - I have a place to live today, but I am worried about losing it in the future
   - I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? 4

   CHOOSE ALL THAT APPLY
   - Pests such as bugs, ants, or mice
   - Mold
   - Lead paint or pipes
   - Lack of heat
   - Oven or stove not working
   - Smoke detectors missing or not working
   - Water leaks
   - None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

Transportation

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
   - Yes
   - No

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - Yes
   - No
   - Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

7. How often does anyone, including family and friends, physically hurt you?
   - Never (1)
   - Rarely (2)
   - Sometimes (3)
   - Fairly often (4)
   - Frequently (5)
8. How often does anyone, including family and friends, insult or talk down to you?
   - Never (1)

- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7–10 are added shows that the person might not be safe

FQHC Social Determinants of Health Screening Tool

1. In the last 12 months, have you been threatened with eviction or foreclosure or been forced to move?

Yes/No

a. Are you worried that this is a risk in the next 3 months?

Yes/No

2. Are you worried about the conditions of your housing (infestation, mold, overdue repairs?)

Yes/No

3. Do you ever have trouble making ends meet at the end of the month?

Always, Rarely, Sometimes, Never

4. In the last 12 months, have you worried that your food would run out before you got money to buy more?

Often, Sometimes, Never

5. In the last 12 months, has the food you bought not lasted and there was no money to buy more?

   Often, Sometimes, Never

6. How often do you need to have someone help you when you read instructions, pamphlets, or other written materials from your doctor or pharmacy?

   Always/Often/Sometimes/Rarely/Never

7. Are you concerned about your family's health and stability for any immigration-related reason?

   Yes/No

8. In the last 12 months, have you or anyone in your family missed a medical appointment due to lack of transportation?

   Yes/No

9. In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?

   Yes/No/Already shut off

10. Are any of these needs something that you would like to address or are there other needs that we haven't asked about that you would like to address?

    Yes/No

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Table 1:

Demographics of study sample

	AHC screener (n=101) %	FQHC screener (n=102) %
Mean Age (SD)	46 (20)	47 (17)
Female	68	67
Caregiver	23	23
Preferred Spanish	100	100
≥1 identified risk *	70	77
Mean identified risks (SD)	1.6 (0)	2.1 (1.8)
Immigration concerns	n/a	12

* AHC screener included up to 6 possible social risks, while FQHC screener included up to 8 possible social risks