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Report

Creating an Oasis: Improving Health Care Delivery to Immigrants Experiencing Homelessness

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Abstract

Background: Immigrants who experience homelessness in the United States are a unique and under-studied population. The determinants of homelessness and immigration increase exposure to health risks. However, there is scant information on the intersection of both groups and little evidence to guide health care practice in this area. Because community health centers serve patients regardless of insurance status, ability to pay, language spoken, or immigration/citizenship status, they are tasked with providing comprehensive care to this unique population. **Methods:** The Oasis Clinic at Boston Health Care for the Homeless was piloted for 12 months prior to the COVID-19 pandemic and explored innovative ways to deliver services to this unique population. Staff and volunteer orientations were provided before each clinic and debriefing sessions were held at the conclusion. Oasis centered the experiences, strengths, and needs unique to immigrants experiencing homelessness. **Results:** The pilot clinic served 330 diverse individuals during 43 weekly clinic sessions for a total attendance of 841. Organizational lessons were learned about distribution of key components of healthcare delivery, improving patient engagement, preventing parallel clinic structures, and creating spaces of belonging for highly marginalized populations. **Conclusion**: Investment in organizational approaches to improve healthcare delivery to immigrant individuals experiencing homelessness may also improve the quality of care delivered to others experiencing homelessness. Critically reflective quality improvement and patient feedback can help guide interventions to address gaps in healthcare disparities for underrepresented groups. The COVID-19 pandemic continues to increase the risk of eviction, unemployment, poverty, and homelessness especially among racial and ethnic minorities. Policies are not adequately addressing the growing problems of affordable housing and access to health care for disenfranchised populations.

Keywords: Immigrant health; Homeless; Healthcare delivery; Limited-English proficiency; Cultural and linguistic barriers; Vulnerable populations; Health equity; Marginalized populations

Abbreviations:

BHCHP: Boston Health Care for the Homeless; BIPOC: Black, Indigenous, and People of Color; FQHCs: Federally qualified health centers; HCH: Health Care for the Homeless; IHC: Immigrant Health Committee; LEP: Limited-English proficient; MLPI: Medical-legal partnerships for immigrants

Introduction

Homelessness continues to be a prevalent concern in the United States. Even before the COVID-19 pandemic, rates of homelessness persisted for decades in the range of half a million individuals on any given night [1] (580,466 in 2020, the 4th consecutive year of increase) and more than one million (1.4 in 2017) people used an emergency shelter at some point during the year [2]. The full impact of the COVID-19 pandemic is expected to exacerbate these numbers as eviction moratoriums and economic supports expire. The term "homelessness" is interpreted broadly as outlined by the HEARTH Act (Homeless Emergency Assistance and Rapid Transition to Housing) in 2009 [3]. This includes individuals "at imminent risk of homelessness, previously homeless people in institutional settings, unaccompanied youth and families with persistent housing instability, and people fleeing or attempting to flee domestic violence." The racial and ethnic identities of people experiencing homelessness vary by geography though on average, Black, Indigenous, and people of color (BIPOC) are disproportionately impacted. These disparities can be traced to historical and structural racism resulting in persistent and wide racial wealth gaps, inequitable rates of incarceration, eviction, and health systems that privilege some groups over others. People who identify as Black or African American represent 39% of those experiencing homelessness (*vs.* 12% of the US population); Latinx individuals comprise 23% of people experiencing homelessness (*vs.* 16% of the US population); Indigenous/Native American individuals make up 5% of people experiencing homeless (*vs.* 1% of US population) [4]. In Massachusetts, there are an estimated 6,233 people experiencing homelessness on any given night [1,p:83], the majority of whom are in Boston [5].

The U.S. is home to over 44.9 million immigrants [6]. Immigration is considered to be a social determinant of health [7] and while there are no reliable estimates of homelessness by language or country of origin, immigrant individuals may experience risk of homelessness because of structural

inequities. Economic deprivation, narrow opportunities for education, exclusion from health insurance coverage, and racism are some of the root causes of disparities in health and access to housing among immigrants. The history of healthcare delivery in the U.S. is embedded within systems of structural racism. This has had a lasting and well-documented impact on health inequities experienced by BIPOC communities [8]. Describing how healthcare services came to be structured this way is historically significant, but beyond the scope of this article. However, the increased focus on health systems and population health discourse around structural racism and intersectional identities helps shed light on the stories of those experiencing homelessness who are also of immigrant /LEP status. While not solely focused on immigrant status, scholars have established links between differences in health outcomes and various social identities that help explain how race and ethnicity as social constructs without biological legitimacy contribute to inequitable systems [9]. In addition to the role of systemic racism impacting healthcare delivery, immigrant individuals are often affected by traumatic experiences that could also impact their health outcomes.

Boston Health Care for the Homeless (BHCHP) is one of approximately 58 federally-funded stand-alone HCH programs in the country and one of six HCH programs in Massachusetts. Founded in 1985 as a four-year pilot program, BHCHP has grown to provide services to approximately 12,000 unique individuals annually at more than 40 locations (including shelters, residential treatment programs, medical respite, and street outreach) and employs hundreds of full-time, part-time and per-diem staff. Seventy-five percent of its funding is from state Medicaid (MassHealth) reimbursements, Medicare, and the Health Safety Net (state reimbursement to clinics and hospitals for services provided to un/underinsured patients), and the remaining 25% from grants and philanthropy [10]. Services provided at BHCHP include comprehensive adult primary care, behavioral health and substance use disorder treatment, family services, medical respite, and oral health. Specialized services include HIV care, curative treatment for Hepatitis C, street outreach and transgender care. BHCHP serves as a national leader and model for medical and behavioral health delivery to individuals and families experiencing homelessness.

Known challenges and previous steps taken to improve healthcare access for LEP patients

Federally qualified health centers (FQHCs) are community health centers with a mandate to provide comprehensive primary care to anyone, regardless of their insurance status, ability to pay, immigration/citizenship status, race/ethnicity or preferred language. While BHCHP has developed expertise in the delivery of primary health care, behavioral health services, and treatment for substance use disorders to individuals experiencing homelessness, its expertise is in development for sub-groups such as limited-English proficient (LEP) patients, a minority of its overall patient population. Because FQHCs are not required to collect or report on countries of origin of patients, estimated numbers of immigrant patients are based on the number of patients who prefer to receive healthcare in a language other than English.

In an effort to address the needs of LEP patients, BHCHP formed an internal Latinx Committee in 2003. To acknowledge the diversity of immigrant patients seen at BHCHP, its name was later changed to the Immigrant Health Committee (IHC). Both the Latinx Committee and IHC have undertaken several important initiatives including increasing language access and evaluating patient satisfaction by language. In 2014, BHCHP conducted its annual patient satisfaction surveys in both English and Spanish. The survey found Spanish-speaking patients were, on average, less satisfied with their experiences of care than English-speaking patients. BHCHP followed up with a series of focus groups conducted in Spanish at various clinic sites to explore the discrepancy. In 2017, a time study was conducted to compare wait times in clinic for English-speaking versus non-English-speaking patients. Non-English-speaking patients were more likely, on average, to take significantly longer to be seen (from check-in/registration to pharmacy for prescriptions). Internal quality measures also demonstrated disparities in control of hypertension and diabetes among LEP patients, particularly those who spoke Haitian Creole.

In addition to bilingual satisfaction surveys, focus groups and the time study, BHCHP made great strides in 2018 by requiring new staff who indicated they were bilingual to demonstrate language proficiency through testing. Current staff were invited to voluntarily take the language proficiency test, though it was not required. Historically, as is done at many health centers, staff self-declared bilingual status. A subcommittee determined minimum proficiency levels for staff who interact directly with patients. In an effort to maintain and expand language access, BHCHP offers financial incentives for bilingual staff.

Understanding the health of immigrants requires nuance and specificity. Some studies have suggested that limited English proficiency (LEP) is associated with negative health outcomes. At a nearby private hospital, patients who spoke little to no English had a 35% greater chance of death due to COVID-19 [12]. Whether due to language discordance between patients and providers, limited opportunities to access timely healthcare, fear, type of health insurance coverage, anticipated stigmatization, or a number of other factors, LEP status can be a marker for health inequities. It is important to note that health inequities for LEP and immigrant communities predate COVID-19. At BHCHP, approximately 11% of patients prefer receiving healthcare in a language other than English, though in recent years this number has been as high as 20% [13]. The majority of LEP patients speak Spanish, followed by Haitian Creole, Portuguese, and Cape Verdean Creole. At the time, BHCHP did not employ in-person medical interpreters but, as with many health centers, staff utilize telephonic interpretation also referred to as the "the language line." Internal data from 2021 showed that of the approximately 400 staff members (including part-time and per diem staff), 134 (34%) are bilingual: 99 speak Spanish, 29 speak Haitian Creole, and 7 speak Portuguese). Though not all

FQHCs maintain updated internal tracking data on bilingual staff by language, proficiency, or role, it is an important function of Human Resources in order to work toward equity in recruitment, retention and quality of care.

Whether fleeing natural disaster, violence, persecution, or severe poverty, immigrant patients at BHCHP are welcomed. However, unless there is clinical relevance, migration status and details are not routinely collected and documented by healthcare professionals in order to decrease legal vulnerability for the patient. Past and potential experiences of trauma are a distressing and acknowledged reality for people experiencing homelessness. A substantial number of patients known to BHCHP have experienced trauma and creating a trauma-informed space was an explicit goal of the Oasis Clinic. While working within constraints of limited space, staffing, and resources, the accessibility to bilingual counselors, recovery coaches, and experienced staff was prioritized. We also conducted volunteer orientations before every Oasis clinic that addressed medical and power control dynamics to highlight the importance of promoting patients' dignity and respect.

Families, children and teens experiencing homelessness is significant in Boston, as well as across the United States [14]. BHCHP has a dedicated Family Team that serves families and youth experiencing homelessness at other locations. Given the diversity of identities of people experiencing homelessness, the Oasis Clinic was designed from the outset to be a family-friendly space. Children and teens attended the Oasis Clinic accompanied by a parent or guardian. Age-appropriate games and activities were led by volunteers and staff. Similarly, limitations around queer-inclusive care were noted as it is well-documented that LGBTQ individuals also experience disproportionate risks and rates of homelessness; Queer and trans youth are estimated to comprise at least 40% of homeless youth despite being about 5-8% of the general youth population [15]. While Oasis offered patient education on sexuality and gender, many patients who are queer or trans were less likely to attend Oasis than the women's clinic which preceded Oasis on Saturday mornings.

Methods: Process of Creating the Oasis Clinic

To pilot new strategies in healthcare delivery for immigrant patients experiencing homelessness, BHCHP first needed to consolidate its linguistic resources. This was helpful in a healthcare organization with a multitude of clinical sites and varying language capacities, spread throughout the city. In September 2018, senior leadership approached the Immigrant Health Committee about launching a new once-weekly clinic. Six members of the IHC (one registered nurse, two case managers, a patient care coordinator, a family nurse practitioner and a physician) expressed interest in being on the core planning team. Five out of the six individuals were first or second generation Latinx immigrants. The team clarified scope and responsibilities, divided up staff and volunteer recruitment, patient outreach, staff scheduling, ordering supplies, clinic programming and orientation. Perhaps most importantly, the team developed clear and targeted messaging strategies for both patients and staff. for both patients and staff. After discussions and conversations with senior leadership, the vision for the clinic evolved into "a multicultural and immigrant-friendly clinic for the marginally housed." The objective was to create a welcoming space for limited English-proficient patients where engagement was the focus. Saturday was selected as the most optimal clinic day for two reasons: 1) the new clinic could occupy the entire lobby with patient engagement activities; and 2) there are very few other programs and resources available on the weekends for patients experiencing homelessness. The clinic launched in March 2019 under the name *Puentes de Salud* (Bridges to Health), however because services were not limited to Spanish-speaking patients, the name was changed to *Oasis*. Oasis has the same meaning of refuge from hardship in English, Spanish, Portuguese and Haitian Creole.

Results

BHCHP is one of many FQHCs where immigrant patients comprise a fraction of the total patient population served. The demographics of Oasis attendees was similar to BHCHP's overall patient population: 67% (134) identified as men and 33% (67) identified as women per electronic health records. The vast majority of Oasis patients were Spanish-speakers from Puerto Rico, the Dominican Republic, El Salvador, Honduras, Guatemala, Mexico and Colombia. Additional patients seen spoke Haitian Creole, French (from Cameroon, Democratic Republic of Congo, and France), Vietnamese and Mandarin. This was consistent with and reflected the remarkable diversity of immigrants in Massachusetts.

Between March 2019 and March 2020, the Oasis Clinic served a total of 330 unique individuals during 43 weekly clinic sessions for a total attendance of 841. Each clinic session lasted four hours. As an engagement space, the Oasis Clinic welcomed 15-30 patients in the BHCHP lobby on any given Saturday afternoon and half were usually patients who had attended at least once before. This space was the primary focus of activities where patients could spend hours in a multi-lingual immigrant-friendly environment. Of those 15-30 individuals, an estimated three to four patients elected to attend medical visits, four to six had nursing visits, and three to four had case management visits. There were many patients who spent numerous hours in the engagement space, some taking many weeks before engaging in medical services or declined to participate in healthcare delivery visits and instead opted for community interaction. Clinic was staffed by one medical provider (MD or NP), one nurse (two nurses if there was no provider), one registration/benefits worker, one case manager and two individuals in a leadership/administrative role. For substance use and behavioral health support, a recovery coach alternated weeks with a behavioral health clinician. The majority of staff in attendance were bilingual English-Spanish speakers. Importantly, there was an active volunteer/intern pool of approximately 20 individuals, five to eight of whom attended

on any given clinic day and managed patient engagement activities. Not all volunteers were bilingual, but all were interested in supporting immigrant patients. The Oasis Clinic was grown in phases and eventually incorporated sessions on trauma-informed yoga, testing and counseling for sexually transmitted infections, and know-your-right presentations from bilingual law students. Additional services, such as legal case management (for immigration, employment and housing issues), ESL classes, in-person medical interpretation (versus telephonic), and asylum evaluations were in the planning process prior to the pandemic.

Leading with engagement and centering the patient experience

The Oasis Clinic proved to be unique in its engagement of patients. Usual clinic models lead with medical services: patients either schedule or drop-in for the explicit purpose of medical care and leave when their visit concludes. Oasis offered a community space for BHCHP's homeless/marginally housed immigrants to stay and engage with one another, staff and volunteers. Many patients who attended Oasis did not choose to have a clinical or case management visit but remained for the duration of the clinic session to eat, listen to music, watch movies, play games or talk. Individuals experiencing homelessness, especially those from other countries, and limited English-speakers are a particularly isolated, marginalized and disenfranchised group. It was not unusual for patients to describe feelings of invisibility or not belonging. The Oasis Clinic was intended to be an antidote for this experience: one in which immigrant patients could first be known as people before being identified and treated as patients. The sense of personhood and belonging was of the utmost importance when creating this space. Patients regularly expressed appreciation for the ability to engage in conversations with staff and volunteers, for the opportunity to have their stories heard, and for being known for more than what they needed or did not have.

Patient feedback was captured through debriefing sessions with volunteers and staff after every Oasis Clinic. During this time, volunteers and staff discussed positive highlights and constructive feedback, both from their perspectives as well as feedback from patients. Detailed notes were taken during these sessions and incorporated into the weekly Oasis Clinic staff meetings for awareness and programmatic changes. A more formal and standardized patient feedback survey was developed but not able to be launched before the pandemic.

Among the patient feedback offered, two examples from Oasis exemplified the clinic's unique ability to reach LEP patients experiencing homelessness. At a clinic session, one patient discussed his past employment history with several staff, showing pictures and describing what his work had been like. He expressed pride in his career as well as disappointment that he was not able to work because of his immigration status. After attending the Oasis Clinic on several occasions, this patient eventually attended a medical visit where he shared with the provider that he had not received medical care for over a decade. In another clinic session, a patient danced for 20 minutes (music from different countries was continuously played in the lobby). It was not uncommon for patients to periodically stand up and dance for a few minutes, but this patient was exuberant and energetic. He later shared with staff it was the first time he had danced in seven years. Many patients responded to the music in a variety of ways: some became tearful when hearing a song reminding them of a lost or estranged parent or child, others distractedly danced in line while waiting for food. Some responded immediately and some took time, but nearly everyone responded. Several patients made comments about the therapeutic quality of music. The integration of music throughout Oasis Clinic sessions, created the space for positive and joyful experiences which had the potential to connect people to care.

Parts of Boston, as in many cities across the U.S., are grappling with the opioid epidemic and the area around BHCHP is a highly visible example of this crisis. It was known that a significant number of patients struggled with active substance use, so Oasis strove to create an environment conducive to recovery and opportunities for treatment. Creating a sober environment, in the midst of an opioid epidemic among patients who are disproportionately affected was an inevitable tension, though proactively navigating this tension was valuable. One patient, who attended nearly every Oasis Clinic, often sat quietly by himself or with a friend watching a movie. Only very occasionally did he engage in either clinical services or more participatory activities, such as games. Some in the clinic wondered why his regular attendance at the Oasis clinic was so important if he did not partake in services. At one clinic session, the recovery coach, who had over 10 years of experience at BHCHP, engaged this patient in conversation. The patient recalled how "I used to hang out with people playing dominoes. I was using [substances] and we were surrounded by drugs and alcohol. Now, here I am, still watching people play dominoes but now I'm surrounded by food and coffee. Look at me now." Creating a sober environment, even temporarily, offers a space in which patients can experience sobriety, a rarity especially during weekends when few services are open. Bilingual staff with expertise, like the recovery coach, had unique opportunities to engage with patients at Oasis and encourage their attendance as a part of their recovery and wellness plans.

As with any pilot program, there were expected logistical and organizational challenges. BHCHP was accustomed to innovation and the need to iterate at Oasis was anticipated. While the organization's flexibility with new programming was helpful, it also resulted in logistical difficulties. For example, the staff who launched and sustained Oasis still had their usual workloads. Because there were not yet additional resources to support increased staffing, core team members needed to find time during the course of their regular workday for Oasis through compensated overtime work. Clinic staff who were recruited to provide clinical services at Oasis were paid for the session, but these were hours in addition to their usual work (unless

they were per diem staff). At times, this created understandable strain for staff members, including the core planning team, for whom Oasis activities were above and beyond their usual responsibilities. The opportunities that arose from this challenge included team leadership (clarifying needs, boundaries and delegation) and identification of new streams of funding. While the impact of the Oasis Clinic on staff members' experiences was not the focus, it was notable. Staff appreciated the opportunity to see patients in a more holistic context. This, itself, was healing for staff to see patients with their children, creating art, enjoying music, and engaging in lengthy conversation with one another. In a clinical environment where needs, vulnerabilities, and deficits are usually centered, the Oasis Clinic provided staff an avenue to engage with patients in their strengths and joys.

Many health centers struggle with recruiting and retaining sufficient bilingual staff, especially for behavioral health services. In addition to this underlying challenge, creating new clinical programming for immigrant patients within a health center where LEP individuals were a minority of the patient population was difficult. This resulted in a small pool of bilingual staff and volunteers from which to recruit and, potentially, created an undue burden. The inevitable need for non-bilingual staff to help with coverage also made programming a challenge when serving patients who spoke a range of languages. Of the five most common languages spoken by patients, no staff or volunteer spoke all five. This created an opportunity for increased familiarity with and utilization of existing resources such as telephonic interpretation and developing new recruitment strategies for increasing bilingual staff and volunteers.

The need for continued staff training, both in terms of individual interactions as well as organizational competencies, to welcome culturally diverse patients remains ongoing. Over the past several years, BHCHP has increasingly fostered an environment of mutual learning and exploration which includes affinity groups, an Equity and Social Justice Committee, an anti-racist book collective, increased incorporation of racial equity topics in Grand Rounds, and expansion of the Justice Equity Diversity and Inclusion (JEDI) department. In addition to the previously mentioned interventions, the following changes were gradually implemented with the support of the Immigrant Health Committee: distribution of laminated cards with the language line number to accompany staff IDs on lanyards; increased financial incentives for bilingual staff; new staff orientation (monthly) about LEP patients and language access; and, when possible, Spanish classes during work hours to any staff member interested. Most recently, and after many years of effort, BHCHP is launching an asylum clinic, medical legal partnership for immigrants, and in-person medical interpretation.

Discussion

Impact of the political climate on health centers

While BHCHP boldly innovated and was accustomed to risk-taking in some areas, like many FQHCs it was cautious in the area of immigrant health. This was, in part, because of the controversial and charged sociopolitical climate surrounding immigration during the previous administration and the unlikely, though potential threat of immigration enforcement or risk to federal funding at health centers. BHCHP took several organizational precautions to maximize the safety of the Oasis Clinic: namely, 1) making it a referral-only clinic where patients were invited and added to a "guest list"; 2) limited advertising. These limitations were understandable though also challenged the growth of the Oasis Clinic. An advantage of the smaller size was a more feasible learning curve for the new pilot. A smaller clinic afforded the core planning team the ability to identify problems and quickly develop solutions without major disruption to Oasis. As a result of the smaller size, additional time was spent adjusting outreach strategies, patient flow, clinical processes, and team roles. It also allowed the core planning team to thoroughly discuss its vision (who was being served, why and how) and communicate it with program leadership.

Risk of unintended consequences: a parallel clinic

BHCHP demonstrated a strong willingness to explore improved strategies for healthcare delivery to its immigrant patients. The Oasis Clinic offered a novel opportunity for the core planning team to trial different approaches, quickly identify what worked, and share learned insights with the health center. A potential unintended consequence was the establishment of a "parallel" clinic for immigrant patients. While Oasis hoped to serve as many immigrant patients experiencing homelessness as possible, the overarching goal was to improve services within BHCHP *overall.* Providing medical, behavioral and case management services to immigrant patients requires expertise, such as prescribing and referring knowledgeably within limited (or no) health coverage, understanding and managing the health implications of immigration status, legal complications related to status that impact health and healthcare, and linguistic capacity including knowing how to effectively and efficiently utilize interpretation. The goal was for this expertise to be concentrated within an interdisciplinary team whose impact was felt across shelters and clinics.

Lessons Learned

Implement an organizational checklist focused on policies and systems

Improving healthcare delivery for immigrant patients requires an interdisciplinary and organizational approach. While it was helpful to have a core group of staff dedicated to this topic, successfully addressing it throughout the program involves efforts across multiple systems. An organizational checklist (Table 1) is a helpful instrument to evaluate the readiness and capacity of a health center to deliver high

quality care to immigrant patients. These systems can be divided into five categories: 1) organizational (e.g. trauma-informed systems, after-hours accessibility, and expansion of patient navigation/community health worker roles); 2) language access (e.g. reliable and efficient modes of communication with limited English-proficient patients, including letters, text reminders, prescription labels, educational pamphlets and after-visit summary notes); 3) internal policies (i.e. create and make easily accessible internal guidelines related to the presence of immigration enforcement at the health center or their requests for patient information); 4) legal resources (e.g. access to access to legal consultation, whether in the form of a formal medical-legal partnership, collaboration with a local law school, or legal case management); 5) internal tools for staff (e.g. organization of resources and education/counseling for patients in the electronic health records through "quick texts" or "smart phrases," and internal links to family preparedness guides, tips for working with interpreters, and guidance on how to complete immigration-related paperwork). An organizational approach will prevent gaps and reduce the burden on individual providers.

5 Pillars: An Organizational Checklist for Health Centers Working with Immigrant Patients	
Organizational Systems	Trauma-informed: transparent, trustworthy, responsive, safe
	Representation of community members among staff
	Welcoming approaches: both signage and actions
	Active and meaningful community engagement
	Core health services include not only primary care, but accessible behavioral health, case management and outreach (CHWs, navigators, peer workers, etc.)
	Accurately-informed staff: periodic trainings and updates
	Structure for processing and debriefing among staff
	After-hours accessibility
	Thirty-minute appointments for primary care visits
Language Access	Reliable and efficient modes of communication: in-person or remote interpretation, multi-lingual phone tree, bilingual staff, signage, answering/on-call service, prescription labels, patient education materials, visit summaries, letters, text reminders, patient electronic health record access in the language of preference, website
	Language proficiency testing for bilingual staff
	Financial compensation ("differential") for staff with bilingual capacity
Internal Policies	Develop and make easily accessible internal guidelines and procedures for presence of immigration enforcement at your health center, data requests by law/immigration enforcement, documentation in the medal record, conducting asylum evaluations at your health center, etc.
Legal Resources	Spectrum of medical-legal partnership and/or reliable legal resources including legal case management, episodic consults with local law schools, regular and more formalized partnerships with immigration attorneys/law schools, pooling resources between several health centers to obtain legal representation for patients, etc.
Tools	Family preparedness guide
	Electronic health record (EHR) quick texts or smart phrases
	Internal links to resources (tips for working with interpreters, immunization/screening guidelines, Know Your Rights cards, how to safely document in the medical record, how to complete immigration-related paperwork, referral list for local legal resources, etc.)

Table 1: Organizational checklist for health centers working with immigrant patients.

Delegate core components by staff role (and avoid limiting to clinical spaces)

A staff/role-oriented approach to the distribution of core components will help streamline implementation of service delivery to immigrant patients (Table 2). Not all staff interact directly with patients, a relatively small number of staff make decisions with program-wide impacts, and some staff have technical expertise such as billing/coding and fundraising that can change the financial outlook for programming. Maximizing the scope of each role will leverage skills while minimizing oversaturation of information. While there are at least two core components applicable to all staff (e.g., knowing how to access and implement procedures in the event of immigration or law enforcement presenting at the health center or requesting patient-related information, and knowing how to access accurate information about policies impacting the health of

immigrant patients, such as public charge), the majority of core components can be distributed along staff roles. Health center leadership can create internal policies and guidelines, anticipate related funding needs and initiate collaborations with community partners to fill service gaps. Billing and coding staff can develop shared best practices for successful reimbursement from safety net funding. Development can meet regularly with teams serving immigrant patients to improve timely identification of well-suited funding opportunities. Front line staff, including reception, greeters and drivers, should be familiar with trauma-informed approaches to interact effectively with patients. Clinical staff should know how to safely and sensitively navigate mandated reporting requirements and navigate coverage gaps within safety net funding and Emergency Medicaid. While there are some areas of overlap between roles, in many cases not everyone needs to learn, access or utilize the same skills.

Role	Components of Immigrant Health Care
Everyone Including administration, support staff, security officers, greeters, drivers	Can easily access and implement organizational policies and procedures (i.e. ICE on campus, law enforcement/ICE requests for information, rapid response network)
	Can easily access reliable and accurate basic information about policy changes impacting immigrant patients (i.e. public charge)
Leadership C-suite executives, program and medical directors	Create and implement immigration-informed guidelines and processes
	Consider health center impacts of changes and potential programmatic adaptations
	Anticipate related funding needs
	Initiate collaborations with community partners to fill service gaps (i.e. medical legal partnerships)
Billing & Coding	Successfully submit requests for safety net/ charity care reimbursement
Development	Familiarity with specific programming that clinical staff and patients need, identify opportunities for related funding
Clinical Staff (staff who access EHR) Case managers, registered nurses, clinicians, medical assistants	Document safely and effectively about impact of immigration on health/access to services in the EHR
	Navigate clinical gaps in healthcare delivery for patients who are uninsured and underinsured (i.e. patients with Emergency Medicaid or safety net coverage). This includes knowledge of which prescriptions, referrals, health services, and durable medical equipment are covered.
	Complete related paperwork (e.g. writing letters of support and completing N-648 immigration forms)
	Safely and sensitively navigate mandated reporting requirements and intimate partner violence resources
	Know where to refer patients for services not offered at the health center (i.e. qualified legal support, social services, food banks, etc.)
	Conduct asylum evaluations (or know how to refer)
Front Line & Clinical Staff (staff who interact with patients) Greeters, drivers, reception/registration, outreach, CHWs, navigators	Familiar with and utilize trauma-informed approaches
	Competently and effectively work with interpreter services
	Ask questions sensitively, explain reasons for asking, describe data privacy policy and limitations in plain language
	Be aware of reasons why patients might not answer phone calls or miss appointments

Table 2: Components of immigrant health care by health center role.

Policy relevance and immigration status

Though this paper addresses health disparities within the immigrant community in the Boston area, these disparities are not synonymous with immigration status as a biological or personal risk factor for negative health outcomes. Immigration status is a risk factor because of institutional and systemic racism which economically, socially, and politically disenfranchises certain groups, increasing their risk of health and housing disparities. In other words, an individual immigrant without authorized immigration status and limited-English proficiency has a greater chance of experiencing homelessness not because of the act of immigration itself, but as a result of larger social, political, and economic forces creating exposure to poverty, violence, and trauma while limiting access to resources and opportunities. Racist and

xenophobic practices and policies that create hurdles for immigrants, such as penalizing mixed-status families that receive federal housing benefits, preventing undocumented students from accessing in-state tuition rates [16], restricting driver's licenses [17], and increased immigration enforcement [18] immigrants with precarious status are at increased risk of impoverishment and homelessness.

Healthcare systems have their own complex webs of policies disadvantaging individuals with precarious immigration status. Eligibility for health insurance is determined by immigration status, effectively blocking millions of people in the U.S. from equitable care. Several types of immigration statuses are subject to a "5-year bar," resulting in the inability to access Medicaid for 5 years after obtaining certain status resulting in millions of individuals and health centers needing to rely on safety net funding for healthcare. Additionally, Medicaid funding of case management services is vital to improving social determinants of health for millions. Even when medical services are accessible, root causes of health inequities such as housing and employment, are out of reach. Case managers help patients obtain housing, employment, substance use treatment, and navigate fragmented healthcare. In Massachusetts, only individuals with certain types of insurance are eligible for reimbursable case management services, meaning that health centers must find other ways of funding case managers (or operate at a financial loss) for the majority of their patient population. This creates ineffective models of care, one in which patients can be treated for an infection, only to return to the street or a shelter where re-infection is likely.

Lastly, policies that exacerbate the number of individuals experiencing either homelessness and/or undocumented immigration status should be avoided. For example, piecemeal and short extensions to COVID-19 eviction moratoriums will continue to put the most vulnerable people at risk of homelessness.

Representation of lived experiences at the leadership level

Lack of multilingual and multicultural representation among medical providers, leaders, and individuals with decision-making power remains pervasive in healthcare systems. Individuals who identify as Hispanic or Latino (referred to here as Latinx) represent 20% of Boston. They are the second largest minority group and experienced the greatest population growth in recent years [19], however they remain underrepresented in healthcare. Nationally, Latinx individuals make up 13% of the healthcare workforce and only 7.2% are immigrants [20]. As continued work in diversity, equity and inclusion continues across many sectors, a critical reflection of the ways in which systemic racism prevents Latinx and immigrant individuals from advancing in the healthcare field should be a priority. Increased representation of healthcare workers and leaders who reflect the patient population being served could improve patient access to services, quality of care received, satisfaction, engagement, and health outcomes among the historically disenfranchised.

In addition to representation at a leadership level, a deeper systemic gap in the healthcare field ought to also be addressed in order to improve the healthcare experience for underrepresented populations seen in community health centers. Health professional training programs/curricula and healthcare organizations should provide learning opportunities [21-24] to increase awareness of structural racism within healthcare systems among both students and staff in order to address and prevent conscious or subconscious biased care that could contribute to inequitable health outcomes for patients in these minority populations.

Conclusion

Moving Forward: Steps for improving healthcare deliver to immigrants experiencing homelessness

Healthcare and social services delivered to immigrants and people experiencing homelessness promotes wellness and healing among highly disenfranchised communities. These services offer hope of rehousing, resolution of legal issues, opportunity of employment, and improved health. Systems of structural racism increase the likelihood of some groups experiencing higher rates of homelessness and immigration-related barriers to care. While little data exist on the intersection of homelessness and immigration, pilot programs can trial and iterate on promising practices for healthcare delivery. FQHCs, are an ideal setting for pilot programs such as Oasis as they are mandated to provide comprehensive health care regardless of insurance, ability to pay, language or immigration status. Once health centers begin to examine their own internal quality data (bilingual staffing, patient satisfaction rates by language, management of chronic disease and routine screening by language, etc.), creation of a pilot program focused on belonging and welcoming of this marginalized community can be better crafted. Leading with patient engagement strategies, centering their experiences, and valuing cultural differences was preferable to an exclusively medical or deficit-based focus. Challenges included increased workloads for bilingual and bicultural staff, identifying new funding sources for program development, innovating during a particularly anti-immigrant sociopolitical climate, and risk of creating a parallel clinic. Lessons learned included the creation of an organizational checklist, acknowledging that staff across roles and not only clinical staff, is helpful to prevent fragmented/inconsistent service delivery or relying on certain individual staff to shoulder an increased burden of work. The opportunity to create a more immigrant-friendly healthcare system can be distributed and shared across organizations and departments. Lastly, there are several policy solutions to systemic and structural inequities which could improve patient-level health outcomes as well as alleviate reimbursement gaps for FQHCs. First, disentangling immigration status from access to health care may be one of the biggest challenges, but likely holds the most promise of reducing health inequities. Secondly, value-based care for individuals experiencing homelessness must include Medicaid reimbursement for case management services. Case managers

get people housed, they connect people to legal resources and obtain identification which allows more people to obtain employment, they help navigate complex and fragmented healthcare systems, and much more. Case managers can have the biggest impact on social determinants of health. Thirdly, policies promoting foreign-trained health professionals can diversify the healthcare workforce. Lastly, sustainable funding of medical-legal partnerships for immigrants can resolve some of the most confusing and costly situations in which housing, health and immigration status are mired in complexity. Creating spaces of belonging and building systems and policies around them to foster their growth, hold great potential to decrease health inequities of our most marginalized communities.

Ethics approval and consent to participate

Not applicable. This is a Report from the Field submission about project implementation and not a research study, ethical approval and consent to participate are not applicable.

Availability of data and materials

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Competing interests

The authors declare that they have no competing interests

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Authors' contributions

M.M.S wrote the main manuscript from first-hand experience directing the Oasis clinic and also prepared the figures. A.S. wrote sections of the manuscript background and results as well as led formatting and editing. Y.M. contributed expertise as staff at the Oasis clinic and was a member of the Oasis Clinic core planning team. Y.M. also reviewed the editing process through the writing of this paper. All authors reviewed the manuscript.

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