Decline in access to healthcare through safety-net clinics by immigrants and refugees in Denver

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Introduction

The Mile High Health Alliance brings together diverse stakeholders from medical care, behavioral health, public health, local government agencies, public schools, and social and community based organizations to collaboratively address Denver’s most difficult health challenges and “Achieve Better Health Through Collaboration.” The Alliance was formally established in January 2015 to fulfill an important recommendation in the Access to Care section of Denver’s 2014 – 2018 Community Health Improvement Plan, namely to create a multi-sector coalition of diverse stakeholders committed to increasing access to care, better coordinating health care services, and decreasing health care costs.

The Alliance’s constituency is delineated geographically as those that reside in the City and County of Denver. The Alliance focuses its efforts on the almost 50% of Denver’s population who are uninsured, underinsured, or publicly insured through Health First Colorado (Medicaid). This includes Denver’s immigrant and refugee communities. Of the 649,654 people living in Denver as of 2015, approximately 16% (104,370 people) are foreign born (US Census Bureau). It is also important to note that the state of Colorado was approved to accept 2,175 refugees for federal fiscal year 2017 alone. Therefore, the foreign-born population who are eligible for Medicaid has been increasing, many of whom are relocated to the Denver Metro area by resettling agencies.

In June of 2017, evidence of a problem affecting the health and well-being of immigrants, refugees, and their families was published in a New York Times article, “Sick and Afraid, Some Immigrants Forgo Medical Care”. The article highlighted reports which indicated that immigrant and refugee patients were becoming increasingly reluctant to seek healthcare. One of these reports was the national poll of providers by Migrant Clinicians Network in which two-thirds of the respondents said they had seen such a ‘chilling effect’ among patients. Clinics across the country that serve an immigrant population have reported significant downturns in appointments and up ticks in no-show rates related to fear of persecution. The
impact of forgoing screenings, medications, and other essential medical care can be quite severe and far reaching.

Simultaneously, some members of the Mile High Health Alliance were raising similar concerns in Denver regarding the decrease in appointments, and increase in cancellations and no-shows. These Health Clinics and Federally Qualified Health Centers (FQHCs), in addition to public hospitals, comprise the safety-net system and are the frontline witnessing the chilling effect on immigrant and refugee communities in Denver.

In an effort to understand the prevalence of this issue in Denver, the Mile High Health Alliance surveyed our organizational members that provide direct healthcare. The survey included 8 questions, seeking qualitative, quantitative, and anecdotal information for the period after January 2017 in comparison to previous years. Additionally, partner organizations with known immigrant or refugee patient populations outside of the Alliance’s membership were also included in the survey result analysis to increase breadth of data collection and interpretation. Not all organizations surveyed were able to provide responses to all the questions within the survey.

Results

On average, neighborhoods in the Denver Metro area had a 16% foreign born population ranging from the highest concentration being at approximately 39% and the lowest at around 4% (US Census Bureau). Many of the entities surveyed are not located in the densest foreign born population areas of the City and County of Denver, even though many of them are the only access point for healthcare for these communities. This means many of the immigrant and/or refugee patients who depend on services from these safety-net providers must travel significant distances to reach health services. Non-emergent medical transportation has been identified as a major barrier to access to healthcare for Medicaid and other communities in Denver. Research from multiple studies has concluded that transportation is a major barrier for immigrant and refugee population (Hacker et al.; Pereira et al.) as well. The New York Times article “Sick and Afraid, Some Immigrants Forgo Medical Care” notes that the consequences for being stopped along the way to medical services can be “far more costly than just a fine” (Hoffman).

Inner City Health is one of the clinics that is located in the neighborhoods with highest concentration of immigrant and refugee residents, at around 21% foreign born, making their experience particularly relevant. According to their estimates, the decrease in appointments made by patients from the immigrant/refugee populations is as much as a 12% from the previous year. Other community based clinics such as Clinica Tepeyac, Colorado Alliance for Health Equity and Practice (CAHEP), and Rocky Mountain Youth Clinics (RMYC) reported similar declines. CAHEP’s estimates were the most similar at 15-20% decrease in appointments made. RMYC, which normally sees a high proportion of immigrant and refugee patients, was able to provide more specific numbers, stating that they had a total of 375 fewer appointments. Clinica Tepeyac was unable to provide a quantitative number but did report experiencing “a slight decrease,” and mentioned the month of February as a notably most affected time. Likewise, clinics that are part of a larger system such as Denver Health and Hospital Authority (“Denver Health”) which includes the Refugee Clinic at Lowry and Denver Health Medical Center, reported an estimated 20% decrease. Figure 1 below illustrates the total yes vs. no reports of this first inquiry into the decline in access
to care for the immigrant and refugee populations. On average, the estimate of overall decrease in appointments made could be approximated to 17% for these safety net providers of healthcare.

![Figure 1: Bar graph representing the total results of the surveyed entities as to whether or not there has been a comparable decrease in appointments made by patients of the immigrant and refugee communities.]

Increase in no-show rates and cancellations was the next issue we tried to gauge. Again, a majority of the organizations surveyed responded affirmatively to having experienced a noticeable increase in no-shows since January of 2017. (Figure 2). Not surprisingly, Denver Health, the largest of the safety-net providers, reported the highest estimates for this increase at 40%. Other organizations reported a varying range of change in no show rates but all in the lower spectrum. RMYC reported only a 2% increase, while Clinica Tepeyac reported a 5% increase; the highest of these was a 15% increase reported by CAHEP. Inner City Health reported they had “no exceptional increase in no-shows.” The average of the estimates reported was calculated at 19% overall.

![Figure 2: Bar graph representing the response of whether or not there had been an increase in no-show rates or cancellations.]

The most difficult measure to quantify through this survey was the increase in requests for mental health resources and the increase in expressed fear or concern about having personal information shared with other agencies. The former is meant to be an indicator of how immigrants and refugees are dealing with the level of stress related to their immediate and public environments. The latter was intended gauge how
concern about the privacy of protected health information could deter patients from seeking care, especially if disclosure could jeopardize continued residency or their legal status. The large majority of responses were affirmative in both these measures for all organizations surveyed (Figure 3 and Figure 4).

The request for mental health resources has become so common that our members mentioned the need for information and resources to assist clinics in responding to requests. Not surprisingly, some organizations reported a hesitancy by patients to ask for help or resources. One example was a patient whose adult child is undocumented; the appointment was spent discussing the concept of “sanctuary cities” and related policies.

As for the issue of information sharing concerns, there have been reports of families dropping their Medicaid coverage due to concern about having their information in “government systems,” refusing to apply for benefits they or their family members qualified for, and simply refusing to answer pertinent questions to care such as country of birth. Denver Health was the only organization that could provide some estimate of how prevalent these measures have been experienced and for both they estimated a 20% increase.

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1 Denver passed a Public Safety law in August 2017 that forbids city/county employees from cooperating with ICE.

Figure 3: Bar graph representing the response as to notable increases in inquiries for mental health resources.
Discussion

Barriers to health care for immigrants and refugees are not a new phenomenon. Much of the literature classifies these experienced barriers in categories such as policy and law, health systems, and at the individual level. Multiple factors exacerbate immigrant and refugee’s limited access to health care within these categories, for example: lack of knowledge of rules and regulations, bureaucratic issues, discrimination, transportation and translation services, etc. (Hacker et al.; Rodriguez et al.). A climate of fear and mistrust can magnify the effects of these barriers, the consequence being an overall underutilization of the health care system (Stimpson et al. 2013 & 2014; Pereira et al.). This underutilization puts at risk the health of the individual, family, and community. Examples of this impact include lack of follow up for infectious diseases, low immunization rates, and untreated mental health issues (Hacker et al; Asch et al; Pereira et al).

A review of the information provided by members of the Mile High Health Alliance reveals evidence of a chilling effect on immigrants and refugees seeking medical care. The time frame in which this effect has been experienced alludes to the possibility that the drop-off is a response to the public anti-immigrant rhetoric and policies, especially at the federal level. The survey that was sent to the participants included an open-ended question in which respondents were asked what they thought was the source(s) of any reported change in patterns. Organizations described the trends as being tied to changes in immigration policies and enforcement, federal administration rhetoric and policy changes, and the news channels highlighting the current political climate. Some organizations even referring specifically to Executive Orders that bar immigrants from certain countries, deny benefits, seek to deport undocumented immigrants, or threaten programs like DACA.

There was a significant variance in some of the reported estimates, particularly that of the increase in no show rates and cancellations, from the community centric health center versus that of large systems. Community based organizations reported rates in the lower end of the spectrum suggesting a difference in the provider-patient relationship and the trust developed in the communities that they serve.
Regardless of the type of organization, all reported taking steps to address problem, which exacerbates inequitable access to health care. Largely these efforts have revolved around messaging and workforce development. Some Alliance members are training staff on how to handle questions about information sharing, and “know your rights” trainings to better equip the staff to give advice about their rights and resources. Patient navigation and cultural competency training were also mentioned as efforts to mitigate this issue.

Conclusion

The survey administered by the Mile High Health Alliance to its members identified new and concerning patterns of behavior among immigrants and refugees who seek care through safety-net clinics. The results paint a picture of decreasing access to health care, which has significant implications for public health. Although many entities have been forward thinking in implementing efforts to mitigate such an issue, the Alliance believes more steps are necessary. Surveys such as this can and need to be used as tools to drive action and develop next steps. Most importantly efforts for intervention around this issue should focus on the privacy, safety, and well-being of the immigrant and refugee communities. Any strategies to address the drop-off should consider the vulnerability of these communities and not make things more difficult for them. Our results will also be shared with other organizations who strive for equitable access to care to help inform and guide their advocacy efforts.
References:


