Improving Access of Low-Income Immigrant Families to Health and Human Services

The Role of Community-Based Organizations

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The Immigrant Access to Health and Human Services project maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants; major barriers (such as language and family structure) to immigrants’ access to health and human services for which they are legally eligible; and innovative or promising practices that can help states manage their programs.

Introduction

Low-income families can face personal, community, and systems barriers to receiving public supports for work, health, and family well-being, such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, and the Children’s Health Insurance Program (CHIP). Organizations providing access to work and family supports have developed innovative approaches for reaching underenrolled children and families; that is, families and children who are not participating in programs for which they are eligible. One of the largest and fastest-growing underenrolled groups is low-income immigrant families. Seventeen million children in 2010, or close to
a quarter of all American children, had at least one foreign-born parent. This total includes 15 million US-born children (Fortuny and Chaudry 2011a). As a companion brief in this series indicates, barriers that often prevent this population from accessing benefits include language and informational issues, cultural norms that discourage receipt of government benefits, and, particularly among undocumented or mixed-status families, immigration-related fears of the consequence of enrolling in programs (Perreira et al. 2012). Policy and practice influences on benefit enrollment rates include state-level policy differences in eligibility guidelines, ease of enrollment and recertification, and outreach and information dissemination. In addition, families experience outreach and enrollment efforts in community and organizational contexts which further facilitate or inhibit their enrollment.

In this brief, we review innovative practices that community-based organizations have used to address under-enrollment of low-income immigrant families in SNAP, TANF, Medicaid, and CHIP. We rely most heavily on the current Immigrant Access to Health and Human Services project’s data gathering in four states—Maryland, Massachusetts, North Carolina, and Texas—chosen for variation in state policies toward health and human services and immigrants’ access to these services (for a detailed description of our methods, see our brief on promising practices [Crosnoe et al. 2012]). We also draw on recent literature on policy implementation and organizational practices related to these programs and immigrant families.

We focus on community-based organizations (CBOs) that were visited in the four states. They included faith-based organizations, organizations focused on specific immigrant groups, health organizations, and advocacy organizations. Most obtained funding for their direct programming and advocacy work from varied foundation and public sources. Most of the organizations’ work involved a blend of direct service provision and advocacy, but the balance varied substantially among them. In addition, agency administrators (of TANF, SNAP, and Medicaid) provided their perspectives on the role of CBOs as partners and as independent forces in addressing immigrant families’ access to health and human services. Box 1 provides two examples of the CBOs we examined; a full list of CBOs consulted for this study can be found in appendix B.
BOX 1
CBO Examples

Boston Medical Center’s Medical Legal Partnership is an example of a CBO focused on legal advocacy in a health organization setting. The Boston Medical Center’s (BMC) Medical Legal Partnership (MLP) was founded in 1993 by the chair of pediatrics at BMC. The purpose of the partnership is to include the participation of lawyers on the health care team in order to alleviate legal issues associated with ensuring all patients receive proper medical benefits. The main tasks of the MLP at BMC include appeals, trainings for hospital workers, and initial eligibility screening. The MLP is a team of six lawyers and four paralegals working in conjunction with clinicians and social workers. The MLP engages in various services to provide immigrant populations with legal assistance regarding their medical and other benefits, eligibility, and other issues.

El Centro Hispano is an example of a comprehensive immigrant-serving organization. It is located in Durham, North Carolina, and in other locations in the state. Its mission is to strengthen the Hispanic/Latino community and improve the quality of life of Hispanic/Latino residents in Durham, Carrboro, Chapel Hill, and surrounding areas. The CBO offers 38 distinct programs in four program areas: support services, education, health, and community. Examples of El Centro Hispano’s services include domestic and sexual violence prevention, legal services, English as a Second Language classes, tutoring, diabetes health education, LGTBQ support groups, and youth and community leadership development.

Note: A full list of CBOs consulted for this study is available in appendix B.

Community-based organizations can affect benefits access and enrollment among families and children for several reasons. As agencies that lie between private and public provision systems, CBOs are key players in implementing health and human services policies in communities across the United States. In particular, because immigrant families may be uncomfortable engaging directly with government agencies, CBOs often function as trusted organizations through which information, enrollment, and recertification services can be provided. Studies find that low-income immigrant parents are more comfortable enrolling in public programs when the services are perceived as directly benefiting children and when enrollment and recertification occur in a trusted setting, facilitated in the context of a trusting relationship (Capps and Fortuny 2006; Chaudry and Fortuny 2010; Yoshikawa 2011).

Community-based organizations are also important because they provide a wide range of services and supports, within which information about public programs can be embedded. Additionally, CBOs engage with low-income immigrant families to an unprecedented degree, owing to the recent rise in immigrant populations in virtually every state.

This brief highlights practices that CBOs engage in and can learn from in their efforts to better respond to the needs and strengths of immigrant parents and their children. All locations visited in this
study had CBOs that provided their own services and facilitated access to government-provided services. The balance between CBO- and government-provided services varied across sites because of several factors, such as relative budgets and capacities, policy and economic environments, demographic factors, and other factors and decisions.

Across sites, three strategies emerged as effective in addressing the persistent barriers immigrant parents and children face. These strategies focus on the following: (1) establishing trust and rapport in relationships; (2) targeting homes and community settings in innovative ways; and (3) establishing networks and relationships among organizations serving immigrant populations. We work outward in this sequence: from the micro settings of individual relationships with immigrant parents, to their homes and community settings, to system-level strategies that involve coordination among multiple organizations. A range of other strategies—including translation and communication strategies, streamlined enrollment and eligibility, and efforts to address cultural and other beliefs about the consequences of program enrollment—are addressed in a companion brief (Crosnoe et al. 2012).

Throughout this brief we highlight, when relevant, the state policy contexts of CBO strategies. The work of any particular organization must be considered in relation to its state policy context. The most relevant policies in this brief are those related to work, nutrition, and health supports for low-income families in general, and for immigrant families in particular. Our CBO examples come from states that vary in such policy characteristics as overall benefit levels, restrictiveness of eligibility, recertification policies, and state funding of benefits for some groups of immigrants whose access was restricted in the 1996 welfare reform legislation. For a more detailed summary of how these states vary in their eligibility guidelines, see Fortuny and Chaudry (2011b).

Targeting Relationships with Immigrant Families

Many low-income immigrant parents and families are reluctant to apply for benefits or services from formal government offices without a specific connection or trusting relationship (Edin and Lein 1997). This discomfort is a primary barrier to enrolling eligible children in such programs as SNAP, CHIP, TANF, child care subsidies, and other work and family supports (Perreira et al. 2012). CBOs can play a critical intermediary role as a trusted community setting and a source for information and resources.

Within CBOs, however, conceptualization and implementation of provider-parent relationships are critical. Research on low-income immigrant parents suggests that information about formal services is more likely to be trusted if it comes from a friend or mentor figure rather than a service provider. When relationships take on mentorship dimensions, outreach may be more effective (e.g. Flores et al. 2005; Lawler and Costello 2005).

Mentorship Models

Several principles emerged from examples of CBO practices aimed at increasing access. For example, rather than focusing on specific programs or offering walk-in consultations, one organization in
Maryland uses a mentorship model that starts with a client-centered view of youth and their families. Staff members first become familiar with the financial circumstances and household composition of youth in their caseload. The menu of services for each family differs and is tailored to the needs of the youth and his or her family, which can include the youth’s own children, siblings, parents, and other household members. Mentors accompany youth to meetings at public agencies, especially for SNAP. Mentors also speak at length with household members, including the youth’s parents, to identify needs such as housing assistance, rental assistance, and after-school programs or child care vouchers.

“Promotoras” and Health Education Models

In several instances across our states, community health advocates (also referred to as “promotoras” in Spanish) educated immigrant parents and youth about basic public health issues and added benefit program enrollment to the array of supports they offered. Although the health advocate model varies, public agencies and CBOs typically train one or more community members to become liaisons between the public health organization and the community. After a modest amount of training, the lay health advisers or advocates work full or part time or volunteer to disseminate information to their communities about health issues such as diabetes, mental health, or obesity. In some cases, the advocates may receive training on linking families to such programs as Medicaid and SNAP.

This model effectively embeds public program information and access within a wider public health agenda. As one New York State report on this model of community-based enrollment stated, “An adolescent may not think that health insurance is important until someone explains to them how it is related to health issues on their minds, like sports or acne” (Lawler and Costello 2005, 8). One public health official in North Carolina described the agency’s approach to training health advocates to provide public program information and support:

> You get a leader within the ranks—in a trailer, an apartment complex, wherever they’re located. You do “charlas” [informal talks]—in living rooms, at a gathering, at a pool party. They become that kind of go-to person. “My Medicaid card is not working any more. I forgot to reenroll. Now he’s sick.” Little things like that happen a lot in our community.

A health advocacy staff member described the model similarly:

> Another really good practice is promotoras. There’s different ways of doing it. Traditionally, it’s a woman, a member of the community who’s serving the community who can bring people in and educate and be a liaison—someone the community trusts, someone who’s able to distribute information and work on health risks and get people to use the clinic’s services.

Professional development and training in this health education model is important. According to our interviews, the model works best when a single person can supervise, train, and coordinate a group of health educators who deliver bilingual and bicultural education and provide case management services (linking families to a range of health and human service programs, and sometimes enrolling them in programs directly). The health educators and advocates then develop strong links to community providers, while the coordinator negotiates and brokers relationships with networks of public, private, and nonprofit entities.
A key element of these efforts’ success is immigrant families’ opportunity to develop sustained relationships with a single trusted individual. These relationships increase families’ comfort with providing the sensitive information required for initial enrollment in many programs, and may also prevent the frequent churning (exits and short-term reentry) that families can experience in SNAP, TANF, and other program enrollment. A sustained relationship over time that is more intensive than typical case management can prevent additional rounds of paperwork and lapses in coverage (Mills, Compton, and Golden 2011).

Immigrant families experiencing relative social isolation because of low coethnic concentrations in neighborhoods, extremely recent immigration, or mental health or other family issues can particularly benefit from such relationships. These families can experience problems accessing information, and they often need material, instrumental, and emotional support. The provision of information in the context of a caring relationship may be more effective than solely providing information through traditional outreach strategies (e.g., ethnic media, flyers) because health educators and advocates are also able to address other important issues in immigrant families’ lives. Box 2 provides evidence about the effectiveness of relationship-based models.

**BOX 2**

**Building Relationships with Immigrant Families to Increase Access among Uninsured Children**

In one of the only experimental evaluations of its kind, Flores et al. (2005) compared a community case manager model with standard CHIP outreach, randomly assigning 300 uninsured Latino children and their families in Boston to one of the models (before Massachusetts’s implementation of universal health care). In the treatment group, case managers developed rapport with families, helped fill out applications, submitted applications, and followed up on enrollment outcomes. In the control group, outreach included mailings, press releases, health fairs, door-to-door canvassing, radio advertisements on Spanish-language programs, bilingual small grants to CBOs to provide outreach and application assistance, and a toll-free number for applying for health benefits. The community case manager approach was more successful than standard outreach in insuring Latino children; after one year, insurance rates were 96 percent for the case manager group and 57 percent for the outreach group.

Other research highlights the level of intensity or frequency that may be required to achieve impact in the provider-parent relationship. For example, literature suggests that more than a few home visits are required for sustained impacts on parenting or child development (Sweet and Appelbaum 2004); a recent meta-analysis shows that at least monthly visits resulted in substantially higher impacts on early child outcomes than less frequent visits (Yoshikawa et al. 2011). Parenting behaviors differ from the behaviors involved in enrolling and participating in public programs, so more research is needed to determine whether visit frequency is a critical factor for enrollment and participation in public programs. However, these findings all indicate the value of creating rapport in a helping relationship.
Targeting Homes and Community Settings in Innovative Ways

Immigrants’ communities include many settings: playgrounds, libraries, strip malls, public agencies, schools, grocery stores, and workplaces ranging from farms to factories and small businesses. All these settings differ in how closely they are associated with danger, trust, or help. Depending on state and local policy contexts (e.g., immigration enforcement or other law enforcement activities), the same type of setting may signal safety or potential danger. Settings “read” differently along these dimensions for low-income immigrants of different statuses and can raise specific concerns that the native-born do not share. Immigrants’ legal status (as well as that of family and network members) may influence their willingness or reluctance to engage with government agencies. Among government agencies, some associated with stigmatized programs (e.g., cash welfare or even work supports) may be less trusted than others (e.g., hospitals or public health clinics, even if they are clearly run by state or local governments; see Capps and Fortuny 2006).

Agencies or organizations not identified formally with the government can therefore be especially effective at providing information or enrollment opportunities for immigrant families. Organizations not associated with social services—such as faith-based organizations, local businesses with extensive and regular contact with community members, and even housing developments with high concentrations of particular immigrant groups—can be effective settings for benefit program application, enrollment, and recertification. In some cases and for some groups, homes are also acceptable and accessible outreach venues through programs like home visiting or home-based health education.

Workplaces, Homes, and Other Community Settings

Community-based organizations can link eligible families to public health and social service programs by targeting community settings. For example, one community health center in North Carolina reached out to new immigrant populations, including migrant farm workers and mixed-status households, by training a large team of paid and volunteer outreach workers to meet with farm workers in the fields where they work and to visit families informally at their homes.

By targeting community settings for outreach and enrollment, CBOs are able to address both immigrants’ and employers’ fears about perceived immigration-related dangers associated with benefits. For example, a health organization in Sampson County, North Carolina, invited farm workers and growers to an evening meeting with tea and biscuits to start developing strategies for ensuring that both growers and workers had easy access to health centers. The organization’s staff convinced the growers that they were not there to “catch” growers, but to make workers healthier. As one staff member explained, “It’s a benefit to the growers. There’s advocacy, too, to go after growers. But it’s important not to block access [to health centers among farmworkers]."
Another health organization in Greene County, North Carolina, improved its rapport with immigrant clients by hiring staff that spoke immigrants’ native languages and training them to understand the cultural backgrounds of their clients. Staff provided transportation to social service offices and one-to-one assistance with applications for services. The organization also expected outreach staff to remain in touch with families over time. As a result, the organization’s rapport with the community and the number of clients it serves have grown over the years. As stated by the service provider:

There’s 50 percent turnover with the migrant farmworker population. So that’s 50 percent that were here before. And the majority knows us and trusts us. I give a lot of credit to our outreach as a big part of the increase in patients. We work on letting them know about our services, in their languages, and in a culturally appropriate way.

By extending outreach efforts to community settings such as schools and both small and large employers, CBOs were able to connect with a broader range of families, especially those fearful of going to public agencies, and to link more of them to health and human services.

In Texas, the Health and Human Services Commission partnered with grocery store chains for outreach efforts. Government offices and CBOs often had health care fairs at these stores, which function as community hubs. Similarly, the Mental Health Outreach for Mothers program in New Haven, Connecticut, trained mothers to provide mental health promotion interventions in supermarkets serving as hubs in low-income neighborhoods (Smith and Lincoln 2011). Box 3 provides an overview of Los Angeles Healthy Kids, a program that leveraged community settings to improve benefit access.

**BOX 3**

**Outreach to Immigrant Latino Children in Community Settings: Los Angeles Healthy Kids**

The Los Angeles Healthy Kids program was designed to enroll children ineligible for federally funded health insurance in low- or no-cost health insurance funded by First 5 LA, which is, in turn, funded by a state tobacco tax. The program targeted mostly undocumented, uninsured children in Los Angeles. The program trained outreach workers to provide immigrant parents with information and enrollment services in an array of community settings. Community settings included Head Start and child care programs, schools, churches and other faith-based organizations, WIC (the Special Supplemental Nutrition Program for Women, Infants and Children) offices, and community health clinics. Over 40,000 children were enrolled in the program in its first four years. There was little evidence of crowd-out; that is, almost none of the children were previously enrolled in employer-provided health care coverage. A quasi-experimental, difference-in-difference design was used to evaluate the program’s impacts, comparing new enrollees to established enrollees. The program produced substantial gains in the proportion of children with a consistent source of physical health and dental care, walk-in and preventive-care visits, and reduced financial worries among parents (Hill et al. 2008).
Placing Public Agency Workers in Community Settings

In recent years, some public agencies have placed staff members in CBOs as a strategy for increasing access to SNAP, Medicaid, and other public programs. However, state budget cuts in North Carolina have made it difficult for agencies to maintain these off-site eligibility services. As described by one CBO: “We used to have an amazing situation. Food stamps [SNAP] and Medicaid . . . staff would come to our office one day a week. [Immigrant clients] would feel safe and comfortable in our office.” In contrast, in Massachusetts, with a better state budget situation, some of these workers were still placed in CBOs.

Training CBO Staff to Enroll Immigrant Parents

In these states, increased budget constraints after the recent recession were accompanied by a surge in the need for programs like SNAP. Amid these difficulties, public systems have been especially strained in trying to meet the needs of immigrant families. In cases where public agencies could no longer afford to make caseworkers available off site, community-based providers often became de facto eligibility workers. During site visits, several providers explained how they worked individually with immigrant clients to complete application forms and gather necessary supporting documents. The community-based service providers also accompanied clients to deliver their completed applications. Public agencies with limited funds for off-site eligibility workers can help support this strategy by offering training for CBO outreach workers.

In Texas, the Health and Human Services Commission has started training food bank workers in the state’s required face-to-face SNAP enrollment procedures. Food bank workers, on the front lines of serving those struggling economically, also provide application assistance for other federal programs, such as TANF and Medicaid. The Health and Human Services Commission’s demonstration project currently covers five sites: North Texas, Houston, Tarrant County, San Antonio, and South Plains (the Lubbock area). It was motivated by a backlog of applications that was partly fueled by the face-to-face interview required under Texas’s enrollment policy. A legislator suggested that the Commission partner with food banks to outsource some of the application burden. Early results are promising but pose questions of scalability and privacy concerns related to the Health Insurance Portability and Accountability Act. Many states have eliminated such face-to-face interview requirements, opting instead to determine eligibility electronically or by mail or phone (Rosenbaum and Dean 2011).

Targeting Immigrant Families’ Social Networks

Another powerful community social setting, one that can cross organizational and physical boundaries, is the social network. The immediate social networks of low-income immigrants are particularly powerful influences in their lives, even compared with those of native-born low-income families. This is partly because the decision to migrate is often network based. For example, those who emigrate from Mexico have more extensive social networks in their towns or cities of origin than their counterparts who do not emigrate (Massey and Espinosa 1997). Once in the United States, networks continue to be important, whether they are coethnic, cross-ethnic but sharing the same language, or other kinds of friendship and kin networks. Harnessing the capacity of positive social influence in networks can be a
central strategy in CBO-sponsored programs. Peer- and group-based models can provide many types of support, including information and enrollment information about health and human services.

For example, a health organization in Boston leverages social networks by providing a new group model, the Centering program, for more consistent and effective prenatal, postnatal, and diabetes care visits. This program changed the model from a one-on-one session with a provider to a group session with a physician leading the discussion. The program speaks to individuals looking for a supportive network of people instead of just a medical appointment. It helps address isolation and creates mutual support in the health care setting, where immigrants do not usually have strong social bonds.

Targeting Networks of Organizations across the Nonprofit, Private, and Public Sectors

Examples of effective and focused partnerships were abundant in our findings and included partnerships between CBOs and faith-based organizations, employers, schools, community colleges, and farmers’ markets. Examples of partnerships include the following:

- Refugee service providers and resettlement organizations partnered with community organizations to ease refugees’ transition to the country.
- Employers and community colleges provided valuable access to on-the-job training, English classes, and career and technical courses essential to self-sufficiency.
- Public agencies worked closely with school districts to reach parents who might not otherwise come to the attention of health and human services providers. School officials referred eligible families to specific services, especially families participating in free or reduced-price school lunch programs.
- Local TANF administrators worked with employers to ensure their clients met work activity requirements.
- Community-based credit unions referred low-income clients to public assistance programs when they knew clients needed additional resources.
- Farmers’ markets partnered with the SNAP program to facilitate access to produce and healthy nutrition options.
- Health and social service agencies sent outreach staff to Latino festivals run by other CBOs.

Such partnerships reflect the ingenuity, dedication, and networking skills of many public agency staff and their colleagues in community organizations. In this section, however, we focus less on partnerships between single organizations and agencies and more on those that link multiple CBOs with each other and with public agencies. In locales with multiple immigrant groups, for example, networks of immigrant-serving organizations have been conducting coordinated campaigns. And some
systems are themselves networks of organizations, whether school districts or hospital and clinic networks. Organizations network with each other in several different ways. Here, we profile five models that study respondents described as particularly effective.

Integrating via Umbrella Organizations and Other Strategies

Developing a single organizational entity to serve multiple geographic locations reduces the existence of multiple organizations that might compete with one another for limited donations and grants, and it reduces administrative costs for each client served. For example, at one time, Chapel Hill-Carrboro and Durham, North Carolina, had separate Latino community service organizations. Today, El Centro Hispano serves both communities. El Futuro, Inc., a nonprofit mental health service provider, established itself in one North Carolina community, then expanded with offices in two other communities.

Other entities are umbrella or intermediary organizations that help multiple immigrant-serving organizations increase their capacity to help families access health and human services. The Illinois Coalition for Immigrant and Refugee Rights, for example, brings together 39 immigrant-serving CBOs from across the state into an Immigrant Family Resource Program that provides Illinois-specific information about eligibility, enrollment, and recertification, as well as solutions to such barriers as transportation, language, and fears of immigration-related consequences of using benefits. The organization also fields a multilingual hotline to answer questions from immigrant families and providers about the full range of public programs.

Advocacy organizations can also play a coordinating role, facilitating immigrants’ interactions with an array of individual services, programs, and organizations. The Massachusetts advocacy organization Health Care for All, for example, fields a similar hotline concerning public benefit programs. Hotline operators are able to provide complex eligibility and application information from multiple agencies and programs in one place. In addition to providing information to immigrant families, advocates in the organization find the service link keeps them updated about the concerns of diverse immigrant communities across the state.

Coordinating Complementary Services across Organizations

The safety net for low-income families is typically spread across a range of private and public organizations and auspices. In response to increasingly scarce funding and resources, some CBOs are coordinating complementary services in order to more comprehensively serve immigrant populations than any single CBO can on its own. For example, one North Carolina community health provider subleases a part of its health facility to a community college and another part to a physicians’ group operating a pharmacy for indigent clients. Thus, clients can access medical, pharmaceutical, and educational services in one location, and these three service providers can share their building and facilities costs.
When hospitals, public health agencies, and community health centers partner, pool their resources, and refer clients when appropriate, immigrant clients find they can more easily navigate health services. In some cases, local organizations reach out to national networks (such as national advocacy organizations or migrant farmworker networks) for guidance on such partnerships.

**Establishing Networks across Advocacy Organizations, Private and Nonprofit CBOs, and Public Sectors**

Networks can bring together advocacy organizations, nonprofit and private CBOs, and public agency entities to share information and work cooperatively. In Massachusetts, an advisory board for the Department of Transitional Assistance (DTA), which oversees SNAP and TANF, is made up of advocacy groups, CBOs, community members, and state government workers (including one representative from each of the 22 state SNAP offices; each SNAP office director selects a CBO representative for the board with input from other organizations). The DTA also communicates regularly with Massachusetts health and child welfare services. The advisory board meets monthly as a subcommittee and holds quarterly meetings with the DTA to report on access and enrollment. The advisory board includes significant representation from groups that work with immigrant populations. Since the DTA brings people together, it allows CBOs to work with each other: advocates provide public agency administrators with information about issues faced by immigrants and other low-income populations, while public agencies can inform CBOs and advocates of changes in policy and implementation. CBOs can then flexibly address these issues. Through monthly meetings, the stakeholders have gotten to know each other well.

Similarly, the 51 grantees funded to provide outreach to immigrant populations under Massachusetts’s universal health care policy are brought together regularly in Massachusetts Health Training Forum meetings. During these meetings, grantees learn about new provisions in state health care and receive technical assistance. In addition, CBOs provide state health care administrators with valuable information about their experiences with immigrant families and children. CBOs are thus able to blend the service and advocacy aspects of their work by leveraging their knowledge from providing direct services to affect state policy. Our study identified a number of cross-sector partnerships that effectively addressed barriers faced by immigrants. Box 4 profiles three such partnerships focused on identification barriers.
BOX 4
CBO Responses to Identification Barriers among Mixed-Status Families: Intermediary-Public Partnerships

One challenge common to mixed-status families is lack of access to widely recognized identification, including the most important form of identification in the United States: the driver’s license. Some cities, such as New Haven, Trenton, and San Francisco, allow a form of local identification to help increase access to resources (Semple 2010).

In New York, a photo ID is required of parents visiting their children’s schools. For years, this ID was a driver’s license. In response to advocacy action, the state allowed consular identification to serve as an additional form of photo ID. The New York Immigration Coalition subsequently worked to partner public schools in high-concentration immigrant neighborhoods with the consulates of multiple countries of origin. Through this innovative partnership, an intermediary organization was able to work with multiple governments to address an access barrier for mixed-status families. ID drives sponsored by the Mexican and Ecuadorean consulates at these schools have resulted in large numbers of immigrant parents obtaining consular IDs. Identification drives and other consular strategies can help mixed-status families acquire forms of identification that then can be used to facilitate enrollment. Similar consulate drives have been successful in other cities, such as Boston (Montero-Sieburth 2007).

One CBO in Maryland has taken another approach to helping eligible applicants meet application requirements. To facilitate the process of applying for public services, the CBO offers families the option of receiving a membership document. The membership document costs $25 and includes the person’s name and address. According to the CBO, such documents have become widely recognized by local public agencies. In addition to providing required evidence of eligibility, the CBO can vouch for the accuracy of the membership document. In the CBO’s view, families who would otherwise have to navigate public benefit applications on their own can use the membership document to complement their applications for benefits. The ability to use the membership document helps immigrants evade potential roadblocks—for example, a lease or utility bill for the family’s residence may feature the name of a different person, such as the owner or another family member. Respondents mentioned that local community members see the organization’s many offices as safe spaces and view the membership document as a tool that also helps secure more positive experiences at local public agencies.

Finally, another local CBO in Maryland works with immigrant laborers and provides proof of income letters for day laborers who lack stable employment. The organization vouches for the number of days a worker has secured employment and how much he or she makes. Such letters help workers apply for benefits that are contingent on work, such as SNAP, TANF, or child care subsidies. Improved ID strategies for immigrant families could also lead to improved access to mainstream financial services.
Integrating IT Systems to Enable Streamlined Eligibility Determination, Enrollment, and Recertification

As the Affordable Care Act's Medicaid provisions are implemented, a new opportunity exists to integrate information technology (IT) systems across Medicaid, other public benefit programs, and the networks of CBOs directly involved in eligibility, enrollment, and recertification (Dorn 2011). The Affordable Care Act provides for federal funding to cover at least 90 percent of IT development costs across Medicaid and health insurance exchanges in the initial phase of implementation (through December 2015). Thus, health service organizations’ IT development costs related to the expansion of health care coverage may be covered, which may enable improvements in organizations’ ability to connect with public agencies on an informational level. With the expansion of health care coverage to certain groups of legal immigrants (for example, legal immigrants with fewer than five years in the United States, who will be eligible to purchase coverage through the new health exchanges), such IT improvements may benefit lower-income immigrant families.

Establishing Networks of Informal Nonservice Organizations

Low-income immigrant families are less likely than many other low-income populations to access formal service organizations. However, they may be more likely to interact with other kinds of organizations, such as faith-based ones. In a New York City study of immigrant families from Latino and Asian backgrounds, mixed-status immigrant families were more likely to attend church regularly than native-born families (Yoshikawa 2011). In addition, national faith-based associations regularly call for more immigrant access to public health and human services programs. The potential for networks of churches and faith-based organizations to provide outreach to immigrants is high (Skinner 2011).

A TANF and faith-based organization partnership supported by the Department of Health and Human Services’ Administration for Children and Families has encouraged partnerships such as one between the New York City Human Resources Administration, a set of faith-based organizations, and two intermediary organizations—the Henry Street Settlement, a long-standing CBO serving low-income families on the Lower East Side; and Seedco, which provides technical assistance to networks of CBOs in workforce development and family and work supports (Delgado and Tung 2011). Although the benefits of the intermediary organizations’ resources and capacity for advocacy were noted in a preliminary evaluation, challenges were also evident regarding faith-based organizations’ capacity for administrative and data-keeping functions, even with the assistance of intermediaries.

Conclusion

Low-income immigrants are underenrolled in health and human services programs nationwide, despite in many instances being eligible. As we have highlighted in this brief, CBOs are essential players in increasing access for this large, fast-growing group. Our site visits in Maryland, Massachusetts, North Carolina, and Texas and our literature review revealed several principles shared by CBOs that are increasing immigrants’ access to and receipt of health and human services.
**Social networks.** Successful CBOs take advantage of a key strength of immigrant communities: strong family and community networks. Social networks are powerful influences in the lives of low-income immigrants. Use of these naturally occurring networks to disseminate information, enroll families in services, and build trust is a successful and relatively low-cost approach to increasing immigrants’ access to health and human services.

**Collaboration.** Another important strategy is collaboration between CBOs and government offices to improve services to immigrant communities. The quality and quantity of services provided to immigrant families can be strengthened when CBOs work together and in conjunction with local government offices.

**Community settings.** In addition to targeting social networks, successful CBOs tend to bring the services to immigrants’ natural settings, including their living rooms and workplaces. This strategy addresses two common barriers to immigrants’ access: their long working hours and transportation problems.

**Coordinating complementary services.** Another successful strategy is to streamline access to multiple service programs. This includes such approaches as integrating IT systems across service programs and bringing together multiple service providers in the same location.

**Strong relationships.** Successful CBOs treat immigrant families as people rather than cases. They develop strong relationships with them and gain knowledge about the people themselves rather than just their health care needs.

**Leveraging trusted community members.** Training trusted community members to disseminate information about health and human services programs successfully addresses language and cultural barriers, and draws on the strength of immigrant social networks.

**Focus on safety.** Fears of immigration-related consequences from enrolling in programs and cultural norms that discourage receiving government benefits are major access barriers for immigrants. Successful CBOs emphasize making immigrants feel safe and secure in sharing information, applying for help, and accessing health and human services programs.

**Addressing immediate needs.** A particularly promising approach is to use a family or individual’s most immediate needs as an entry point for accessing broader services. For example, a CBO used common adolescent concerns about acne as a launching pad for enrolling youth in health and other service programs.

These shared, related principles and approaches have been used by CBOs in different contexts across the United States to increase low-income immigrants’ access to vital health and human services. Importantly, given reduced government budgets and competing public needs, many of these strategies are cost-saving approaches to assisting low-income immigrants. Increasing enrollment in health care programs, for example, can lead to cost savings in various ways, including reducing emergency room visits, increasing preventive care, and controlling potentially expensive chronic and common health conditions, such as diabetes. As a powerful force for integration of often-marginalized populations,
CBOs are particularly important for improving access of low-income immigrant families to health and human services.

Appendix A. Definitions

**Foreign-born:** Someone born outside the United States and its territories, except those born abroad to US-citizen parents. The foreign-born include those who have obtained US citizenship through naturalization and people in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to US-citizen parents, are native-born.

**Immigrant:** A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 and the following (similar to the statutory term “alien”). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this brief adheres to the legal definition of immigrant.

**Lawful permanent residents (LPRs):** People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

**Naturalized citizens:** LPRs who have become US citizens through naturalization. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

**Refugees and asylees:** People granted legal status because of persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum applications are approved. Refugees and asylees are eligible to apply for permanent residency after one year.

**Undocumented or unauthorized immigrants:** Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

**Lawfully present immigrants:** Lawfully present immigrants include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period for work, as students, or because of political disruption or natural disasters in their home countries. Some may seek to adjust their status and may have a status that allows them to remain in the country but does not grant the same rights as LPR status. The term “lawfully present” is used for applying for
Title II Social Security benefits and is defined in the Department of Homeland Security regulations at 8 CFR 103.12(a). The same definition is also used by the US Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid issued guidance to states that further defined “lawfully present” for determining eligibility for Medicaid and CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009.

**Qualified immigrants:** The following foreign-born people are considered eligible for federal benefits:

- LPRs
- refugees
- asylees
- people paroled into the United States for at least one year
- people granted withholding of deportation or removal
- people granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees and asylees)

**Nonqualified immigrants:** Immigrants who do not fall into qualified immigrant groups, including immigrants formerly considered permanently residing under color of law, immigrants with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

**Five-year ban:** Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.

### Appendix B. CBOs Consulted for This Study

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<tr>
<th>Organization name</th>
<th>Organization type</th>
<th>State</th>
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<td>Southwest Key</td>
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<td>Travis County Health and Human Services, Veterans Service Office</td>
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References


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Hirokazu Yoshikawa is the Courtney Sale Ross university professor of globalization and education at New York University. He conducts research on the effects of policies and programs related to early childhood development, immigration and poverty, and parental human capital on child and youth development. His work encompasses the United States and work in low- and middle-income countries. His recent books include Immigrants Raising Citizens: Undocumented Parents and Their Young Children. He serves on the Leadership Council and is cochair of the Early Childhood Development and Education workgroup of the UN Sustainable Development Solutions Network, the research and technical group advising the secretary-general on post-2015 sustainable development goals.

Christina Weiland is an assistant professor in educational studies at the University of Michigan School of Education. Her research focuses on the effects of early childhood interventions and public policies on children’s development, including the development of children from immigrant families, and on the mechanisms by which such effects occur.

Kjersti Ulvestad is the former associate director of research and evaluation at Jumpstart, an early education nonprofit, and currently works as a consultant for Boston Public Schools’ early childhood department. While working on this project, Ulvestad was a research assistant at the Harvard Graduate School of Education on the Preparing to Succeed study, a regression discontinuity study evaluating the impact of Boston Public School’s preschool classes on children’s progress and future school success, funded by the US Department of Education’s Institute of Education Sciences.

Krista M. Perreira is a professor of public policy and associate dean of the office for undergraduate research at the University of North Carolina at Chapel Hill. As a health economist and demographer, she studies disparities in health, education, and economic well-being and interrelationships between family, health, and social policy. Focusing on
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Robert Crosnoe is the Elsie and Stanley E. (Skinny) Adams, Sr., centennial professor in liberal arts at the University of Texas at Austin, where he is the chair of the department of sociology and holds faculty appointments in the population research center and (by courtesy) department of psychology. A developmental scientist, sociologist of education, and social demographer, he conducts mixed-methods research on connections between the general development and academic progress of children and adolescence and how these connections factor into socioeconomic and immigration-related disparities in educational attainment. He is particularly interested in the early education of low-income Mexican immigrant children in Texas.

Ajay Chaudry was until recently the deputy assistant secretary for human services policy in the Office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services. From 2007 to 2011, he was a senior fellow and director of the Center on Labor, Human Services, and Population at the Urban Institute, and contributed to this project in that capacity. Chaudry has led public policy research on child poverty, child well-being and development, human services programs in the social safety net, and the early childhood care system. From 2004 to 2006, he was deputy commissioner for child care and Head Start at the New York City Administration for Children’s Services, where he oversaw early childhood development programs serving 150,000 children in low-income families. He is the author of *Putting Children First: How Low-Wage Working Mothers Manage Child Care*.

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