BRIEFING PAPERS

Immigration Status

as a Social Determinant of Health
The Consumer Health Foundation would like to thank La Clinica del Pueblo for its partnership on the briefing paper focusing on health. La Clinica del Pueblo is a non-profit, federally qualified health center that serves the Latino and immigrant populations of the Washington, DC metro area. Its goal is to provide culturally appropriate health services, focusing on those most in need.
# Table of Contents

4  Glossary  
6  What are social determinants of health?  
7  What do we mean by immigration status?  
8  What are the characteristics of the immigrant communities in the Washington, DC region?  
38  How is immigration status a social determinant of health?  
40  Focus on Health: La Clinica del Pueblo  
42  How does La Clinica integrate immigration status in its service model approach?  
44  What are the policies that facilitate this approach?  
47  What are the gaps in policies?  
49  Resources  
55  Footnotes
The term “foreign born” refers to people residing in the United States at the time of the population survey who were not U.S. citizens at birth. The foreign born population includes naturalized U.S. citizens, lawful permanent immigrants (or green-card holders), refugees and asylees, certain legal nonimmigrants (including those on student, work, or some other temporary visas), and persons residing in the country without authorization.

The term “U.S. born” refers to people residing in the United States who were U.S. citizens in one of three categories: people born in one of the 50 states or the District of Columbia; people born in U.S. Insular Areas such as Puerto Rico or Guam; or people who were born abroad to at least one U.S. citizen parent.

Persons are considered to be in the civilian labor force if they were employed or if they were unemployed but actively looking for work. Persons not in the labor force include homemakers, retirees, students who do not work, and others who are neither working outside the home nor looking for work. Civilian labor force excludes members of the armed forces (Army, Navy, Air Force, Coast Guard, and Marines). Civilian employed population includes anyone who reported performing full or part-time work during a reference week, being temporarily absent from a job, or performing unpaid work for a family business or farm.

The term Limited English Proficient (LEP) refers to any person age 5 and older who reported speaking English “not at all,” “not well,” or “well” on their survey questionnaire. Persons who speak only English or who report speaking English “very well” are considered proficient in English.

Poverty status is not determined for unrelated individuals under the age of 15 (such as foster children) or for persons lacking conventional housing.

The term “home ownership rate” refers to the percentage owner households represent among all occupied households.
Introduction

In the Consumer Health Foundation’s (CHF) 2014-2016 strategic plan, “immigration status” was added to our vision statement as one of the identities around which barriers are often created that limit people’s ability to live a healthy and dignified life.

CHF and our partners are presenting a series of briefing papers to explore this concept as it relates to health, hunger and poverty, and workers’ issues. We have also included immigration data profiles and information on the undocumented population in Washington, DC, Maryland, and Virginia. We encourage service providers, nonprofit organizations, foundations, and local governments to use the briefing papers as resources in discussing programs and policies that impact immigrant communities.

Given the growing population of immigrants to the Washington, DC region, CHF then hosted a conversation with grantee partners and other stakeholders about immigrant health equity. Our goal was to better understand the concept of immigration status as a social determinant of health in order to best ensure positive health outcomes for this group of DC area residents.

While immigration status is of utmost importance in the lives of many in our region, one grantee partner pointed out that African Americans and Native Americans have “legal status,” yet their health outcomes remain the lowest compared to their white peers because of other social factors such as institutionalized racism. Therefore, it is important to note that immigration status is one factor that intersects with others to facilitate or hinder positive health outcomes.
What are social determinants of health?

According to the World Health Organization, the social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

These forces and systems include economic policies and systems (e.g., wages), social norms (e.g., discrimination), social policies (e.g., availability of affordable housing) and political systems. In the United States access to health care is a social determinant because access is determined by social factors such as working for an employer who provides health insurance as a benefit and the ability of individuals and families to cover health costs.

While access to health care has been viewed as the primary driver of positive health outcomes, we now know that most of health is socially determined. According to the County Health Rankings and Roadmaps, 50% of health is determined by social, economic and environmental factors, and 30% is determined by health behaviors, which are also partially influenced by social factors. The remaining 20% is determined by medical care.
What do we mean by immigration status?

*Immigration status is a legal term. It refers to the legal permission to reside in a foreign country. The general population is familiar with two statuses — documented and undocumented.*

However, there are multiple immigration statuses for immigrants who are documented or “lawfully present”, each with different levels of eligibility for federal, state, and local benefits.

**Eligibility for federal safety-net benefits are different for immigrants in these major categories:**
- Immigrants who have become citizens
- Legal permanent residents living in the country for more than five years
- Legal permanent residents living in the country for less than five years
- Immigrants who are lawfully present in the country but are not legal permanent residents
- Lawfully present immigrants with temporary, provisional or other documentation
- Undocumented immigrants

In addition to these many layers of status, families can have mixed status. For example, one parent might be a resident of more than five years while the other might be a resident of less than five years with children who are both citizens and undocumented.

These mixed status families face particular burdens as they navigate systems that require different statuses in order to be eligible for various social goods. In addition, family members with citizenship live in fear of the deportation of their loved ones. This is particularly traumatic for children with parents who are undocumented.
In 2010, more than one-in-five residents were foreign born, which made the DC metropolitan area the 7th largest destination in the United States for immigrants. The immigrant population has helped to increase racial and ethnic diversity in the region, hailing from as many as 193 different countries.

The Brookings Institute referred to the Washington metropolitan area, which includes 22 separate jurisdictions in Virginia, Maryland, West Virginia, and Washington, DC as the “new immigrant gateway.”

In this briefing paper, we included data on demographics, workforce, and income and poverty from the Migration Policy Institute and Center for Migration Studies. The information is based on the U.S. Census Bureau’s 2014 data. The complete data can be found in their respective websites.
In DC, Maryland, and Virginia, whites compose the largest foreign born population by race. DC and Maryland have the largest Black foreign born population (23.3% and 23% respectively) and Virginia has the largest Asian foreign born population (35.2%).

Based on the place of birth, many foreign born immigrants came from Latin America and the Caribbean (DC-43.1%; MD-39%; VA-35.9%). Virginia has the largest Asian foreign born population by place of birth (41.9%). Overall, the foreign born population in DC, MD, and VA are within the 18-64 age group.
According to the Pew Research Center, the Washington, DC-Arlington-Alexandria, VA metropolitan area has the third largest black immigrant population (6% of the foreign born black population overall). The metropolitan region is also home to the largest black Ethiopian immigrant community in the country. There are 46,000 black Ethiopian immigrants in the region which is 24% of the community’s population in the US.  

Source: Immigration Data Profile (2014), www.migrationpolicy.org
Maryland Population

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREIGN BORN</td>
<td>890,439</td>
</tr>
<tr>
<td>US BORN</td>
<td>5,085,968</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,976,407</td>
</tr>
</tbody>
</table>

Maryland Population by Place of Birth:
- Born in North America: 39.0%
- Born in Oceania: 16.1%
- Born in Europe: 10.5%
- Born in Latin America: 6.0%
- Born in Asia: 3.1%
- Born in Africa: 0.3%
- Born in Other races: 0.7%
- Born in Native Hawaiian and other Pacific Islander: 0.3%
- Born in Born in North America (Canada, Bermuda, Greenland, and St. Pierre and Miquelon): 1.0%

Demographics & Social Immigrant Data

- Foreign Born by Race:
  - White: 29.6%
  - Black or African American: 23.0%
  - American Indian and Alaska Native: 13.8%
  - Asian: 12.9%
  - Other race: 6.0%
  - Two or more race: 2.3%
  - Native Hawaiian and other Pacific Islander: 0.3%

- Foreign Born by Age Group:
  - under 5: 1.0%
  - 5-17: 0.3%
  - 18-64: 31.0%
  - 65+: 80.4%
  - Born in North America (Canada, Bermuda, Greenland, and St. Pierre and Miquelon): 12.9%
  - Born in Oceania: 6.0%
  - Born in Europe: 10.5%
  - Born in Latin America (South America, Central America, Mexico, and the Caribbean): 33.1%

Total Population of Latinos of Any Race: 275,875

Source: Immigration Data Profile (2014), www.migrationpolicy.org
**Demographics & Social Immigrant Data**

**Virginia Population**
- FOREIGN BORN: 1,005,620
- US BORN: 7,320,669
- TOTAL: 8,326,289

**Foreign Born by Race**
- White: 41.4%
- Black or African American: 8.8%
- American Indian and Alaska Native: 11.1%
- Asian: 0.1%
- Other race: 3.1%
- Two or more race: 0.3%
- Native Hawaiian and other Pacific Islander: 0%

**Foreign Born by Place of Birth**
- Born in North America (Canada, Bermuda, Greenland, and St. Pierre and Miquelon): 10.4%
- Born in Oceania: 41.9%
- Born in Africa: 1.4%
- Born in Asia: 35.9%
- Born in Europe: 10.0%
- Born in Latin America (South America, Central America, Mexico, and the Caribbean): 0.3%

**Foreign Born by Age Group**
- under 5: 0.9%
- 5-17: 11.3%
- 18-64: 6.5%
- 65+: 81.3%

**Total Population of Latinos of Any Race: 332,221**

Source: Immigration Data Profile (2014), www.migrationpolicy.org
Immigrants make up a significant portion of the workforce in DC, MD, and VA as well. More than 70% of the foreign born population age 16 and older are in the civilian labor workforce.
## WORKFORCE: Civilian Labor Force (Age 16+)

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (Age 16+)</td>
<td>86,344</td>
<td>844,017</td>
<td>945,700</td>
</tr>
<tr>
<td></td>
<td>468,782</td>
<td>3,931,126</td>
<td>5,718,881</td>
</tr>
<tr>
<td>Civilian Labor Force (Age 16+)</td>
<td>62,081</td>
<td>618,664</td>
<td>676,176</td>
</tr>
<tr>
<td></td>
<td>316,897</td>
<td>2,606,337</td>
<td>3,625,771</td>
</tr>
<tr>
<td>% In the Civilian Labor Force</td>
<td>71.9%</td>
<td>73.3%</td>
<td>71.5%</td>
</tr>
<tr>
<td></td>
<td>67.6%</td>
<td>66.3%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Unemployed Civilian Labor Force</td>
<td>3,166</td>
<td>39,594</td>
<td>35,161</td>
</tr>
<tr>
<td></td>
<td>30,422</td>
<td>192,869</td>
<td>224,798</td>
</tr>
<tr>
<td>% Unemployed of the Total Civilian Labor Force</td>
<td>5.1%</td>
<td>6.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td>9.6%</td>
<td>7.4%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Civilian Employed Workers (Age 16+)</td>
<td>58,902</td>
<td>579,042</td>
<td>640,914</td>
</tr>
<tr>
<td></td>
<td>286,690</td>
<td>2,415,259</td>
<td>3,398,770</td>
</tr>
</tbody>
</table>
**WORKFORCE: Foreign Born Civilian Employed Workers (Age 16+) by Period of Entry**

**Washington, DC Workforce**
- RECENT ARRIVALS (within 10 years): 23,056
- ARRIVED 11+ YEARS AGO: 37,129
- TOTAL: 59,886

**Maryland Workforce**
- RECENT ARRIVALS (within 10 years): 169,427
- ARRIVED 11+ YEARS AGO: 402,962
- TOTAL: 572,390

**Virginia Workforce**
- RECENT ARRIVALS (within 10 years): 183,346
- ARRIVALS WITHIN 11+ YEARS: 457,724
- TOTAL: 641,070

Source: Immigration Data Profile (2014), www.migrationpolicy.org
In DC and Maryland, most of the foreign born civilian employed workers come from Latin America. In Virginia, they come from Asia and Latin America.

** Latin America (South America, Central America, Mexico, and the Caribbean)
* North America (Canada, Bermuda, Greenland, and St. Pierre and Miquelon)
WORKFORCE: Percentage of Foreign Born by Industry

Total Foreign Born Civilian Workers (Age 16+): 58,902

- Construction: 40.8% (24,032)
- Manufacturing: 23.6% (13,901)
- Wholesale trade: 23.6% (24,032)
- Retail trade: 15.3% (9,012)
- Transportation and warehousing, and utilities: 19.4% (11,427)
- Information: 7.8% (4,594)
- Finance and insurance, and real estate and rental, and leasing: 16.2% (9,542)
- Professional, scientific, management, administrative, waste-management services: 16.5% (9,719)
- Educational services, and health care and social assistance: 13.7% (8,070)
- Arts, entertainment, recreation, accommodation, and food services: 32.8% (19,320)
- Other services (except public administration): 15.7% (9,248)
- Public administration: 10.9% (6,420)
- Agriculture, forestry, fishing and hunting, and mining: 0.0% (0)
- All civilian workers: 17.0% (10,013)

Source: Immigration Data Profile (2014), www.migrationpolicy.org
WORKFORCE: Percentage of Foreign Born by Industry

Source: Immigration Data Profile (2014), www.migrationpolicy.org

Total Foreign Born Civilian Workers (Age 16+): 579,042

1. All civilian workers
   - 19.3% (111,755)

2. Agriculture, forestry, fishing and hunting, and mining
   - 14.6% (84,540)

3. Construction
   - 24.7% (143,023)

4. Manufacturing
   - 18.3% (105,965)

5. Wholesale trade
   - 15.2% (88,014)

6. Retail trade
   - 17.3% (100,174)

7. Transportation and warehousing, and utilities
   - 16.7% (96,700)

8. Information
   - 14.0% (81,066)

9. Finance and insurance, and real estate and rental, and leasing
   - 14.3% (82,803)

10. Professional, scientific, management, administrative, waste-management services
    - 21.9% (126,810)

11. Educational services, and health care and social assistance
    - 18.1% (104,807)

12. Arts, entertainment, recreation, accommodation, and food services
    - 24.7% (143,023)

13. Other services (except public administration)
    - 28.0% (162,132)

14. Public administration
    - 10.8% (82,537)

---

Focus on Health • 18
WORKFORCE: Percentage of Foreign Born by Industry

Source: Immigration Data Profile (2014), www.migrationpolicy.org

Total Foreign Born Civilian Workers (Age 16+): 640,914
### WORKFORCE: Immigrant Workers’ Education & English Proficiency

**Civilian Employed Workers (Age 25+)**

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Born</td>
<td>55,566</td>
<td>541,047</td>
<td>590,466</td>
</tr>
<tr>
<td>US Born</td>
<td>256,085</td>
<td>2,117,755</td>
<td>2,945,232</td>
</tr>
</tbody>
</table>

**Low-educated Workers (i.e., those with high school diploma)**

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Born</td>
<td>12,755</td>
<td>104,031</td>
<td>109,912</td>
</tr>
<tr>
<td>US Born</td>
<td>7,280</td>
<td>81,539</td>
<td>150,473</td>
</tr>
</tbody>
</table>

% Low-educated of All Workers

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.0%</td>
<td>2.8%</td>
<td>19.2%</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

**High-educated Workers (i.e., those with at least a bachelor’s degree)**

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Born</td>
<td>28,572</td>
<td>234,050</td>
<td>254,323</td>
</tr>
<tr>
<td>US Born</td>
<td>176,342</td>
<td>944,692</td>
<td>1,263,726</td>
</tr>
</tbody>
</table>

% High-educated of All Workers

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.4%</td>
<td>68.9%</td>
<td>43.3%</td>
<td>43.1%</td>
</tr>
</tbody>
</table>

**Limited English Proficient (LEP) Workers (Age 25+)**

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Born</td>
<td>18,880</td>
<td>186,086</td>
<td>232,028</td>
</tr>
<tr>
<td>US Born</td>
<td>2,162</td>
<td>9,083</td>
<td>13,561</td>
</tr>
</tbody>
</table>

% LEP Among All Workers

<table>
<thead>
<tr>
<th></th>
<th>DC</th>
<th>MD</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.0%</td>
<td>0.8%</td>
<td>34.4%</td>
<td>39.3%</td>
</tr>
</tbody>
</table>

Source: Immigration Data Profile (2014), www.migrationpolicy.org
income & poverty

Approximately 66% of immigrants in DC and 70% in Maryland and Virginia for whom the poverty status could be determined have incomes that are at or above 200% of the federal poverty level (which is $32,049 and above for a family of 2 in 2016).

There are 16.5% in DC, 11.2% in Maryland, and 12.3% in Virginia who have incomes that are below 100% of the federal poverty level (which is $16,020 and lower for a family of 2.) Low earnings create barriers to housing, education, employment, and safe and healthy neighborhoods, making income an important indicator for health outcomes.

In DC, approximately 22.3% of noncitizens do not have health insurance coverage; 37% in Maryland; and 40.2% in Virginia. The diverse immigrant community has the same basic health needs as other residents. Cultural and linguistic limitations often prevent immigrants from seeking specialists or preventative care instead preferring to rely on emergency services. Securing adequate healthcare is especially challenging in a region with little foreign language resources. As of 2010, 44% of physicians in DC lacked proficiency in any other language besides English. There are hardly any physicians who speak Tagalog, Chinese, or Vietnamese in the region.
Focus on Health

INCOME & POVERTY:
Immigration Data Profile

Foreign vs. US Born Poverty Level Comparison

<table>
<thead>
<tr>
<th>Category</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 100%</td>
<td>16.5%</td>
<td>17.9%</td>
</tr>
<tr>
<td>100-199%</td>
<td>17.2%</td>
<td>13.2%</td>
</tr>
<tr>
<td>At or Above 200%</td>
<td>66.3%</td>
<td>68.9%</td>
</tr>
<tr>
<td>Total</td>
<td>86,951</td>
<td>537,376</td>
</tr>
</tbody>
</table>

Foreign vs. US Born Full-Time, Year-Round Workers Earnings Comparison (Age 16+)

<table>
<thead>
<tr>
<th>Earnings Range</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-$9,999</td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>$10,000-$14,999</td>
<td>2.1%</td>
<td>1.8%</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>11.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>34.8%</td>
<td>44.6%</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>17.2%</td>
<td>21.8%</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>19.0%</td>
<td>21.8%</td>
</tr>
<tr>
<td>$75,000+</td>
<td>66.3%</td>
<td>68.9%</td>
</tr>
<tr>
<td>Total</td>
<td>40,234</td>
<td>223,512</td>
</tr>
</tbody>
</table>

Source: Immigration Data Profile (2014), www.migrationpolicy.org
INCOME & POVERTY:
Immigration Data Profile

Foreign vs. US Born Poverty Level Comparison

<table>
<thead>
<tr>
<th>Category</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 100%</td>
<td>98,818</td>
<td>490,354</td>
</tr>
<tr>
<td>100-199%</td>
<td>157,933</td>
<td>643,899</td>
</tr>
<tr>
<td>AT or above 200%</td>
<td>625,555</td>
<td>3,818,818</td>
</tr>
<tr>
<td>Total</td>
<td>882,306</td>
<td>4,953,071</td>
</tr>
</tbody>
</table>

Foreign vs. US Born Full-Time, Year-Round Workers Earnings Comparison (Age 16+)

<table>
<thead>
<tr>
<th>Category</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-$9,999</td>
<td>6,822</td>
<td>23,008</td>
</tr>
<tr>
<td>$10,000-$14,999</td>
<td>17,908</td>
<td>37,167</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>57,563</td>
<td>146,900</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>70,781</td>
<td>215,926</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>79,308</td>
<td>320,349</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>77,176</td>
<td>423,002</td>
</tr>
<tr>
<td>$75,000+</td>
<td>116,831</td>
<td>605,301</td>
</tr>
<tr>
<td>Total</td>
<td>426,390</td>
<td>1,769,885</td>
</tr>
</tbody>
</table>

Source: Immigration Data Profile (2014), www.migrationpolicy.org
INCOME & POVERTY: Immigration Data Profile

Foreign vs. US Born Poverty Level Comparison

<table>
<thead>
<tr>
<th>Category</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 100%</td>
<td>122,399</td>
<td>828,967</td>
</tr>
<tr>
<td>100-199%</td>
<td>176,134</td>
<td>1,055,693</td>
</tr>
<tr>
<td>AT OR ABOVE 200%</td>
<td>696,577</td>
<td>5,200,529</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>995,110</td>
<td>7,085,190</td>
</tr>
</tbody>
</table>

Foreign vs. US Born Full-Time, Year-Round Workers Earnings Comparison (Age 16+)

<table>
<thead>
<tr>
<th>Earnings Range</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-$9,999</td>
<td>5,546</td>
<td>37,994</td>
</tr>
<tr>
<td>$10,000-$14,999</td>
<td>20,335</td>
<td>75,988</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>68,861</td>
<td>283,690</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>76,256</td>
<td>364,743</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>81,340</td>
<td>496,456</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>85,037</td>
<td>536,983</td>
</tr>
<tr>
<td>$75,000+</td>
<td>124,783</td>
<td>737,086</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>462,158</td>
<td>2,532,941</td>
</tr>
</tbody>
</table>

Source: Immigration Data Profile (2014), www.migrationpolicy.org
INCOME & POVERTY: Median Household Income

Foreign vs. US Born Comparison

- DC: $61,219
- MD: $73,167
- VA: $72,086
- US Born: $64,312

Naturalized vs. Noncitizens Comparison

- DC: $69,657
- MD: $82,623
- VA: $79,838
- Naturalized Citizens: $54,615
- Noncitizens: $61,111

Source: Immigration Data Profile (2014), www.migrationpolicy.org
INCOME & POVERTY: Home Ownership Rate

Foreign vs. US Born Comparison

<table>
<thead>
<tr>
<th>Region</th>
<th>Foreign Born</th>
<th>US Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>33.3%</td>
<td>41.8%</td>
</tr>
<tr>
<td>MD</td>
<td>56.8%</td>
<td>55.3%</td>
</tr>
<tr>
<td>VA</td>
<td>67.6%</td>
<td>66.8%</td>
</tr>
</tbody>
</table>

Naturalized vs. Noncitizens Comparison

<table>
<thead>
<tr>
<th>Region</th>
<th>Naturalized Citizens</th>
<th>Noncitizens</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>50.2%</td>
<td>18.9%</td>
</tr>
<tr>
<td>MD</td>
<td>34.2%</td>
<td>72.1%</td>
</tr>
<tr>
<td>VA</td>
<td>33.3%</td>
<td>71.0%</td>
</tr>
</tbody>
</table>

A significant number of immigrants also own homes. However, the Department of Housing and Urban Development (HUD) has cited cases where building owners denied housing to foreign language speakers despite protections under the Fair Housing Act, which forbids discrimination based on race or ethnicity.  

Source: Immigration Data Profile (2014), www.migrationpolicy.org
INCOME & POVERTY:  
*Health Insurance Coverage Data*

**Washington, DC**
- **Naturalized Citizens**: 94.3%
- **Noncitizens**: 5.7%
- **With Health Insurance Coverage**: 32,840
- **No Health Insurance Coverage**: 1,985

**Maryland**
- **Naturalized Citizens**: 91.2%
- **Noncitizens**: 8.8%
- **With Health Insurance Coverage**: 393,546
- **No Health Insurance Coverage**: 37,974

**Virginia**
- **Naturalized Citizens**: 88.7%
- **Noncitizens**: 11.3%
- **With Health Insurance Coverage**: 435,887
- **No Health Insurance Coverage**: 55,530

Source: Immigration Data Profile (2014), www.migrationpolicy.org
Most undocumented immigrants are employed in various industries. In DC, 41.7% were employed in the service industry while 16% work in some type of managerial or professional specialty position.

In Maryland, the trends are similar. 31.6% of undocumented labor work in the service industry; 19.1% were in precision production, craft, and repair industries; 15% and 11.9% work in technical, sales and administrative support and managerial or professional specialty industries, respectively. In Virginia, 31.1% of these workers were employed in the service industry; 16.9% as operators, fabricators, or laborers; 17% and 15.8% were employed in technical, sales and administrative support and precision production, craft, and repair industries. A number were unemployed in DC (6.3%), MD (6.8%), VA (3.3%).
UNAUTHORIZED POPULATION: Demographics & Social Data

Total Unauthorized Population: 20,420

Source: Data from Center for Migration Studies, www.cmsny.org
UNAUTHORIZED POPULATION: Demographics & Social Data

Total Unauthorized Immigrant: 232,673

Source: Data from Center for Migration Studies, www.cmsny.org
UNAUTHORIZED POPULATION: Demographics & Social Data

Total Unauthorized Immigrant: 268,916

Race by Ethnicity:
- White (Not Hispanic): 64.6%
- Black (Not Hispanic): 21.0%
- Hispanic: 4.5%
- Asian (Not Hispanic): 9.0%
- Other (Not Hispanic): 0.9%

Continent Region of Origin:
- Africa: 29.1%
- Asia: 28.2%
- Europe: 19.5%
- South America: 15.8%
- Oceania (0%)
- North America: 10.0%
- Caribbean: 9.5%
- Central America: 7.3%
- Less than 5: 0.5%
- 5-9: 0.5%
- 10-14: 2.2%
- 15-19: 22.1%
- 20+: 25.6%
- 20+: 30.0%

Age (in years):
- Under 5: 15.4%
- 5-17: 19.5%
- 18-20: 28.2%
- 21-24: 29.1%
- 25-34: 7.3%
- 35-44: 4.9%
- 45-64: 22.1%
- 65+: 1.0%

Source: Data from Center for Migration Studies, www.cmsny.org
# Unauthorized Population: Occupation (Age 16+ in the Labor Force)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial &amp; Professional Specialty</td>
<td>16.0%</td>
<td>2,538</td>
</tr>
<tr>
<td>Technical, Sales &amp; Administrative Support</td>
<td>14.4%</td>
<td>2,285</td>
</tr>
<tr>
<td>Services</td>
<td>41.7%</td>
<td>6,623</td>
</tr>
<tr>
<td>Farming, Forestry &amp; Fishing</td>
<td>3.6%</td>
<td>580</td>
</tr>
<tr>
<td>Precision Production, Craft &amp; Repair</td>
<td>13.8%</td>
<td>2,201</td>
</tr>
<tr>
<td>Operators, Fabricators &amp; Laborers</td>
<td>10.5%</td>
<td>1,670</td>
</tr>
</tbody>
</table>

**Total Unauthorized Population in the Labor Force:** 15,897

*Source: Data from Center for Migration Studies, www.cmsny.org*
UNAUTHORIZED POPULATION: Occupation (Age 16+ in the Labor Force)

Managerial & Professional Specialty: 11.9% (20,716)
Technical, Sales & Administrative Support: 15.0% (26,068)
Services: 31.6% (54,749)
Farming, Forestry & Fishing: 6.3% (10,962)
Precision Production, Craft & Repair: 19.1% (33,122)
Operators, Fabricators & Laborers: 13.8% (23,883)

Total Unauthorized Population in the Labor Force: 173,414

Source: Data from Center for Migration Studies, www.cmsny.org
UNAUTHORIZED POPULATION: Occupation (Age 16+ in the Labor Force)

Managerial & Professional Specialty: 12.2% (24,056)
Technical, Sales & Administrative Support: 17.0% (33,487)
Services: 31.1% (61,058)
Farming, Forestry & Fishing: 5.9% (11,583)
Precision Production, Craft & Repair: 15.8% (31,090)
Operators, Fabricators & Laborers: 16.9% (33,265)

In DC, 14.5% of individuals are living at or below the federal poverty level; it is 16.8% in Maryland; and 16.9% in Virginia.

Source: Data from Center for Migration Studies, www.cmsny.org
UNAUTHORIZED POPULATION:
Employment Status (Age 16+)

Washington, DC
- Employed: 14,893
- Unemployed (but seeking work): 1,004
- Not in labor force: 2,463
- Total: 18,360

Maryland
- Employed: 158,963
- Unemployed (but seeking work): 14,451
- Not in labor force: 39,517
- Total: 212,931

Virginia
- Employed: 188,220
- Unemployed (but seeking work): 8,303
- Not in labor force: 51,618
- Total: 248,141

Source: Data from Center for Migration Studies, www.cmsny.org
UNAUTHORIZED POPULATION: Poverty Status

WASHINGTON, DC 20,420
MARYLAND 232,673
VIRGINIA 268,916

Source: Data from Center for Migration Studies, www.cmsny.org

Above Poverty Threshold
At/below Poverty Threshold
UNAUTHORIZED POPULATION: 
*Health Insurance Coverage*

**Washington, DC**
- WITH COVERAGE: 12,214 (59.8%)
- WITH NO COVERAGE: 8,205 (40.2%)
- TOTAL: 20,419

**Maryland**
- WITH COVERAGE: 108,087 (46.5%)
- WITH NO COVERAGE: 124,587 (53.5%)
- TOTAL: 232,673

**Virginia**
- WITH COVERAGE: 128,076 (47.6%)
- WITH NO COVERAGE: 140,839 (52.4%)
- TOTAL: 268,917

Source: Data from Center for Migration Studies, www.cmsny.org
How is immigration status a social determinant of health?

There is a history of exclusion and discrimination based on immigration status, and in recent years there has been an increase in anti-immigrant sentiments in the United States. In addition, the language that we use to describe those with noncitizen status has “criminalized” immigrants.

It wasn’t until 2013 (through the efforts of Race Forward) that the term “undocumented” began to be used by the media — instead of “illegal” — when describing unauthorized immigrants.

Status determines how a new person to this country will lead their lives. For example, besides income, immigration status is the only requirement for Medicaid eligibility in states that have expanded Medicaid. In addition, precarious immigration status can compound other identities such as gender, sexual orientation and gender identity. For example, immigrant women have specific experiences. They arrive with their children or not (either causes stress) and work in traditionally female occupations, such as domestic work. The lack of employment opportunities and fear of deportation make them vulnerable to sexual harassment and gender-based violence.

Studies consistently show that children of immigrant parents are more likely to lack health insurance than children with U.S.-born parents and are less likely to be taken to the doctor. Studies also show that a parent’s undocumented status is associated with lower levels of cognitive development and educational progress for the child. The most damaging effects seem to stem from parental detention or removal, which impacts the economic and psychological well-being of the child. The psychological distress experienced by parents who are undocumented is also associated with negative developmental effects for their children. Nearly 50 percent of parents who are undocumented reported that their child had been anxious, and almost 75 percent reported that a child had shown symptoms of post-traumatic stress disorder resulting from the threat of detention and deportation.
How is immigration status a social determinant of health?

A study\(^\text{11}\) of barriers within the health system for persons with undocumented status included bureaucratic obstacles such as paperwork and registration systems, limited and overwhelmed safety net systems and widespread discriminatory practices within the health care system itself. At the individual level, barriers included fear of deportation, stigma, and lack of capital (both social and financial) to obtain services.

Recommendations identified in the papers reviewed included advocating for policy change to increase access to health care for undocumented immigrants, providing novel insurance options, expanding safety net services, training providers to better care for immigrant populations, and educating undocumented immigrants on navigating the system.

This paper provides an overview of the concept of immigration status as a social determinant of health. We share one example of a comprehensive approach used by CHF’s partner La Clinica del Pueblo to advance immigrant health equity including the incorporation of services and advocacy that address immigration status. Comprehensive immigration reform is what this country needs to begin to right the health and social inequities facing immigrant families. As advocates work toward this goal, there are local solutions that the social profit sector can employ now to create systems that support immigrant health.
La Clinica de Pueblo is a community-based, federally qualified health center that provides primary medical care, mental health and substance abuse services; social services; interpreter services; comprehensive HIV care; health education; and advocacy for the rights of men, women and children throughout the Washington, DC metropolitan area.

Since 1983, La Clinica has worked to meet the comprehensive needs of vulnerable, low-income, limited English proficient Latino immigrants. La Clinica’s mission is to build a healthy Latino community through culturally appropriate health services, focusing on those most in need. La Clinica’s fundamental approach values health equity, and recognizes health as a human right. La Clinica was originally created and inspired by social justice and human rights movements that helped Central American survivors of the civil wars and dictatorships in the 1980s, and is embedded in Latino community and culture in the DC metropolitan area.

In order to maintain its roots and, at the same time, provide high quality health care, La Clinica designs and implements programs and services using the following strategies:

- Creating a welcoming, safe, accessible, culturally, linguistically appropriate and patient centered medical home.
- Serving all, reaching out to those socially excluded due structural determinants (poverty, race, ethnicity, sexual orientation, gender, immigration status, language)
- Meeting individual health care needs by seeing the whole person and their context.
- Engaging in ongoing community dialogue to inform our model of care with the context in which our community lives.
Focus on Health: La Clinica del Pueblo

- Identifying complex patterns impacting the well-being of the whole community.
- Searching and adapting evidence-based public health community interventions.
- Identifying solutions to barriers created by the health care system and social determinants.
- Building and sharing evidence-based creative, high quality health care services.
- Integrating care and population health, ensuring language access, coordinating across multiple disciplines, partnering with others, and strengthening the broader health care system.
- Empowerment, training, and supporting the development of community members as leaders and staff to guarantee cultural roots.
- Advocating for systems change to ensure health equity.

La Clinica’s ultimate goal is to dramatically improve health outcomes of its patients, who are 85% foreign born, with the majority indicating El Salvador, Honduras, Guatemala, and Mexico as their country of origin.
La Clinica del Pueblo has identified that, more than any other social determinant, immigration status affects the ability of patients (and their families) to obtain the needed social stability in which positive health outcomes can be achieved.

Immigration status shapes access to health care coverage within our jurisdictions, and is a key determinant in the mental and physical health of our clients and patients. Adjusting immigration status becomes a key element of care plans and psychosocial programs, in much the same way that a health care provider who works with the homeless must integrate achievement of housing stability as a critical element of care. For La Clinica’s patient base, achieving legal stability with respect to their immigration status is the core social goal. At the community level, achieving at minimum health care coverage regardless of immigration status is a key health equity issue.

La Clinica has experience integrating immigration legal services into services. One such case is Entre Amigas, a 15-year old program housed within its Gender and Health unit which provides education, support groups, and navigation to Latina immigrant women around women’s health issues. Entre Amigas has formal partnerships with domestic violence legal providers, trains promotores as legal navigators, and supports women through complicated legal cases involving their own immigration cases, criminal cases against an abuser, child custody, and the cases of their immigrant minors.

Dozens of Entre Amigas participants have been able to obtain a U-Visa, which provides immigrant women with a pathway to citizenship, as a result of this program. Critical to this program’s success has been dedicated staff focused on this key social determinant, partners, and in-house legal education provided by a legal consultant. Lessons learned from this program also include that women
How does La Clinica integrate immigration status in its service model and approach?

La Clinica’s ¡EMPODÉRATE! Program is another example of this approach. ¡EMPODÉRATE! provides a safe space for the LGBTQ Latino community in the DC area to obtain HIV and substance abuse prevention services, as well as navigation and support around key health and social issues.

This program also uses the model of legal services navigation embedded within core health and prevention services to comprehensively support clients. In this case the program serves a sector of the Latino community that is highly exposed to discrimination and gender-based violence in their country of origin, and whose vulnerability is exacerbated in the US due to uncertain immigration status.

¡EMPODÉRATE! has helped a larger number of clients to stabilize their legal status by investing time and energy to obtain legal support from many avenues.

The above programs are also successful because they include the following elements:

- Clear points of contact within the organization that can support all staff with clients who can benefit from legal navigation.
- A network of pro bono lawyers & legal partner organizations that provide support for individual cases as needed.
- Protection for patients from being exploited from fraudulent legal advertisement and practices.
What are the policies that facilitate this approach?

**Health care programs and policies that view and integrate immigrants as another sector of the overall population to be served are an important component of a strategy that improves the health of immigrants.**

Sadly, this is not a given in today’s public health community, as the Affordable Care Act (ACA) ushered in an era where health access was expanded for all except undocumented immigrants, and Medicaid coverage was expanded (in all willing states) to the nations’ low-income families except for immigrant low-income families where the “five-year bar” is not met. Every major immigration reform initiative currently under consideration perpetuates and in some cases seeks to expand the exclusion of immigrants, both legal and undocumented.

Fortunately, in our region several federal and local programs exist that either do not exclude immigrants, or proactively seek to include them in recognition of the growing gap in health access based on immigration status. These go above and beyond the typical health department services available to immigrants (for example, treatment of communicable diseases and/or prenatal care). Each of the programs below are results of movements that sought to expand both health care access and ensure high quality primary care to underserved communities.

**Federally Qualified Health Centers (FQHC) model**

This program traces its origin to the 1965 War on Poverty during the Johnson administration. Today FQHCs provide comprehensive primary care for patients of all ages, regardless of their ability to pay, and receive grant funding under Section 330 of the Public Health Service Act. FQHCs also receive a host of benefits that include cost-based reimbursement from Medicare and Medicaid, access to National Health Service Corp (NHSC) programs, participation in the Public Health Act 340B drug
What are the policies that facilitate this approach?

discount program, and malpractice insurance under the Federal Tort Claims Act (FTCA). FQHCs are viewed as safety net providers for the thousands of immigrants who will remain uninsured post-ACA.

**DC-Healthcare Alliance Program (“the Alliance”)**

This locally-funded program is designed to provide medical assistance to District residents who are not eligible for Medicaid. The Alliance program serves low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare. To be eligible for the DC Healthcare Alliance, a patient must be a resident of the District of Columbia, meet financial eligibility requirements, not have any other health or medical coverage and complete a face-to-face interview. The DC Alliance was born as a result of a coalition of primary care providers seeking to improve the health status of DC residents more than 10 years ago; care for the undocumented was explicitly included in its vision and purpose. This program was supported by an existing proclamation made by former Mayor Marion Barry, extending all DC services to District residents regardless of immigration status. The Alliance covers visits to doctors, preventive care, prescription drugs, laboratory services, medical supplies, and dental services up to $1000. It does not cover vision care, mental and behavioral health and substance abuse services, non-emergency transportation services, and long term care services that extend more than 30 days.

**MD-Montgomery Cares**

This is a County-funded program that reimburses community-based clinics for health care provided to low-income, uninsured adults in Montgomery County. The program offers: (1) Medical check-ups by a doctor/nurse; (2) Sick Visits by a doctor/nurse; (3) Medications; (4) Lab tests; (5) X-Rays; (6) Flu Shots; (7) On-site behavioral health care; (8) Access to specialty care; and (9) Access to Oral Health.

This program is funded through local funds, in recognition of gaps in health care coverage in the
What are the policies that facilitate this approach?

County, including those faced by its large, multilingual immigrant community. This program is historically in keeping with the County’s proactive, welcoming approach to immigrants and commitment to universal health coverage for all its residents.

**Federal-Ryan White HIV/AIDS program**

This funding stream was enacted through legislation in 1990 to provide cities, states, and local community-based organizations with the financial support needed to provide services to those who do not have sufficient health care coverage or financial resources to cope with HIV.

The majority of Ryan White HIV/AIDS program funds support primary medical care and essential support services. A significant component of the Ryan White program is ADAP, the AIDS Drug Assistance Program, which provides pharmacy coverage to uninsured and underinsured persons living with HIV across the country. Ryan White services are available to all persons living with HIV regardless of immigration status; because of this and the historic commitment of Ryan White to those most in need, this program provides an important source of immigrant health in our communities.

**Maryland All-Payer System**

Maryland is the only state in the nation which provides a single rate of payment to hospitals, regardless of the hospital’s insurance mix. This means that this system potentially incentivizes hospitals to form partnerships with primary care organizations in order to reduce hospital costs fueled by patients with poor primary care. This system is still too new to evaluate in terms of results in access, but has the potential to increase access and improve quality through the vehicle of payment reform.
What are the gaps in policies?

Despite the programs available to residents in our area, there are significant limits to what they are able to provide, and policy changes are needed to truly address immigrant access to care and immigrant health outcomes in our area. These gaps include but are not limited to the following.

Partial response to a comprehensive health care need

Each program above is unable to provide the full range of health care services needed by any individual and family, and standardized by the ACA. Uninsured clients of FQHCs or Ryan White providers do not have access to hospital or specialty coverage; the Ryan White system only covers those with HIV; and the DC Alliance has no mental health benefit. The safety net clinics are at capacity and a greater influx of uninsured threatens their financial viability.

Regional differences

We live in a region made up of two states and the District of Columbia, with widely varying approaches to health access and health for immigrants. Immigrant families are inhibited in their ability to make choices as to where to live and move within the region, as changes in a county or state may make a significant difference in their health access and health status.

For example, Virginia is the only state in the Washington, DC region that has not expanded Medicaid. Approximately 14% of the population is uninsured. Immigrants have lower rates of health insurance coverage compared to other Virginians. Almost half of Hispanic or Latino immigrants have no health insurance coverage. In addition, Virginia’s Medicaid income eligibility requirement is among the lowest in the country. Parents with dependent children are eligible if their household income is up to 49% of the federal poverty level ($9,700/year for a family of three).
Northern Virginia’s federally qualified health centers are integrating behavioral services in their programs. Virginia has a well-developed behavioral health system through its Community Service Boards. Although it is not adequate to meet the needs of the uninsured and immigrant populations.

**Health access does not equal high quality care**

The fragmentation of health systems; lack of integration of the health system with legal, financial and social supports; and the lack of culturally and linguistically appropriate inter-sectoral services and organizations contribute to health disparities, and impose a barrier to the establishment and maintenance of a robust navigation program for immigrants.

**Xenophobia and its impact**

The lack of comprehensive immigration reform and the increasing criminalization of undocumented immigrants places a risk to openly discuss and document immigration status with patients. In turn this makes it difficult to capture quantitatively the impact of immigration status on health. The desire to protect undocumented patients also has an impact on advocacy, as service providers sometimes fear repercussions or retaliations that could occur from anti-immigrant policymakers and/or public.

Nonprofit and advocacy organizations continue to advocate for policies, programs, and processes to ensure that immigrants have an opportunity to live a healthy and dignified life.
**Resources: Health Care Coverage in the Washington, DC Region**

Federally qualified health centers and other safety net clinics are important resources for immigrant health care. The following primary care associations and coalition in the Washington, DC region can provide information for the community health centers and clinics in their networks.

**DC Primary Care Association**
The DC Primary Care Association is a non-profit health equity and advocacy organization dedicated to improving the health of DC’s vulnerable residents by ensuring access to high quality primary health care, regardless of an ability to pay.

**Primary Care Coalition of Montgomery County**
The Primary Care Coalition of Montgomery County works with clinics, hospitals, health care providers, and other community partners to coordinate health care services for its most vulnerable neighbors. It envisions a community in which all residents have the opportunity to live healthy lives.

**Northern Virginia Health Services Coalition**
The Northern Virginia Health Services Coalition is comprised of primary care providers committed to access to quality care for low income residents of Northern Virginia.

**Regional Primary Care Coalition**
The Regional Primary Care Coalition is a collaboration and learning community of health philanthropies and primary care provider coalitions serving the region’s low income residents in Washington, D.C., Northern Virginia, and Suburban Maryland.
Resources: *Health Care Coverage in the Washington, DC Region*

Immigrants can also inquire about the following state and local health care programs. Please check their websites for the most current information on eligibility requirements.

<table>
<thead>
<tr>
<th><strong>Washington, DC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DC Medicaid</strong></td>
</tr>
<tr>
<td><strong>DC Healthcare Alliance</strong></td>
</tr>
<tr>
<td><strong>Immigrant Children’s Program</strong></td>
</tr>
</tbody>
</table>
Maryland’s Medicaid program is available for immigrants that can prove that they have resided in Maryland for at least five consecutive years and meet the income eligibility requirements.

MCHP is available to children under the age of 19 who are not covered by Medicaid. Eligibility is based on household income.

Care for Kids is a health care program that provides access to health care services for uninsured children in Montgomery County.

The Care for Kids Program provides free healthcare services to uninsured children who live in Prince George’s County.

Montgomery Cares provides basic medical services for people who do not have, and cannot get, insurance.
Resources: Health Care Coverage in the Washington, DC Region

Immigrants can also inquire about the following state and local health care programs. Please check their websites for the most current information on eligibility requirements.

<table>
<thead>
<tr>
<th>VIRGINIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virginia Newcomer (Refugee and Immigrant) Health Program</strong></td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
</tr>
<tr>
<td><strong>Family Access to Medical Insurance Security</strong></td>
</tr>
<tr>
<td><strong>Medical Care for Children Partnership (Fairfax County)</strong></td>
</tr>
<tr>
<td><strong>Community Health Care Network (Fairfax County)</strong></td>
</tr>
</tbody>
</table>
Resources: Others

Washington, DC Region

- Equitable Growth Profile of Fairfax County, PolicyLink and University of Southern California’s Program for Environmental and Regional Equity. http://nationalequityatlas.org/sites/default/files/Fairfax-Profile-6June2015-final.pdf


**Resources: Others**

**National**


- Community Education Resources, National Immigration Law Center. [www.nilc.org/get-involved/community-education-resources](http://www.nilc.org/get-involved/community-education-resources)

- How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents? An Analysis of Three Coverage Options, Community Service Society. [nyshealthfoundation.org/resources-and-reports/resource/how-can-new-york-provide-health-insurance-coverage-to-uninsured-immigrants](http://nyshealthfoundation.org/resources-and-reports/resource/how-can-new-york-provide-health-insurance-coverage-to-uninsured-immigrants)
Footnotes


2. Ibid


8. Center for Migration Studies, [http://data.cmsny.org](http://data.cmsny.org)


12. We’re in This Together African-American and Immigrant Communities Share Challenges and Policy Solutions, [www.thecommonwealthinstitute.org/wp-content/uploads/2016/05/in_this_together_FINAL_v2.pdf](www.thecommonwealthinstitute.org/wp-content/uploads/2016/05/in_this_together_FINAL_v2.pdf)