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Development and Content Validation of the Policy Exposure Index: A Modified Delphi Study of Provider Exposure to Immigration Enforcement

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1. Background

Immigration enforcement in clinical spaces challenges a fundamental premise of healthcare: that patients can disclose pain, fear, and vulnerability without those disclosures being used against them. Following the January 2025 rescission of the Department of Homeland Security's (DHS) Protected Areas Policy [1], news reports have documented an increase in Immigration and Customs Enforcement (ICE) activity near and within hospitals, including bedside presence and arrests [2–5]. When a clinical encounter risks becoming a point of surveillance, trust is compromised not only for undocumented patients but also for citizen and lawfully present patients in mixed-status families, who have likewise been shown to avoid care [6–8].

This enforcement has rapidly become a structural barrier to care that reshapes the clinical encounter. Mistrust is compounded by perceptions that providers cooperate with ICE [9] and by federal actions such as the Centers for Medicare & Medicaid Services' (CMS) agreement to share Medicaid enrollee data, including home addresses, with DHS [10,11], signaling to patients that information disclosed during care may not remain confidential. Patients may respond by not disclosing symptoms, delaying treatment, and forgoing care [6,7]. In a 2025 national survey, 14% of immigrant adults, and 48% of those classified as likely undocumented (noncitizens without a green card or valid visa), reported that they or a family member had avoided medical care because of immigration-related concerns [12]. Immigrant populations rely more heavily on emergency departments and less on primary care, a pattern associated with delayed presentation and greater disease severity [13,14] and one that moves care away from the continuous relationships in which trust is built.

These enforcement-related pressures extend directly to the healthcare workforce. Frontline clinicians encounter enforcement personnel, face pressure regarding patients' status disclosure [15], and navigate legal uncertainty about their own obligations and institutional policies [16], all while trying to sustain patient trust. One in six U.S. hospital workers is foreign-born [17], meaning that a substantial share of the workforce navigates these policies both personally and professionally.

A substantial body of research has documented patients' avoidance of care [8], providers' knowledge of and attitudes toward enforcement [18], and institutional sanctuary policies that limit cooperation with immigration authorities [19]. No instrument, however, captures what providers themselves encounter when enforcement enters clinical work. This gap matters because patient avoidance originates in the same settings providers work in: the enforcement activity that deters patients also reshapes the conditions under which care is delivered. Without a measure of provider exposure, institutions cannot identify where exposure is concentrated, design protective policies, or test whether reducing it improves patients' access to care.

Closing this gap first requires defining what providers are exposed to. We refer to this condition as *immigration policy exposure*: the extent to which providers' clinical work is shaped, interrupted, or constrained by immigration enforcement and the policies and institutional responses that surround it. Although this exposure has been described piecemeal across multiple studies, it has not been operationalized as a measurable construct. This paper reports the first phase of a multi-phase validation of the Policy Exposure Index (PEI), a provider-reported measure of such exposure intended for nurses, physicians, social workers, and other frontline staff working across U.S. states with differing enforcement environments, and for the researchers and health system leaders who study and respond to it. Because no item pool or comparable instrument currently exists, and because the construct spans clinical, legal, and

policy expertise that no single discipline holds, we used a two-round modified Delphi method with an interdisciplinary expert panel to establish content validity before field testing.

1.1 Theoretical Framework

The PEI draws on three theoretical frameworks: legal violence, structural vulnerability, and medical legal violence. Menjívar and Abrego's [20] concept of legal violence describes how immigration law produces structural harm: enforced selectively by race and geography, it creates pervasive uncertainty and constrained agency. In healthcare settings, legal violence surfaces when providers face state mandates that conflict with clinical ethics, and when patients must weigh the benefits of seeking care against the risk of state detection and associated penalties. Structural vulnerability [21] locates that constraint in the institutional environments that shape clinical agency, treating vulnerability as a product of structural position rather than individual characteristics. Applied to providers, it describes how clinicians' capacity to act is bounded by their position within institutions (employer policies, legal mandates, and, for immigrant clinicians, their own exposure to immigration law) rather than by individual skill or commitment. The medical legal violence perspective [22] explains how healthcare institutions themselves become sites of harm through enforcement-adjacent practices, the extraction of immigration-sensitive data, and the erosion of sanctuary norms under institutional pressure. Together, these frameworks position policy exposure as an active structural force rather than a backdrop to care: the PEI measures how state enforcement (legal violence) and institutional complicity (medical legal violence) converge to constrain frontline providers (structural vulnerability).

1.2 The Policy Exposure Construct

We operationalize policy exposure as routine, work-embedded encounters with immigration enforcement, both direct (e.g., enforcement personnel at the facility) and indirect

(e.g., patients avoiding care or institutional changes made in response to enforcement), and its administrative consequences, such as documentation requirements and eligibility restrictions that determine how, when, and whether care is provided. The PEI was designed to measure these conditions of practice rather than their downstream consequences, such as provider moral distress, burnout, or patient health outcomes, allowing future researchers to examine whether policy exposure predicts those outcomes.

The instrument comprises six scored exposure domains and a seventh, Organizational Preparedness, that is administered but excluded from the composite score because it describes conditions that may buffer exposure rather than exposure itself (Table 1). Institutional protocols such as warrant verification, data minimization, and structured training can serve as structural buffers [23]; where they are absent, providers often rely on improvised, individual workarounds. Scoring preparedness alongside the exposure domains would therefore conflate the stressor with the buffer, so it is retained instead as a contextual variable whose moderating effects can be tested directly. This study establishes the content validity of these domains as the first step toward testing such relationships empirically.

2. Methods

2.1 Study Design

Instrument development proceeded in two phases: item generation and expert content validation using a two-round modified Delphi. In a Delphi process, experts rate items independently and anonymously over successive rounds, each consisting of a survey followed by aggregated group feedback, until agreement is reached [24,25]. A modified Delphi, which replaces open-ended item generation in Round 1 with a pre-formulated, evidence-based item pool, was chosen to ground the instrument in existing theory and evidence while limiting panelist burden. Reporting follows the ACcurate COnsensus Reporting Document (ACCORD) guideline

[26]; the completed checklist is provided in Supplementary File 1. The study was not prospectively registered. The first author administered the process with methodological guidance from a senior investigator; neither rated items or contributed to consensus votes.

2.2 Item Generation

A 14-item pool across seven domains was drawn from prior literature, ProQuest media reports of clinical enforcement events (2025–2026), and a published integrative review [23]. That review's themes of policy-as-intervention and institutional mediation directly shaped items in the Enforcement Presence, Documentation and Data Practices, and Organizational Preparedness domains. Before Round 1, panelists received a description of the theoretical frameworks and domain definitions, but not a summary of the underlying evidence. The instrument was not piloted before the Delphi; field testing with frontline providers constitutes the next validation phase.

Instrument format and scoring. Exposure items assess how often each situation occurred over the past six months (1 = never to 5 = very often). Domain scores are the mean of completed items within each domain, computed when at least 50% of a domain's items are answered, and allow exposure to be profiled by type; the overall Exposure score is the mean of all 10 exposure items and summarizes total exposure, with higher scores indicating greater exposure. Organizational Preparedness items are rated *yes, consistently*; *yes, sometimes*; *no*; or *not sure/not applicable*, are summarized descriptively, and do not contribute to the Exposure score.

2.3 Expert Panel

Panelists were selected purposively by the first author to ensure interdisciplinary representation. Eligible experts met at least one criterion: (1) active clinical practice with immigrant populations, (2) legal expertise in immigration or healthcare law, or (3) research

expertise in health equity, immigrant health, or instrument development. A target of eight to ten panelists was set, consistent with recommendations for content validity panels [27,28]. Fifteen experts were invited by email with a description of the project; eight agreed (53%). The panel included two immigration attorneys who also hold law faculty appointments, one registered nurse, one advanced practice registered nurse (APRN), one physician with health policy expertise, one social worker with practice and academic roles, one nurse scientist in health equity and immigrant health, and one instrument development specialist. No patients or community members participated, and panelists received no incentive for participation.

2.4 Delphi Procedure

Both rounds were conducted in English through Qualtrics between February and March 2026. Each round remained open for two weeks, with one reminder email, and a one-week interval between rounds was used for analysis and revision. Panelists completed each survey independently and at their own pace and did not know one another's identities; responses were identifiable only to the first author (quasi-anonymity). Informed consent was obtained electronically before Round 1.

Round 1 assessed the relevance and clarity of the initial item pool and identified needed revisions; Round 2 re-evaluated the revised instrument. In each round, panelists rated every item on relevance to the construct (1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, 4 = highly relevant) and clarity (1 = unclear, 2 = somewhat clear, 3 = clear, 4 = very clear) and were encouraged to use an open-text field for each item to comment on wording, conceptual concerns, and domain placement or to propose new items. Between rounds, panelists received each item's I-CVI and anonymized summaries of qualitative commentary. All items, including those that met consensus in Round 1, were re-rated in Round 2 because most had been revised. Panelists were informed at enrollment that up to three rounds might be conducted.

2.5 Data Analysis

Content validity was assessed with two indices: the item-level content validity index (I-CVI), calculated for each item as the proportion of panelists rating its relevance 3 or 4, and the scale-level index (S-CVI/Ave), the average I-CVI across items in a subscale [27,28]. Consensus was defined a priori as I-CVI ≥ .78 and S-CVI/Ave ≥ .80, thresholds recommended for panels of six to ten experts [27,28]. Medians and interquartile ranges for both ratings were reviewed descriptively to guide revision but were not consensus criteria.

Open-text comments were analyzed by the first author using inductive thematic analysis [29]. Codes were developed iteratively and recorded in an audit trail linking each comment to its code and to the resulting item revision, and coding decisions and emerging themes were reviewed with a senior investigator throughout the analysis (peer debriefing). Beyond wording, the analysis examined the conceptual boundaries of the construct, item-to-domain mapping, and how institutional context shapes provider exposure. Theme summaries were returned to panelists with Round 2 materials, allowing them to respond to the interpretations that informed revisions. After Round 2, the first author and senior investigator decided not to conduct a third round: the Exposure subscale had met scale-level consensus, and the remaining disagreement concerned whether Organizational Preparedness belongs in an exposure measure, a conceptual question that further rating rounds were unlikely to resolve [25,30].

3. Results

Round 1

All eight panelists completed Round 1. Both subscales exceeded the S-CVI threshold (Exposure = .847; Organizational Preparedness = .850), and 9 of 14 items met the I-CVI criterion. Five items fell below it: E2 (.625), E6 (.625), E8 (.750), OP4 (.750), and OP5 (.750). E6 also had the lowest clarity (median = 2.0). Item-level statistics for both rounds appear in Table

2. Panelists provided 48 open-text comments, from which four cross-cutting themes were identified (Table 3).

Theme 1: The missing enforcement link. Five panelists noted that items did not name immigration enforcement, so their wording could apply to policy changes unrelated to immigration. The concern centered on E6 (four panelists) and OP5 (three panelists; one asked, “What does this item have to do with immigration?”). Revisions added explicit immigration qualifiers, and E6 was reframed around time spent addressing patients’ immigration-related concerns.

Theme 2: Coded institutional language. Comments on E2 pulled in opposite directions. One panelist asked that the item refer “specifically to changes in immigration policy and enforcement,” whereas another cautioned that organizations may make such changes “in terms of ‘identity verification’… where they don’t specifically mention immigration, but it’s clearly a response to enforcement.” Two others recommended separating general safety policies from immigration-specific ones. E2 was split into E2a (general safety or access policy changes) and E2b (immigration-specific protocols), allowing exposure to be recognized whether or not institutions label it as enforcement-related.

Theme 3: Observable versus inferred exposure. Panelists questioned whether E3 and E8 captured provider exposure or patient reactions, noting that providers may observe missed visits but not hesitation: “I am not sure I would know if someone hesitated.” Revisions anchored both items in observable patient behavior.

Theme 4: Jurisdictional fragmentation of law. Law- and program-specific examples in E7 (SB 4, Title 8) and E8 (TPS, DACA) drew the most divided feedback, with some panelists recommending removal and others clearer descriptions. Panelists noted that “Title 8 is the

whole immigration law, not policy," that SB 4 "can mean different things in different time periods," and that clinicians may be unfamiliar with TPS and DACA. Statutory citations in E7 were replaced with action-based examples, and program names were removed from E8.

Panelists also proposed additional or split items (e.g., separating administrative workload from visit length; distinguishing facility-provided from self-directed training); apart from the E2 split, these were addressed through rewording. No items were removed.

Round 2

Seven panelists completed Round 2 (87.5% retention); the non-responding panelist was one of the two immigration attorneys, leaving one legal expert in this round. The Exposure S-CVI rose from .847 to .900, and 8 of 10 Exposure items met the I-CVI criterion. E6 and E8, together with OP4, moved from below to above threshold following revision (Table 4). Two Exposure items did not meet criterion. E2b (.714), new in this round, drew one comment that "implemented" was an inaccurate verb for the item. E4 (.714), which had met criterion in Round 1 despite one panelist's concern about overlap with E1, declined in both relevance and clarity (medians = 3.0).

Organizational Preparedness items retained uniformly high clarity (all medians = 4.0), but relevance ratings declined, lowering the S-CVI to .743; four of five items fell to .714, each reflecting two of seven panelists rating relevance below 3. The only related comment expressed uncertainty about how these items contribute to measuring exposure; no wording concerns were raised. Changes in I-CVI across rounds are shown in Supplementary Fig. S1.

4. Discussion

After two Delphi rounds, the PEI Exposure subscale met scale-level content validity (S-CVI/Ave = .847 to .900), with eight of ten exposure items reaching item-level consensus. These

findings establish preliminary content validity; reliability, structural validity, and construct validity remain to be tested. Prior research has documented the downstream effects of enforcement on patients' care-seeking [6–8,12] and, among providers, knowledge, moral distress, and institutional sanctuary designations [15,18,19]. The PEI bridges these bodies of work by measuring the work-embedded exposures upstream of provider distress and patient avoidance, in a form comparable across health systems, jurisdictions, and policy periods.

4.1 Enforcement Made Invisible

Panel commentary showed that enforcement can be hard to see at two levels. Items that did not name enforcement were read as routine administrative burden, and organizations may adopt enforcement-responsive changes under neutral terms such as "identity verification." This pattern is consistent with accounts of legal and medical legal violence, in which enforcement operates through routine bureaucratic channels rather than through dramatic state action alone [20,22]. For measurement, it suggests that a single direct question (e.g., "Have you encountered immigration enforcement at work?") may undercount exposure. The E2a/E2b split offers two routes to recognition, through general access policy changes and through explicitly immigration-specific protocols, so that exposure can be captured even when institutions do not label it as enforcement-related.

4.2 Mediated Exposure

The debate over whether providers can report patient fear as their own exposure points to a feature of the construct rather than a measurement error. Providers who see patients miss appointments, delay care, or withhold information absorb enforcement pressure without direct contact with immigration authorities [23], a form of mediated exposure that parallels secondary traumatic stress among clinicians [31–33]. Anchoring E3 and E8 in observable behavior allowed

them to capture this exposure without asking providers to infer patients' internal states; both reached full consensus in Round 2.

4.3 Organizational Preparedness

Preparedness items retained high clarity while relevance declined (S-CVI/Ave = .850 to .743), driven by low ratings from two of seven panelists rather than by wording concerns. This pattern is consistent with the a priori decision to treat institutional infrastructure (e.g., warrant response protocols, legal consultation pathways, staff training) as a potential buffer rather than an exposure [21,23], but it does not establish that preparedness functions as one. Retaining preparedness as a separately scored module allows future research to test whether it moderates the effects of exposure on provider burnout, moral injury, and clinical decision-making [23,32].

4.4 Limitations

The panel was small, and the loss of one of two attorneys in Round 2 left law-related items evaluated by a single legal reviewer. The panel did not include community health workers, including promotoras (lay health workers drawn from the Latino communities they serve), or patient representatives, whose perspectives may reveal additional dimensions of exposure. Coding was conducted by a single analyst; although it was reviewed with a senior investigator and theme summaries were returned to panelists, independent double-coding was not performed. Finally, surveys were conducted in English only, items reflect the U.S. enforcement environment of early 2026, and several domains currently contain a single item.

4.5 Implications

Next steps include refining E2b and E4, expanding single-item domains, and field testing in large clinician samples to evaluate reliability and construct validity. Once validated, the PEI could give researchers an independent variable for examining how enforcement affects care

access, quality, and workforce retention, including across policy shifts such as the 2025 rescission of the Protected Areas Policy [1]. For health systems, domain-level exposure profiles could help target safeguards, such as workforce support, data governance, or legal protocols, where exposure is concentrated [16,19,23].

5. New Contribution to the Literature

- Defines immigration policy exposure as a provider-level construct distinct from downstream outcomes such as moral distress and burnout.
- Reports the first content-validated instrument measuring frontline providers' exposure to immigration enforcement.
- Shows that enforcement effects may be obscured by neutral institutional language, with direct implications for how exposure is measured.

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Table 1 Domains and items of the Policy Exposure Index

Domain	Definition	Items
Enforcement presence & institutional response	On- or near-site immigration enforcement activity and institutional responses to it (e.g., access or safety policy changes, immigration-specific protocols, enforcement at other traditionally protected sites).	E1, E2a, E2b, E4
Patient fear & chilling effects	Patient avoidance, delay, or discontinuation of care, or withholding of information, due to immigration-enforcement concerns.	E3
Documentation & data practices	Collection or recording of immigration-related information in the EHR or intake templates, and risk of disclosure beyond clinical use.	E5
Resource & workflow strain	Additional visit time or workload arising from patients' immigration-related concerns.	E6
Policy landscape interaction	Effects of the current immigration-enforcement policy landscape, and of uncertainty around immigration protections, on how and to whom care is provided.	E7, E8
Cross-sector coordination	Coordination with, or referral to, legal, advocacy, or community resources prompted by immigration-related needs.	E9
Organizational preparedness (context module)	Organizational policies and protocols, training, legal or ethics consultation, documentation guidance, and leadership communications that contextualize exposure.	OP1–OP5

Note. The 10 exposure items (E1–E9, with E2 split into E2a and E2b after Round 1) contribute to the Exposure score. Organizational Preparedness is a context module excluded from that score; it captures institutional conditions that may buffer or amplify exposure rather than exposure itself. EHR = electronic health record. Full item wording is provided in Supplementary File 2.

Table 2 Item-level content validity of the Policy Exposure Index across two Delphi rounds (Round 1 n = 8; Round 2 n = 7)

Item	Item content (Round 2 unless noted)	R1 clarity Mdn (IQR)	R1 relevance Mdn (IQR)	R1 I-CVI	R2 clarity Mdn (IQR)	R2 relevance Mdn (IQR)	R2 I-CVI	R2 criterion
Exposure subscale								
E1	Enforcement activity within or immediately outside my facility	4 (1)	4 (1)	1.00	4 (0)	4 (0.5)	1.00	✓ Met
E2	Changes in institutional policy tied to enforcement (Round 1; split in Round 2)	3 (2)	3.5 (2)	.625 ✗	—	—	—	Split
E2a	Organization changed general safety/access policies re: enforcement	—	—	—	4 (1)	3 (1)	.857	✓ Met
E2b	Organization implemented immigration-specific policies/protocols	—	—	—	4 (1)	4 (1.5)	.714	✗ Not met
E3	Fear/concern about enforcement led patients to avoid, delay, or stop care	3.5 (2)	4 (0.75)	.875	4 (1.5)	4 (0)	1.00	✓ Met
E4	Enforcement at protected sites other than my facility	4 (0)	4 (0.75)	1.00	3 (1)	3 (1)	.714	✗ Not met
E5	EHR templates/workflows prompted or required collection of immigration data	3 (1.75)	3.5 (1)	.875	4 (0)	4 (0.5)	1.00	✓ Met
E6	Extra visit time on patients' immigration concerns beyond usual role	2 (2.75)	3 (2)	.625 ✗	4 (0)	4 (0.5)	.857	✓ Met
E7	Enforcement policies/actions directly affected how or whom I can serve	3.5 (1.75)	4 (1)	1.00	4 (0)	4 (0)	1.00	✓ Met
E8	Uncertainty about status led patients to avoid, delay, or stop care	3 (1.75)	4 (1.75)	.750 ✗	4 (1)	4 (0)	1.00	✓ Met
E9	Coordinated care or referred patients to legal, advocacy, or community resources	4 (1)	4 (1)	.875	4 (0)	4 (0)	.857	✓ Met
Organizational Preparedness subscale (context module; excluded from Exposure score)								
OP1	Organization has policy/protocol for responding to enforcement actions	4 (0)	4 (0.75)	.875	4 (0)	4 (1)	.714	✗ Not met
OP2	Organization provided training on responding to enforcement situations	4 (0)	4 (0.75)	.875	4 (0)	4 (1)	.714	✗ Not met
OP3	Organization provides access to legal/ethics support for enforcement incidents	4 (1.75)	4 (0.75)	1.00	4 (0)	3 (1)	.714	✗ Not met
OP4	Organization provided role-specific guidance on protecting immigration information	4 (1.5)	3.5 (1.75)	.750 ✗	4 (0)	4 (1)	.857	✓ Met
OP5	Leadership provides timely updates on immigration-related policy changes	4 (0.75)	4 (1.75)	.750 ✗	4 (0)	4 (1.5)	.714	✗ Not met
	S-CVI/Ave, Exposure subscale			**.847**			**.900**	
	S-CVI/Ave, Organizational Preparedness subscale			**.850**			**.743**	

Note. Mdn = median; IQR = interquartile range; I-CVI = item-level content validity index (proportion of panelists rating relevance 3 or 4); S-CVI/Ave = mean I-CVI across items in a subscale. Consensus criteria: I-CVI ≥ .78 and S-CVI/Ave ≥ .80. Medians and IQRs were reviewed descriptively to guide revision and were not consensus criteria. ✗ in Round 1 columns marks items below criterion in Round 1. Item content is abbreviated; full wording for both rounds is provided in Supplementary File 2.

Table 3 Cross-cutting themes from Round 1 panel comments (48 comments across 14 items) and the revisions they informed

Theme	Description	Items	Panelists	Illustrative comment (verbatim)	Revision informed
1. The missing enforcement link	Item wording did not name immigration enforcement, so items could apply to policy changes unrelated to immigration.	E6, OP5, E2	5 of 8	"The additional workload must be specified as linked with immigration issues." (E6) "What does this item have to do with immigration?" (OP5)	Explicit immigration qualifiers added; E6 reframed around visit time spent on patients' immigration-related concerns.
2. Coded institutional language	Organizations may adopt enforcement-responsive changes under neutral administrative terms; panelists disagreed on whether the item should name enforcement explicitly.	E2	4 of 8	"…in terms of 'identity verification', etc and other phrases where they don't specifically mention immigration, but it's clearly a response to enforcement." "Make sure the respondent knows that the item refers specifically to changes in immigration policy and enforcement."	E2 split into E2a (general safety/access changes) and E2b (immigration-specific protocols).
3. Observable vs. inferred exposure	Whether providers can report patient fear and avoidance as their own exposure, or are asked to infer patients' internal states.	E3, E8	2 of 8	"I am not sure I would know if someone hesitated." (E3) "This question also seems to get at a secondary impact, with the primary impact on patients." (E8)	Items anchored in observable patient behavior (avoiding, delaying, or stopping care); indirect exposure retained.
4. Jurisdictional fragmentation of law	Law- and program-specific examples vary across states and legislative sessions, may be unfamiliar to clinicians, and date quickly.	E7, E8	5 of 8	"Title 8 is the whole immigration law, not policy." (E7) "SB 4 can mean different things in different time periods…" (E7) "Take out the examples. It might confuse people unfamiliar with immigration policy." (E7)	Statutory citations in E7 replaced with action-based examples; TPS/DACA removed from E8.

Note. Panelists = number of the eight Round 1 panelists whose comments contributed to the theme. Comments are reproduced verbatim; ellipses mark omitted text. The item to which each comment referred is shown in parentheses.

Table 4 Joint display integrating Round 1 panel feedback with item-level content validity change

Item	Round 1 concern	What panelists raised	Revision	I-CVI R1 → R2	Round 2 outcome
E2	Coded institutional language (T2); missing link (T1)	Item conflated general safety changes with immigration-specific protocols; panelists split on naming enforcement explicitly	Split into E2a (general safety/access) and E2b (immigration-specific protocols)	.625 → .857 (E2a) .625 → .714 (E2b)	Partially resolved: E2a met; E2b not met (verb "implemented" flagged)
E6	Missing enforcement link (T1)	Workload not tied to immigration; workload and visit length combined in one item	Reframed as extra visit time addressing patients' immigration-related concerns	.625 → .857	Now meets criterion
OP5	Missing enforcement link (T1)	Leadership updates could concern any policy area	Immigration-related qualifier added	.750 → .714	Not met; relevance concern persists
E3	Observable vs. inferred (T3)	Hesitation not observable; "fear of exposure" ambiguous; item may capture patient rather than provider experience	Anchored in observable behavior; enforcement named explicitly	.875 → 1.00	Met in both rounds
E8	Observable vs. inferred (T3); jurisdictional fragmentation (T4)	"Affected care" open to two readings; TPS/DACA unfamiliar to clinicians	Reframed as patient avoidance or delay due to status uncertainty; program names removed	.750 → 1.00	Now meets criterion
E7	Jurisdictional fragmentation (T4)	SB 4 and Title 8 jurisdiction-specific or inaccurate; "affected" vague	Action-based examples; effect specified as how care is provided or who can be served	1.00 → 1.00	Met in both rounds
OP4	Item-specific	Dense wording; organizational framing hard to evaluate	Plain-language, respondent-centered wording	.750 → .857	Now meets criterion
E4	Item-specific	Overlap with E1 for facility-based providers; unclear geographic scope	Scoped to protected sites other than the respondent's own facility	1.00 → .714	Not met; flagged for restructuring

Note. T1 = missing enforcement link; T2 = coded institutional language; T3 = observable vs. inferred exposure; T4 = jurisdictional fragmentation of law. Item-specific = concern raised for a single item and not part of a cross-cutting theme. I-CVI ≥ .78 indicates consensus. Outcome text is provided alongside shading for grayscale reproduction.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryFile1ACCORDChecklist2.docx
- SupplementaryFile2PEIItemWording2.docx
- SupplementaryFile3FigureS1.docx