Survey of Refugee Patients with Reduced Post-Medicaid Health Care

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Abstract

This project identified refugee patients at risk of not returning to the International Family Medicine Clinic for recommended follow-up care due to lack of health insurance coverage. This involved a detailed analysis of the clinic's patient database and a subsequent comprehensive chart review of records identified by the database analysis. The second part of this project was to contact patients to elicit their own reasons for reduced or non-existent follow-up care at the IFMC. This phase of the project was begun but not completed by the end of the summer, and will be continued by other clinic staff.

Introduction & Background

The primary goal of this project was to investigate the access to health care of refugee patients of the International Family Medicine Clinic (IFMC). Initially, refugees welcomed to make their homes in the United States are apportioned Medicaid insurance for eight months, after which they are expected to have secured health insurance through their employment. Even if health insurance is available, it is still possible that some patients in serious need of care are lost to the health care system for a number of reasons.

To understand how and why it is that refugee patients of IFMC may not have the means to secure continued health care, it is necessary to examine the unique circumstances of refugees resettled in the United States and abroad. Refugees are defined as "persons forced to flee their country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group."[1] Often refugee arrivals in the United States have lived for years or even decades in United Nations refugee camps with substandard living conditions including inadequate food and unclean drinking water. These conditions lead to preexisting poor health upon arrival to the United States. Post-Traumatic Stress Disorder, intestinal parasites, tuberculosis, and developmental delays in children are just some of the conditions that can plague newly arrived refugees.[2] [3] [4] In addition, because of the circumstances that lead to their status as refugees, there may be an innate mistrust of the state, including institutions such as public university hospitals. Studies have also found that immigrants in general may mistrust Western-style health care. Increased trust correlates directly to increased length of stay in the United States, although not necessarily with increased health care utilization.[5]

The International Rescue Committee (IRC) assists refugees resettling in Charlottesville. IRC helps refugees with everything from enrolling them in English as a Second Language classes, to securing employment and housing, to compliance with US Citizenship and Immigration Services health requirements and introduction to the unique health care system of the United States. These last two resettlement tasks are accomplished in two ways. First, newly arrived refugees are taken to the Virginia Department of Health (VDH), Thomas Jefferson Health District, as soon as possible, preferably within their first week in the United States. VDH screens them for infectious diseases and updates immunizations. Second, refugees are brought to the IFMC to establish a primary care relationship and to address more complicated health issues than the bare minimum addressed by VDH.

Attempts are made to initiate care at IFMC as soon as possible after the first VDH visit. Patients seen soon after arrival are able to quickly address health problems allowing them to begin their life and work in the United States in their best form. Additionally, early visits to IFMC allow refugees to maximize usage of Medicaid benefits before they end in eight months.

Studies of patients receiving Medicaid in the United States indicate that their unmet needs are only slightly less serious than the needs of people lacking any health insurance whatsoever.[6] For people in the United States lacking health insurance coverage, the number of medical visits for both children and adults is decreased by as much as one per year compared to people enrolled in a health insurance plan.[7] One study found that uninsured individuals in higher-income areas had greater access to health care due to a higher number of physicians, among other factors.[8] Given the large number of physicians in the Charlottesville area, this would imply that the uninsured of Charlottesville stand a better chance of receiving adequate health care as compared to less well-served areas.

For the purposes of this study, immigrants are considered to be any non-US citizen who makes their home in the United States. Therefore, immigrants are a larger group within which refugees are a unique subset. Immigrants are found to have reduced access to health care when compared to the entire US population.[9] Furthermore, disparities in access to health care for minority groups, another category of which many refugees are a subset, is a well-documented phenomenon in the United States.[10] Refugees coming to resettle in the United States are therefore faced with various potential obstacles to adequate access to health care.

At the IFMC, it was observed that a significant number of refugee patients have not been returning for

recommended follow-up care after their eight months of Medicaid coverage expired. Given the unique circumstances of refugees, it was suspected that they are not returning in part because of inadequate access to insurance coverage, but other factors may also be at play. The primary goal of this project is to improve the service delivery to IFMC patients by identifying refugee patients at risk of being lost to the health care system and investigating their individual reasons for not returning to the IFMC. There are two main research questions for this project. How many refugee patients do not return to the IFMC for care after their Medicaid ends and what are the reasons for non-return?

Methods

An initial review of pertinent literature revealed that little research has been done to examine health care access issues for refugees as a distinct group in the United States population. Research efforts in a number of other areas provided useful models for this project including: refugee camp health care surveys, refugee health care access studies in other Western countries, minority access studies, immigrant health care access and lower income or uninsured health care access studies. On an individual basis, IFMC refugee patients may face issues common to minorities, non-refugee immigrants, lower-income and uninsured Americans, and patients with either limited English proficiency (LEP) or limited health literacy.

The initial task of this project was to identify patients who met criteria for inclusion (Figure 1). Starting in mid-June and using the IFMC patient database, patients were selected who were classified in the database as: refugee, asylee, and other/unknown. The data status categories were assigned based on patient interviews during the first visit. Asylees were selected because they are treated in much the same way as refugees once their asylum status is established. Patients with the status of other/unknown were selected because they may have been refugees unsure of how to self-identify during their initial clinic visit. Further analysis of individual situations was required to determine their status.

From the initial list of refugee patients, 314 were refugees, two were asylees, and 42 were other/unknown. Out of this group of 358 records, 209 fit the time-frame criteria for being post-Medicaid coverage. They either had clearly been in the United States longer than eight months or had not visited the clinic in the past eight months. It was necessary to use this second criterion because some patient records did not include their arrival date to the United States.

The 209 qualifying patient charts were reviewed for additional information regarding health insurance, clinic visits not reflected in the IFMC database, refugee or immigrant status, and whether or not the patient was still living in the Charlottesville area. Out of these 209 records, 141 were selected to further review with the clinic director, Dr. Hauck. Dr. Hauck had access to additional information in the Care Cast System about each patient medical record and was able to determine whether a reasonable time period for follow-up visits had passed. Following this final review, 85 patients from a total of 50 households were identified to be contacted for this project.

During the time that the list of patients to contact was being refined, a survey was also designed to guide subsequent patient interviews. Attempts were made to obtain the instruments used in two different health care access studies: the RAND Health Insurance Experiment and the Primary Care Assessment Survey. Published and unpublished resources were used to identify parts of these instruments although the entire instruments were never obtained.[11] [12] [13] [14] The final questionnaire developed for this project was based on these instruments, other relevant literature, and interviews with IRC employees and local refugees.[15] [16] [17] It is a hybrid qualitative-quantitative questionnaire with a large number of open ended questions (Appendix A). There is a slightly modified version for interviews with guardians about their wards (Appendix B). The answers to many of the questions can later be coded for quantitative analysis.

The questionnaire begins by establishing the work status of the interviewee followed by an inquiry into their insurance plan. The questionnaire then divides into two separate but similar pathways regarding the interviewee's insurance options and use of health care. The questionnaire is designed to be administered over the phone with the use of the CyraCom interpreter phone if necessary.

An introductory speech was written to accompany the questionnaire. It explains the reason for the phone call, provides identifying information, and assures the interviewee of confidentiality. Another accompaniment is a list of phone numbers should the interviewee have further questions. These include the appointment number for IFMC, the Health System billing office, the IRC office phone number, and the phone number for Family Access to Medical Insurance Security (FAMIS), the Commonwealth of Virginia's low cost health insurance program for children.

Results and Discussion

Of the 85 people from the contact list there is little significant difference based on age or gender. The male to female ratio is 40:44 (with one unknown gender). The adult to minor ratio is 46:39. The majority of the patients on the list are more recent arrivals (Figure 2).

The 50 family groups are skewed by country of origin with 11 of the family groups coming from Afghanistan (Figure 3). Country of origin data are examined in terms of family groups because some children were born in refugee camps but are ethnically, socially, and often politically identified with the country from which their parents or guardians fled. In a few cases it was not possible to determine the minor patient's guardian.

The questionnaire was "pilot tested" with three different LEP individuals, two of whom were from the list of patients to contact generated from patient records. Attempts were made to contact non-English speakers via interpreter phone, but no one was available at the time of the calls.

Of the questionnaires already completed with IFMC patients, one interview concerned all four members of the family. Three of the four family members have health insurance: the husband through his job and the two children through the FAMIS program. The wife is uninsured because she is unemployed and it was considered to be too expensive to insure her. The husband and children obtain medical care at another facility in Charlottesville where their insurance companies told them to go.

The other completed questionnaire was with an uninsured individual who was employed and waiting for his work-related insurance to commence. He has received *pro bono* care from medical practitioners outside of the IFMC during the interim.

Conclusions

By establishing an initial primary care relationship with newly arrived refugees receiving Medicaid, IFMC actively attempts to reduce potential access problems of refugee Medicaid recipients. However, confounding factors may lead to their reduced utilization of health care resources. These may include lack of health insurance due to cost or non-availability, lack of knowledge related to need for follow-up care, inability to leave work, unavailability of child care or others.

Preliminary results indicate that refugees from certain countries, such as Afghanistan, Togo, and Somalia (Figure 3), are at a higher risk of not utilizing health care resources at IFMC. This may be useful in treatment of future arrivals from those areas.

Conclusions concerning length of stay in Charlottesville and health care utilization cannot be made without further analysis of the clinic database. The clinic database could also be used to make comparisons between returning and non returning patients. Either of these avenues of inquiry may prove fruitful.

A barrier in this project was the lack of time to complete more pilot interviews. A greater number of pilot interviews would have enabled more questionnaire refinement. An undergraduate student from the University of Virginia is assuming the task of completing the pilot and final interviews. She may provide insight into possible changes needed in the questionnaire before it is administered to the entire call list. She will also learn if a telephone survey works successfully with a LEP population. It is anticipated that this survey will provide valuable information to the IFMC to aid in improving health care delivery to the refugee patients whom the clinic serves.

References:

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Figure 1: Refining the Patient Call List

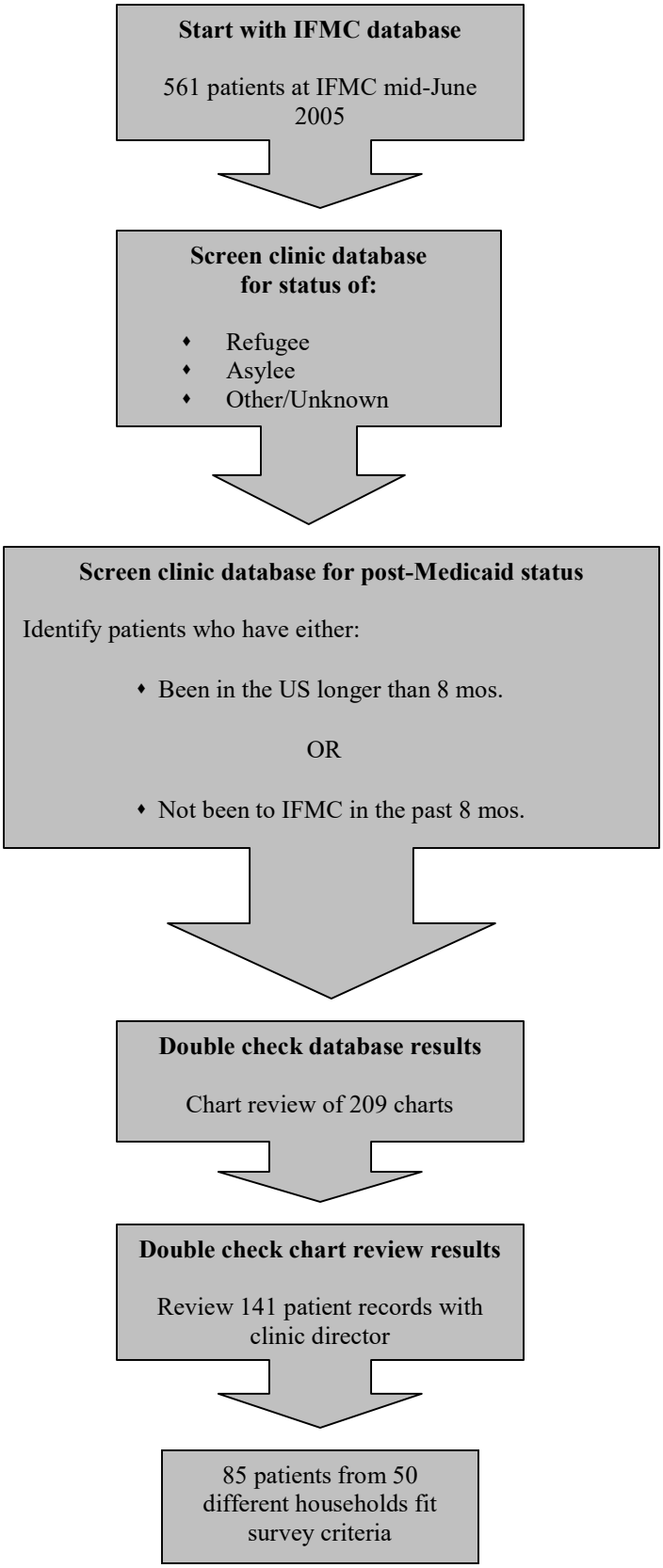

Figure 2: Establishing Post-Medicaid Status

	Number of Families in 1999	Number of Families in 2000	Number of Families in 2001	Number of Families in 2002	Number of Families in 2003	Number of Families in 2004
Arrival Date	1	2	2	2	22	36
Most Recent Visit to Family Medicine	X	X	X	2	12*	6**

NOTE: Either the date of arrival in the United States or the most recent recorded visit to the Family Medicine Clinic was used to determine whether the eight months of Medicaid expired. It was necessary to use this second date because the arrival date was not available. The most recent visit to the clinic date was the only other date data extracted from the database.

* Of these 12 family groups, 8 possibly arrived in 2002 because the most recent visit was in first 8 months of 2003.
** All possibly arrived in 2003 because the most recent visit was in first 8 months of 2004.

Figure 3: Home Countries of Family Groups

Country of Origin	Number of Family Groups Identified with Country of Origin
Afghanistan	11
Togo	7
Somalia	7
Liberia	5
Bosnia	4
Sudan	4
Kenya (possibly of Somali heritage)*	3
Azerbaijan	1
Iran	1
Iraq	1
Ivory Coast (possibly of Liberian heritage)*	1
Kirgistan	1
Kosovo	1
Sierra Leone	1
Yugoslavia	1
Zambia	1

*These subjects are minors. It remains inconclusive whether their guardians are refugees from these countries or were in exile in these countries prior to arrival in the United States.