Models of Refugee Health Care

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Introduction

Refugee health care has many unique challenges, including language barriers, cultural differences, complex medical problems, significant past trauma, limited financial resources, and more.[1-3] Caring for the needs of such a diverse population is challenging, yet worthy of consideration. As human beings who have experienced significant hardship, they are deserving of the same quality of care afforded to other members of the community, and it is important to find the most efficient and equitable care practices to best serve this population. This paper explores various models of care currently in practice to address the unique concerns of caring for refugees, with the aim of finding what has worked well and has not worked as well, uncovering common challenges and focusing on lessons learned and key take-aways for improving the care of this vulnerable patient population.

The International Family Medicine Clinic

Charlottesville, Virginia

The International Family Medicine Clinic (IFMC) at the University of Virginia began in 2002 and has grown to become the primary provider for most refugees arriving in Charlottesville.[4] The university, the local resettlement agency (the International Rescue Committee or IRC), and the local health department carefully coordinate services through frequent communication and quarterly coordination meetings. All new refugees arriving to the area from abroad have an initial health screening done at the health department. This is followed by an initial provider visit at the IFMC, the refugee clinic embedded within the University of Virginia Family Medicine Primary Care Center Practice. During that visit, an in-person interpreter is typically present to assist, provided by an interpretation service run by the IRC and contracted by UVA. In cases where in-person interpretation is not possible, dedicated phone lines are available in each room that connect to interpreters at a contracted language company (CyraCom).

Patients are seen by all second- and third-year residents in addition to certain faculty and nurse practitioners in the clinic with expressed interest in refugee health; a department-wide curriculum provides ongoing training and education to all providers and supervising attending physicians. After the initial visit, a one-month follow-up visit is scheduled for every patient with other follow-up visits and referrals scheduled as appropriate. The IFMC becomes the refugees' primary care home; the residency additionally provides inpatient services, including pediatric, adult, pregnancy and newborn care. Any lab work needed can be completed at the lab across the hall, limiting barriers to access. Likewise, the pharmacy and imaging suite located nearby on campus provide a convenient option for those without sufficient transportation. Refugees are often brought to their appointments by volunteers or interns from the IRC, in coordination with their health care case worker. They receive Medicaid benefits for at least the first 8 months after arrival, which aids in getting critical care that was often neglected abroad.

Continued care is aided by the assistance of a designated refugee nurse care coordinator, as well as a social worker and in-house pharmacist. For the psychiatric and mental health concerns common amongst this population, the IFMC has access to both

the department's Family Stress Clinic with designated psychologists and therapists, as well as a team of psychiatrists that see patients within the Family Medicine Clinic itself, thus reducing the "stigma" of receiving psychiatric care, as patients can receive the needed services without their family members' knowledge if they so desire.

To better assist the significant ethnic Nepali Bhutanese refugee population in the area, one of the clinic nurse practitioners additionally leads a Nepali-speaking elder support group. This group meets bi-monthly for a two-hour session that includes a health-related presentation by a community guest speaker and time for group discussion and interaction. The nurse practitioner also uses the time for a short check-up on each individual's health concerns. The group has seen great success with regular attendance by roughly 10 elderly Nepali-speaking patients.

Current health challenges facing refugees in Charlottesville include a lack of options for affordable dental care, difficulty obtaining timely appointments with some specialty offices, and financing their health expenditures once they no longer qualify for Medicaid. The integration of services and coordination between the various stakeholders provides a safe and culturally-sensitive medical home for the area's refugees.

The CARE Clinic

Boise, Idaho

In Boise, Idaho, Saint Alphonsus Health Systems began their program in 2009 after convening focus groups of refugee women to best assess the needs of the community.[3] From there the role of CARE (Culturally Appropriate Resources and Education) Clinic Health Advisor was created in conjunction with the CARE Clinic. These CARE Clinic Health Advisors are central to the model, providing a culturally safe bridge between the refugees and providers. Only women are allowed to apply for the positions, and in addition to speaking the language of part of the refugee population they serve, they also receive training in health care access, thus acting as the go-between during refugee-clinician encounters. One of these women is additionally charged with "scheduling taxi transportation, education, and other office or community duties."[3] The Clinic Health Advisors, separate from certified medical interpreters, which are also trained through the program, can serve in capacities of education and advocacy in addition to providing interpretation during visits.

Referral to the CARE Clinic comes largely by word-of-mouth, though local resettlement agencies will also send patients directly. Unique features of this clinic include group educational sessions, nutrition classes taught in the adjacent kitchen, and an incentive store set up to provide free diapers, baby supplies, and personal hygiene products in exchange for points earned through timeliness and healthy behaviors. The clinic is also decorated with art from the refugees' respective countries, and soft music plays in the background to add to the "milieu" of the group clinic sessions. Overall, the efforts from this clinic have led to a 22.5-percentage-point drop in missed appointments, as well as 100% compliance with child vaccinations through the first year of life.

The Refugee Health Clinic

Providence, Rhode Island

The Hasbro Children's Hospital in Providence, Rhode Island established its refugee clinic in October 2007 as a "medical home" for refugee children.[5] Their model is comprised of, "(1) patients, (2) primary care providers, (3) trained medical interpreters, (4) mental health professionals, (5) dental

health professionals, and (6) the International Institute of Rhode Island (IIRI)." Similar to the Boise model, the interpreters, many of them refugees themselves, are trained to become community health workers and assist patients in navigating the health care system. As in other programs, initial intake evaluations of each refugee child are completed within 30 days of arrival, with subsequent close follow-up by the same provider. Since beginning this program, the Hasbro Refugee Health Clinic has seen screening rates increase to nearly 100% for diseases such as HIV, TB, and lead poisoning, up from a prior low of 41%. Furthermore, the mean number of missed appointments, and therefore missed opportunities to improve health, decreased by 43%.

Several additional features somewhat unique to this program include universal dental and mental health screening. Starting in 2010, the clinic began a dental screening program during the initial visit in which a dental resident from the nearby dental center evaluates each child and then arranges any necessary follow-up care. They also developed a mental health screening tool, in a collaborative effort between psychologists and the community health workers to ensure cultural appropriateness. This screening tool is given once each child has had at least six months to adjust to life in the United States. Mental health providers also participate in subsequent appointments, even in the absence of a known psychiatric condition.

The Refugee-Centered Medical Home
Louisville, Kentucky

Like the above examples, the Refugee-Centered Medical Home, which is run by the Division of Infectious Diseases at the University of Louisville School of Medicine, emphasizes creating a centralized health care center for refugees, with many similarities to the programs previously discussed.[1] They likewise hired and trained new Global Health Navigators (GHNs) as liaisons between the refugee communities and the health system. Instructed in health education and fluent in the native languages of the refugees, these GHNs focus on health education and facilitating better communication between the patient and the health care team. The program also includes a "full spectrum of mental health services on-site" and emphasizes making other aspects of care, such as lab work, easy to access through close locations. Several unique features of this program include mass immunization events and adapting appointment times and scheduling to the needs of the refugees, making changes to the times the clinic is open to better accommodate refugees and their difficult work schedules.

The Philadelphia Refugee Health Collective
Philadelphia, Pennsylvania

Officially formed in 2010 after a pilot trial program in 2007, the Philadelphia Refugee Health Collective grew to encompass eight clinics receiving patients from the three refugee resettlement agencies in the city, as of 2016.[6] In addition to quarterly coordination meetings, efforts between the groups are organized through a designated staff member at each resettlement agency, known as a Clinic Liaison, who is responsible for relations with each clinic. These Clinic Liaisons arrange scheduling and transport for patients, field questions, coordinate volunteer and intern efforts, and encourage greater communication between stakeholders. The Collective likewise aims for early initial screenings and close follow-up. Unique features include a medical student-led "monthly informational clinic" and a staff member with a public health

background tasked with various public health and access projects, such as the creation of a "photo-map" for easy refugee identification of key people and places. This initiative has led to dramatic reductions in wait times for initial evaluations, as well as earlier enrollment in health care benefits, earlier detection of cancers, and improved treatment rates for diseases like latent tuberculosis.

Rochester General Hospital
Rochester, New York

In New York State, after years of refugees being refused care at various clinics, Rochester General Hospital, in conjunction with the New York State Health Foundation, began implementing a model in 2009 to make providing care to refugees financially sustainable.[7] Rather than having a centralized clinic dedicated to providing refugee care, the hospital system developed partnerships with multiple primary care providers in the area near Rochester, distributing refugee patients among them. However, to avoid duplicating efforts certain resources, such as social workers and interpreters, were shared between the providers.

To encourage participation in the program, this pilot venture aimed to collect the federal money normally given through the state for the initial health examinations and to give 50% of that money directly to providers. Much of this money was previously claimed by other organizations, non-profit or otherwise, who performed the initial screenings but later did not provide ongoing care. This effort to join forces between various providers to reduce cost and improve efficiency led to a strong collaboration between multiple clinics and resettlement agencies in the area, and eventually to the expansion of the program to other parts of the state. Additional funding was subsequently awarded to the Rochester General Medical Group, associated with the hospital, to continue providing refugee care in the area.

Another unique result of this program was the creation of a national refugee health conference held every year to further the discussion and advancement of best practices.

Conclusion

While the above cases are by no means a comprehensive list, they do provide examples of ways communities in the U.S. are addressing the unique health care needs of refugees. Other refugee-receiving countries, such as Canada and Australia, have likewise placed an emphasis on finding best practices in the field.[8-11] In particular, work is underway in Australia to run a "quasi-experimental trial" of various refugee health care delivery programs.[11] Other groups are thinking outside the box to reach the refugee community, including mobile health (mHealth) initiatives to increase patient-provider communication and reduce language barriers.[2]

In the U.S., much has been accomplished by refugee-centered health care initiatives, though most refugees still face significant challenges. A common issue, as can be expected, is funding. Many of the referenced programs relied on grants to overcome the financial hurdles, either for the initial jumpstart or further expansion efforts. Others, like the Philadelphia Refugee Health Collective, were able to reduce costs by utilizing established service organizations like AmeriCorps and college internships to fill necessary roles. The most significant costs faced by many of these programs include those required for adequate interpretation services, even in states where such services are partially reimbursed by Medicaid. By centralizing interpretation services and conducting their own interpreter hiring and training, many of

the above programs were able to minimize the financial burden presented by the language barrier.

Another common theme was difficulty accessing affordable dental care. In many areas few dentists are willing to accept Medicaid, especially for patients who also need interpretation services. This is further complicated by the fact that many refugees have extensive dental needs that require multiple visits and procedures to resolve, in addition to close preventive follow-up. Further, Medicaid only covers dental care for children, adolescents, and pregnant women so adults either need to pay out of pocket, purchase employer-based dental insurance, or seek care at free or low-cost clinics. The Hasbro Children's Hospital in Rhode Island was able to tackle this challenge through tapping into the resources of the local dental school to turn it into a learning opportunity for budding dental practitioners. For many programs, however, adequate access to dental care remains a challenge yet unresolved.

However, despite frequent challenges, there are several key take-aways evident from the successes of the programs discussed. Common themes include the training of culturally competent providers as well as interpreters. Further success was seen in several of the programs when the interpreters or other refugee community members were also trained to serve as community health workers or patient advocates. Additionally, an emphasis on creating a safe, centralized medical home for the refugees was key in the majority of the highlighted programs. Inclusion of on-site mental health services, enhanced coordination with the resettlement agencies, catering the hours and clinic location to better fit refugee needs, and close and consistent follow-up were also prominent themes in these success stories. While challenges remain, great progress has been made in recent years to be more medically welcoming and inclusive of some of the newest members of our communities.

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