



Opening Doors: A Sustainable Refugee Health Care Model

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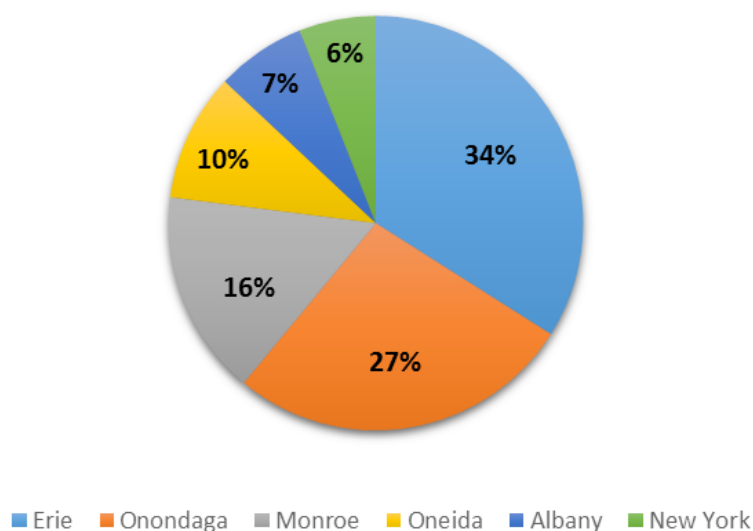
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Background

The United States has a longstanding history of accepting refugees in search of a new life, all of whom have fled war-torn countries or cannot safely return to their home country because of persecution based on religion, race, nationality, or other factors. Since the approval of the U.S. Refugee Act in 1980, 3 million refugees have resettled in the United States. After a lengthy vetting process that takes 18–24 months on average, refugees approved to enter the United States are resettled where other relatives are already living or placed in areas based on the best match between a community’s resources and a refugee’s needs.¹ Approximately 3,000–5,000 refugees per year have resettled in New York State, many in the upstate region. The proportion of refugees resettling upstate also is growing each year. In 2006, 76% of New York’s refugees were placed upstate; by 2008, that number had increased to 87%. Currently, 96% of refugees resettling in New York State are located upstate, particularly the greater Buffalo, Rochester, and Utica areas.² Although refugees come from different parts of the world, many share similar health-related challenges—including previous inadequate medical care, exposure to torture or terrorism, poverty, and language barriers—that make it difficult to access health care.

Refugee Arrivals by New York State County 2013-2014

Source: Worldwide Refugee Admission Processing System



¹ U.S. Department of State, Refugee Admissions Program, <http://www.state.gov/j/prm/ra/admissions/index.htm>, accessed January 2016.

² New York State Office of Temporary & Disability Assistance, Bureau of Refugee and Immigrant Assistance population report, <https://otda.ny.gov/programs/bria/documents/population-report.pdf>, accessed January 2016.

Background *(continued)*

In the last decade, upstate New York has been home to health care clinics that have either shut their doors to new refugees or have closed down altogether because of the financial burden of treating these patients. In most cases, reimbursement comes from Medicaid, but standard rates are often too low given the complex health needs of refugees. Additionally, most refugees require interpreters during their visits; however, although Medicaid does reimburse for interpretation services, the rate is low and not enough to cover the costs.

For many providers, the provision of care to refugees has proven to be a financial stress or unsustainable. Metropolitan areas in upstate counties have cobbled together informal networks of clinics, health departments, and for-profit agencies in an effort to keep up with the health care needs of the increasing flow of refugees entering their geographic areas. However, these efforts can contain inefficiencies. For example, each clinic or agency either has its own interpreters or uses outside interpretation services at a substantial cost. The capacity for clinics to treat refugees also varies widely, and no coordinated system for equally distributing newly arrived refugees exists.

Furthermore, all refugees must receive a federally mandated health assessment, to be completed within 90 days of arrival, by a health care provider or agency. However, the federal funds distributed by the State to entities that complete the health assessments often do not flow to the primary care practices that manage the medical conditions of refugees during the post-resettlement period. Instead, many outside agencies (nonprofit and for-profit) perform these assessments and collect the fees, but don't provide ongoing care to the refugees thereafter. Consequently, funds are bypassing primary care providers that could be used to support some of the expenses associated with ongoing provision of primary care to refugees.

The Project

In Rochester, two health centers began to see new refugees in an organized fashion starting in 2000. After a few years, both of these health centers closed their doors to refugees because of the financial burden of providing primary care to this complex group of patients. By 2008, Rochester faced a crisis—no primary care practices were accepting refugees as new patients into care, despite the arrival of 800 refugees on average each year. Thus, newly arrived refugees had no access to the health care system other than through emergency rooms or urgent care clinics.

In response to this burgeoning problem, Rochester General Hospital (RGH) approached the New York State Health Foundation (NYSHealth) in 2009 for help. NYHealth encouraged RGH to first determine the major factors contributing to refugee health care crisis so as to better understand how to create a sustainable model of care for this vulnerable population.

Through research and extensive on-the-ground work, RGH identified two issues as the largest barriers to a financially sustainable model of care:

1. The agencies performing the refugee health assessments were not primary care providers and therefore were not connecting refugees to follow-up primary care after assessments were completed. These organizations (some of which were for-profit) were receiving reimbursement simply to screen refugees, rather than the primary care providers that could benefit from the additional revenue and establish ongoing patient relationships.
2. Medicaid coverage for refugees automatically expires after six months of living in the United States. Even though almost all remain eligible for ongoing coverage, many refugees are either unaware that they must renew or face a variety of obstacles to recertifying, including language barriers, mental health problems related to trauma, and general misunderstanding and misinformation.

Once apprised of the fundamental obstacles, NYHealth understood this was an opportunity to help develop and test a new, innovative refugee health care model. With guidance from NYHealth, RGH subsequently proposed a primary care model for refugees that addressed both issues by:

- Shifting the refugee health assessments to agencies that already delivered primary care or partnered with primary care providers to link refugee patients to preventive care; and
- Adding a document to the immigration paperwork refugees are required to fill out that gives consent to the State to send a Medicaid recertification application to the nearest hospital (to be filled out by hospital staff on behalf of the refugee). This allows for continuous Medicaid coverage of all eligible refugees, in turn allowing primary care clinics full reimbursement for all primary care services provided.

In 2009, with NYHealth funding, RGH began to pilot the model using specific strategies that included developing strong partnerships with refugee resettlement agencies; providing the initial refugee health assessments and capturing the associated reimbursement funds; helping refugees retain Medicaid coverage after their initial six-month coverage period expired; recruiting new primary care practices to treat refugees; and coordinating patient services (e.g., transportation, interpretation, and patient navigation).

The Project *(continued)*

Staffed by the director of refugee health care at RGH, three refugee patient navigators, one patient services coordinator, and rotating student volunteers, RGH's refugee health care program proved to be the first financially sustainable model of care that allowed primary care practices in Rochester to see new refugees without becoming financially overwhelmed.

The model's unique features included:

Coordination of Services

A hospital director acts on behalf of primary care practices within the hospital's medical groups to evenly distribute incoming refugees to those practices willing to accept them. Additionally, the director works with resettlement agencies and primary care practice leaders to coordinate important services such as transportation, interpretation, and patient navigation.

Consolidation of Resources

A centralized approach is employed that uses resources, such as social workers and interpreters, and allows them to be shared among sites as needed, thereby avoiding duplication or underuse of services.

Increased Primary Care Capacity

A robust educational curriculum is used to engage physicians and staff members who want to accept refugees into their practices, as well as to provide the educational tools necessary to develop culturally competent medical providers. Educational tools include in-service presentations, one-on-one discussions with physicians, workshops, websites, and medical conferences.

Financial Stability

Fifty percent of the federal reimbursement that the State distributes to primary care practices for performing refugee health assessments is used for continued operating costs of the program, with the other half going to the physicians caring for the refugees. Thus, primary care practices receive operational support for refugee care, but still receive supplemental reimbursement (in addition to Medicaid billing) for providing primary care to refugees.

Two years after the pilot was launched in Rochester, its outcomes demonstrated the model's transformative potential to increase refugees' access to high-quality and continuous primary care services. Among the model's outcomes:

- Scheduling processes and procedures were created;
- Strong collaborations were formed among multiple agencies;
- Patient access to interpretation services increased;
- Eligible refugees retained their Medicaid coverage beyond their initial six-month coverage period;
- A refugee health care website was created;³

³ The Center for Refugee Health, <http://centerforrefugeehealth.com>, accessed January 2016.

The Project *(continued)*

- A curriculum for cultural competency training was developed to better prepare providers to meet the challenges of treating refugee patients;
- An annual national refugee health care conference was instituted for health professionals to discuss topics such as best health practices, challenges for optimal care, and research and advocacy for the refugee patient population;
- Twenty primary care physicians were engaged to accept refugees into their practices;
- Eighty percent of refugees entered into a primary care practice within 30 days of arrival; and
- The RGH refugee health care program gained financial self-sustainability, as did the participating practices.

By 2012, approximately 1,953 refugees had been served by this program, which resulted in \$240,000 per year in additional health assessment reimbursement—of which half was used toward operational costs and half was distributed to physicians as an incentive to provide services to refugees. Since the development of this model, 96% of refugees relocated to Monroe County, of which Rochester is the county seat, have been accepted into primary care practices—and these practices have not experienced financial strain as a result. To date, nearly 6,000 refugee patients have received care and services. To the best of anyone's knowledge, no other refugee health care program in New York State can claim that level of success.

Additionally, because of the program's success, the New York State Department of Health awarded the Rochester General Medical Group, an RGH affiliate, a five-year, \$1.2 million contract to provide refugee health assessments.

Som Gurung* resettled in Rochester in 2015. He was a victim of ethnic cleansing in Bhutan in the early 1990s and fled to Nepal, where he lived in a refugee camp for 21 years. Som entered the camp alone at the age of 13 and has spent the majority of his life behind its barbed wire confines. At the camp, he suffered from severe weight loss, but the camp doctor treated him only with vitamins. After resettlement in Rochester, Som met with staff members from the refugee health care program, and it was quickly discovered that he had juvenile diabetes that was never treated. Som entered into immediate treatment and was introduced to his new doctor. Over a period of several weeks, his diabetes was controlled and he returned to a normal weight. Initially, Som's care was delivered in Nepali and all his prescriptions and patient information were written in Nepali so he could understand. Since his arrival, he has learned English and is now in a local community college learning to be a nurse. Without the intervention of the program, Som would have continued to suffer from his untreated diabetes and would eventually have ended up in the hospital with serious complications and expensive care as a result.

To date, the Rochester refugee health care program has entered more than 6,000 newly arrived refugees into primary care services—each one with a similar story. Through the efforts of the program, thousands of refugees have been able to access appropriate health care while the community has benefited from decreased health care costs through the elimination of unnecessary emergency department visits and hospitalizations.

**Name changed to protect privacy*

The Project *(continued)*

Mohammed Hussan* is an Arabic-speaking refugee from Iraq; because of his Christian faith, he was jailed and beaten in his home country. He fled the Gulf War with his wife and two children and was housed in a temporary refugee camp in Jordan. Mohammed could never return to Iraq, and Jordanian authorities wouldn't allow him to gain citizenship there. An intelligent, hardworking man who had worked as a carpenter in Iraq, Mohammed and his family arrived in Rochester in 2014. They spoke no English and knew no one here. Mohammed also suffered from post-traumatic stress disorder (PTSD). Despite their best efforts to survive in their new city, Mohammed and his family were isolated and had no understanding of how to access resources for help.

Through the Rochester General Hospital's (RGH) regional refugee health care program, Mohammed and his family received immediate access to care with a culturally sensitive doctor. The site where he received care had appropriate interpreters and support personnel who could help Mohammed beyond the delivery of medical care. His family was assigned an Iraqi peer counselor through the clinic, and they were taught how to increase their independence in accessing health care and how to use the bus route to the clinic. The family's medical issues were appropriately addressed, and Mohammed gained access to mental health services.

The peer counselor connected the family with an Arabic support group, English classes, and job training at a local nonprofit educational center. Mohammed's wife was connected with a person in the children's school system who spoke Arabic and helped the children enroll in school. A few months after arrival, Mohammed was able to find a job as a carpenter—enabling the family to get off public assistance. Mohammed's therapy sessions helped him overcome some of the symptoms of PTSD, and the family is getting regular preventive care check-ups and has developed a trusting relationship with their new doctor.

Without the interventions of RGH's refugee health care program, Mohammed and his family would have been at high risk for multiple emergency department and urgent care visits, as well as not getting connected with the right resources to successfully resettle in Rochester. Thanks to the program's interventions, the family is living independently as productive citizens in Rochester.

**Name changed to protect privacy*

Plans for Replication

Based on the model's success in Rochester, NYSHealth awarded RGH a second grant to replicate it elsewhere in the State. After careful consideration, it was determined that the communities of Utica and Buffalo would benefit most from this model.

The selection of Utica (in Oneida County) was partly based on RGH's previous relationships in the community as a health provider and with the city's health system leaders, as well as for its potential to quickly identify on-the-ground physician leaders to champion the program. The city's demographics were also a key consideration—Utica is the fourth-largest resettlement area in New York State. It has one main resettlement agency and, for the most part, only one clinic that accepts newly arrived refugees as new patients. Additionally, RGH has a close working relationship with the Rochester Primary Care Network, which owns and operates Utica's clinic that accepts refugees. This environment, very similar to that of Rochester back in 2008, gave RGH a high likelihood of success for replicating the model.

Buffalo (in Erie County), offered the most potential in terms of the volume of refugees resettled—it received 35% of newly arrived refugees in 2014—and has a critical need for the type of model RGH had developed. However, the challenges of replicating the model in Buffalo were considerable. It is a large geographic area with six resettlement agencies and multiple clinics that only perform refugee health assessments, whereas other clinics in the area deliver primary care to refugees but are not authorized to conduct refugee health assessments.

Given the landscape and conditions in both cities, RGH first began replicating the model in Utica in 2012. It then began work in the Buffalo area toward the end of 2014.

Four critical factors were deemed necessary for successful replication:

1. An implementation plan for the model designed so that any health system could begin applying it without having to devote substantial time and resources researching and investigating the model;
2. Commitment by senior health system leadership at the sites where the model was going to be implemented;
3. The presence of on-the-ground physician leaders to champion the model and perform the necessary implementation work; and
4. Ongoing technical support from RGH to prevent health systems from faltering during the implementation period.

Plans for Replication *(continued)*

Utica Replication

In the first quarter of 2012, Utica encountered major obstacles in the delivery of health care to refugees. The clinic that had previously accepted newly arrived refugees had reached financial and physical capacity and stopped accepting new refugee patients. The Oneida County Health Department (OCHD) ceased offering public health screenings to refugees, instead contracting out that work to a for-profit agency that didn't connect refugees to ongoing primary care. The Utica Community Health Center (UCHC) also had to close its doors to new refugees for financial reasons. As a result, Utica was left with no primary care options for the anticipated 400 new refugee arrivals expected each year.

The political landscape in Utica also was difficult for an outsider to maneuver, resulting in significant delays in the model's implementation. Successful replication required an on-the-ground presence; however, through persistence and extended time spent in Utica, RGH was able to make progress. From January 2012 through December 2013, RGH's director of refugee health care invested considerable time in Utica, traveling there from Rochester most weeks to facilitate collaborations and help implement the model.

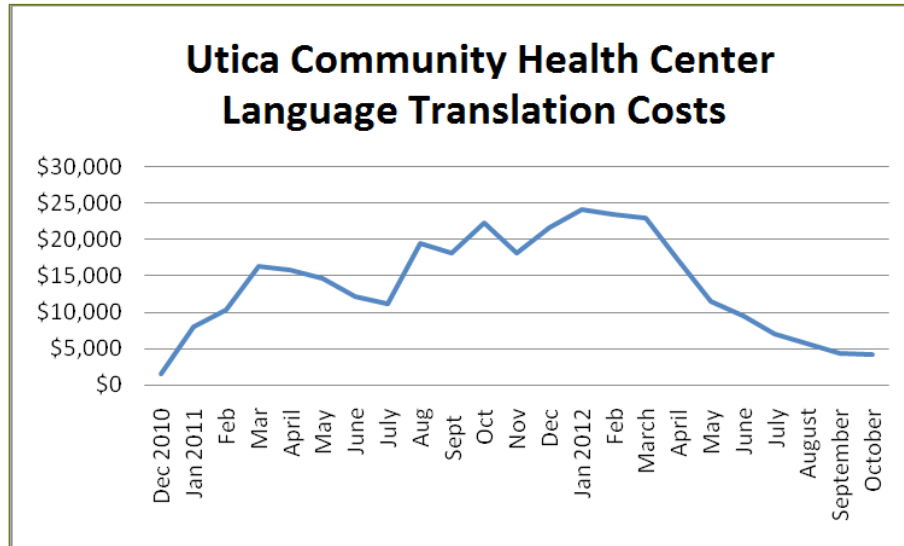
As a result, by mid-2013, the following results had been achieved:

- UCHC agreed to accept new refugees once again, provided that RGH implement the model at its site. UCHC received a State contract to perform refugee health assessments, hired additional staff members, switched to a new interpretation service to decrease costs, and developed a good working relationship with Mohawk Valley Resource Center for Refugees (MVRRCR) and OCHD. By early 2014, UCHC had fully implemented the model and was seeing all newly arrived refugees for initial health assessments and providing them with follow-up primary care. To date, UCHC's refugee health program is running a net-positive operating margin and it has leveraged the program's success to obtain additional funding from Health Resources and Services Administration to add more resources for refugees, such as mental health services.
- MVRRCR established a productive relationship with UCHC and has referred all newly arrived refugees to UCHC for health care services.
- OCHD began working closely with UCHC on follow up and subsequent treatment for refugee arrivals who tested positive for tuberculosis.

Overall, replicating the refugee health care model in Utica was successful, achieving the overarching goal of connecting refugees to primary care. However, RGH experienced significant challenges along way—some anticipated, others unforeseen.

It took an extended time for UCHC to receive its State contract to offer refugee health assessments. This delay kept UCHC from receiving anticipated revenue, which in turn slowed down project implementation. Once the contract was in place, however, UCHC was able to quickly move ahead with implementation plans.

Plans for Replication *(continued)*



UCHC also faced some personnel challenges. Two of its medical providers left the facility; thus, UCHC's capacity for new patients was not only diminished, it struggled to keep up with existing patient appointments. To overcome this obstacle, RGH help UCHC hire two physician assistants.

Like many small cities, Utica has its own local dynamics. Consequently, outside entities can face difficulties forging partnerships or creating collaborations. The project manager spent much more time than expected holding meetings with OCHD, the resettlement agency, United Way of the Valley and Greater Utica Area, interpretation service firms, and other community agencies to gain support for the project. As a result, more time and grant funds than expected were directed toward Utica, leaving fewer resources for replication efforts in Buffalo.

Buffalo Replication

In mid-2014, RGH turned its attention to the Buffalo area. However, replication plans in Buffalo proved to be even more complicated than in Utica because of the greater number of newly resettled refugees and refugee resettlement agencies, as well as the political landscape at the time. Both RGH and NYSHealth underestimated the challenges in establishing the model in Buffalo. As a large Rochester-based hospital network, RGH encountered some difficulties in advising Buffalo-based health care providers on how to deal with their refugee health care issues.

By the end of the grant period, only two providers, Catholic Charities of Buffalo and D'Youville College Health Center, agreed to use the model, and both began plans to open primary care practices that would accept refugee patients.

Lessons Learned/Next Steps

The collaboration between RGH and NYSHealth on planning and implementing the refugee health care model was highly successful in Rochester. Replicating the model in other areas of the State with large refugee populations was the natural next step for the project in 2012. However, unanticipated barriers made replication more difficult than expected in both Utica and Buffalo. In Buffalo, in particular, the lack of an on-the-ground, locally-based partner made it difficult for RGH to solicit support for the project.

Despite the unforeseen challenges to replication, the refugee health care model has proven successful. With 96% of New York State's refugees resettling upstate, it was expected that this region would face common challenges and benefit from a similar solution. Both the immediate and long-term impact of the model will decrease unnecessary hospitalizations, emergency room visits, and adverse health outcomes for refugees entering New York State. Demonstrating to other health systems in New York that the model was successfully replicated in Utica will encourage them to explore the adoption of this model at their own sites.

RGH will continue work in Buffalo, although on a somewhat limited basis as a result of funding constraints. In conjunction with Catholic Charities of Buffalo and D'Youville College, a new health center accepting refugee patients is expected to open in early 2016. The health center will provide health care to refugees; however, the center is still waiting for a State contract to conduct refugee health assessments.

With NYSHealth support, RGH helped to develop the annual North American Refugee Health Conference, which has become one of the largest clinical conferences on refugee health globally, attracting more than 600 participants annually.⁴ This unique conference—co-hosted with Canada—is the only conference on the continent completely dedicated to educating physicians about the primary care needs of refugees. RGH will continue to run this conference and use it as a venue for disseminating information about the refugee health care model. Additionally, RGH launched the Center for Refugee Health, a stand-alone health center completely dedicated to serving the needs of newly arrived refugees in the Rochester area.⁵

As a result of the model's success in Rochester and Utica, RGH, with approval from New York State, has created the North American Society of Refugee Healthcare Providers (NASRHP).⁶ In its first three months of operation, NASRHP secured 140 founding members. Additionally, NASRHP has more than 1,800 subscribers to its information listserv, a global tool for medical providers focused on refugee health care issues.

The refugee health care model, which began as an initial idea and pilot project with some early NYSHealth funding in 2009, has expanded into a global initiative with Rochester (and New York State) as its epicenter. It has filled a void by making primary care services available to refugees and allowing health centers to provide that care in a sustainable, cost-efficient manner.

⁴ Learn more at <http://centerforrefugeehealth.com>, accessed January 2016.

⁵ Learn more at <http://centerforrefugeehealth.com>, accessed January 2016.

⁶ Learn more at <http://nasrhp.org>, accessed January 2016.



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