Assessing Perceived Barriers to Health Care Access for Resettled Refugees in the Western United States

ASSESSING PERCEIVED BARRIERS TO HEALTH CARE ACCESS FOR RESETTLED REFUGEES IN THE WESTERN UNITED STATES

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Abstract

Refugee health in the United States is an understudied subject, particularly on the West Coast. Little is known about the health needs of diverse refugee groups in the country outside of their initial health assessments upon entering the country for resettlement. This project explored perceived barriers to health care for refugees in three areas: Seattle/King County, Washington; Los Angeles, California; and Tucson, Arizona. Interviews and surveys were conducted with a range of key informants in each area to understand more about refugee health needs. The interviews revealed a wide range of perceived barriers, including: acculturation, language and communication, and unmet mental health needs. These barriers, both on the demand side and the supply side, are complex, inter-related, long-standing, and in many cases, not unique to resettled refugees. Some could be addressed with additional funding and the development of new programs, although most do not lend themselves to simple or short-term solutions, even with additional investments, but instead require sustained interventions across multiple sectors to address health system issues and social determinants of health. The paper discusses priority areas for policy consideration that could help reduce barriers, address gaps in care, and improve health for resettled refugees

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Section 1
Proview Overview and Project Description

The United States has resettled nearly 3 million refugees since the Refugee Act of 1980 (Krogstad & Radford, 2017). While the number of refugees allowed into the country fluctuates on an annual basis, the U.S. continues to run the world's largest official resettlement program in the world (Capps & Fix, 2015). In the midst of the current global migration crisis, the largest since World War II, refugees have been forced to migrate to new lands like the United States, but with their unique backgrounds, cultural traditions, and health customs still intact (Martin, 2016; Fazel, 2018; Li, Liddell, and Nickerson, 2016). During this resettlement process, the health needs of refugees are often overlooked, especially in refugee camps or temporary shelters (Meyer, Yu, Hermosilla, & Stark, 2017; Vossoughi, Jackson, Gusler, & Stone, 2016; Bell, Lori, Redman, & Seng, 2016).

In addition to the traumatic experiences many refugees endured which caused them to flee their native countries, and the situations they encountered in secondary nations or refugee camps, they also go through the process of resettling in a new county with ample needs and few material possessions. The resettlement process itself is a trying endeavor, and then fully integrating into a new nation poses many additional challenges, especially in accessing the health system. When refugees are eventually rehomed in their new county in the U.S., basic needs like housing, food, transportation, and education are initially met by each person's assigned refugee resettlement agency (RRA). Navigating the health system in the United States, however, is not a service provided by RRAs nor any other organization, forcing resettled refugees to complete tasks like re-applying for health insurance, understanding medication instructions, and requesting

specific health care services unassisted. Facing these types of barriers and gaps that prevent access to health care, refugees' options for obtaining high quality medical treatment from culturally sensitive providers becomes limited.

Despite the millions of refugees resettled in the United States, this population and its health challenges are understudied. Though many of these issues are universal to the refugee experience around the world, a number of groups have unique needs and conditions specific to the areas in which they are resettled. For this reason, this project investigated these barriers and gaps in three specific local regions of the western U.S.: Seattle/King County, Washington; Los Angeles, California; and Tucson, Arizona. These regions were selected because of their unique refugee population demographics and public health infrastructure related to refugees. The goal of the project is to help identify the perceived reasons refugees are not able to access and maintain the care they need in the United States and how the health system can address these barriers. It will attempt to answer the following questions:

- What barriers prevent resettled refugees from accessing health care in these regions?
- What gaps in coverage exist for this population?
- What interventions can help improve these issues?
- What programs and organizations are providing exemplary services and can serve as a model for refugee health care?

Section 2
Host Organization

This DELTA project was hosted by the François-Xavier Bagnoud (FXB) Center for Health & Human Rights, at Harvard Chan, and supervised by Professor Jackie Bhabha. The FXB Center for Health & Human Rights was established in 1993 as a collaboration between world-renowned physician and global health leader Dr. Jonathan Mann and Countess Albina du Boisrouvray (Hilts, P.J., 1998; FXB Center, 2018). After the loss of her son during a rescue helicopter flight he was piloting in Mali, Countess du Boisrouvray stepped away from her role as a successful film producer and devoted her life to humanitarian causes to honor the focus of her son's life: helping those in need. This is why – after dedicating her work to helping vulnerable children in the wake of the AIDS epidemic – du Boisrouvray teamed up with Dr. Mann, the founder of the WHO's Global Programme for AIDS and Project SIDA, to create the Global AIDS Policy Coalition (GAPC) at the Harvard School of Public Health in 1991, which Dr. Mann led while concurrently serving as a Professor at the school.

In 1993, Countess du Boisrouvray donated $20 million to fund the construction of a seven-story building and finance a Professorship at the school, and Dr. Mann was appointed the Founding Director of the duo's new organization, the FXB Center for Health & Human Rights. Since its establishment, the FXB Center has served as a global hub of academic research, teaching, and policy development in the field of international human rights. The Center now works in collaboration with a large number of nongovernmental organizations (NGOs), academic institutions, practitioners, policymakers, and international agencies to "[E]xpand knowledge through scholarship, professional training, and public education; develop domestic and international policy focusing on the relationship between health and human rights in a global

perspective; and engage scholars, public health and human rights practitioners, public officials, donors, and activists in the health and human rights movement" (Health and Human Rights Journal, 2018).

After hosting numerous international conferences on health and human rights, influencing the development of international humanitarian aid policies, and combining scholarship and education with advocacy and policy formation, the FXB Center has become an interdisciplinary facility supporting pivotal research on some of the most pressing threats to the health and wellbeing of people worldwide (FXB, 2018). The FXB Center is now headed by Professor Jennifer Leaning and focuses mainly on child protection, war and conflict studies, and distress migration. One of the specific fields in which the FXB Center is a global expert is refugees and forced migration. Professor Jacqueline Bhabha, Professor of the Practice of Health and Human Rights at the Harvard T.H. Chan School of Public Health (formerly the Harvard School of Public Health), is one of the FXB Center's leading scholars of refugees and health and the organization's Director of Research. Uniquely positioned as both a human rights attorney and an academic at Harvard Chan, Harvard Kennedy School, and the Harvard Law School, Professor Bhabha's work converges on the intersection between refugee law, child protection, citizenship, and migration. In addition to dozens of publications, Professor Bhabha serves on many boards, including the Journal of Global Health Studies, the U.S. section of International Social Services, and the World Peace Foundation. Professor Bhabha also founded and chairs the board of the Scholars at Risk Network, a nonprofit that serves as" [An] international network of higher education institutions and individuals working to protect scholars and promote academic freedom" (Scholars at Risk, 2018).

Professor Bhabha's work at the FXB Center focuses on refugee health and rights. This project helps to enhance FXB's research in the United States' resettled refugee population, a vastly understudied and poorly understood group. Aiding refugees through research and resulting policy in low-income, conflict, and foreign countries is crucial to the mission of the FXB Center, but promoting the health and well-being of resettled refugees within the United States' borders is also of critical importance.

Under Professor Bhabha's guidance, this project attempts to model the collaborative and partnership-based relationships of the FXB Center. Working with state and local Departments of Health, refugee resettlement agencies, refugee-focused nonprofits, religious groups, academics, and community activists in the Seattle/King County, Los Angeles, and Tucson regions, this project aimed to work with collaborators to focus on an emerging field in refugee health: gaps and barriers in the American health system for resettled refugees.

Section 3
Public Health Context for the Project: Why Is health care access for resettled refugees important?

Refugee Background

In order to gain a deeper understanding of why the barriers and gaps in health care exists in this vulnerable population, it is necessary to first define the term "refugee."

Article 1 of the 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as:

> "...[A] person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution" (UNHCR, 2011).

This 'fear of persecution' can stem from traumatic experiences in war zones and armed conflict, famine, violence, genocide, and human trafficking (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Pearlman & Courtois, 2005). Following these experiences, a majority of refugees spend a large portion of their lives in refugee camps before they are resettled in a new country. A lack of medical resources along with an increase in emotional stress can exacerbate any health issues refugees may already have, or even lead to the development of others (Morris, et al, 2005). In addition to any communicable or non-communicable diseases refugees are at risk of acquiring while in refugee camps or fleeing dangerous situations in their home or secondary countries, exposure to violence has also been noted as a significant risk factor for mental illness (Fazel, Reed, Panter-Brick, & Stein, 2012; Lindencrona, Ekblad, & Hauff, 2008). Outside the

initial health screening all refugees must receive before being resettled, little else is known about the health needs and statuses of refugees when they arrive in the United States (Paardekooper, De Jon, & Hermanns, 1999; Richard & Rahe, 1978; Harris & Zwar, 2005).

Problem Overview

The United States has conducted the world's largest refugee resettlement program for many years, accepting over 54,000 people into the country in 2017 alone (Fix, Hooper, & Zong, 2017). Since 1980, over 3 million refugees have been resettled within the United States from roughly 100 countries (Krogstad & Radford, 2017). During the first eight months after their arrival to the United States, most resettled refugees qualify for a number of government benefits, including cash assistance programs, case management, employment services, and medical coverage through the Refugee Medical Assistance (RMA) program or Medicaid (including the Children's Health Insurance Program or CHIP) (Migration Policy Institute (MPI), 2017).

Despite the availability of these health care benefits during the first eight months of a refugee's resettlement in the United States, a number of studies have documented gaps between the types of medical services offered and the specific care needed by these resettled populations (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; McKeary & Newbold, 2010; Omeri, Lennings, & Raymond, 2006; de Anstiss & Ziaian, 2010; Ellis, Lincoln, Charney, FordPaz, Benson, & Strunin, 2010; Othieno, 2007). Beyond the gaps in services offered, other pervasive barriers prevent refugees from accessing the care benefits to which they are entitled, and these gaps often vary by region and state of resettlement (Asgary & Segar, 2011; Palmer, 2006; Herrel, Olevitch, DuBois, Terry, Thorp, Kind, & Said, 2004; Davidson, Skull, Burgner, Kelly, Raman, Silove, & Smith, 2004; Lamb & Smith, 2002; Clark, Gilbert, Rao, & Kerr, 2014).

A review of the literature on health care for resettled refugees found a number of documented barriers and gaps in health care for this population. The studies have occurred primarily in Canada, the United Kingdom, and Australia, though several of the research articles were written about resettled refugee populations in the United States' health system. These barriers and gaps found in this review are summarized below.

Language and Communication

Though the challenges newly resettled refugees face in accessing health care vary in complexity, the most frequently cited obstacles include difficulties in language and communication differences between resettled refugees and their health care providers (Morris, et al, 2010; Morris, et al, 2009; Allotey, 1999).

Trauma

Most resettled refugees have experienced significant mental, physical, and emotional trauma, arising from issues such as: female genital mutilation; genocide; terrorism, war; kidnapping; forced departure from one's homeland and family; sexual abuse; domestic violence; spousal conflicts; depleted social networks; loss of all personal wealth and material possessions; loss of occupation and professional status; and severe isolation and loneliness. Many health professionals are unaware of or unprepared to treat these issues in a culturally appropriate or effective method (McKelvey, et al, 2002; Makwarimba, et al, 2013; McKeary & Newbold, 2010). Additionally, for resettled populations who had experienced torture or mental health issues in their pasts, seeking care from a knowledgeable and culturally aware physician with experience in trauma-based care methods may be challenging due to the stigma surrounding

mental health care, lack of self-awareness of a psychiatric condition, or personal views on suffering (McKeary & Newbold, 2010; Sharpe, 1997; Uba, 1992). Barriers surrounding mental health and trauma continue to affect the ability of resettled refugees to access necessary treatment.

Acculturation to the Medical and Health Beliefs of Systems

More intricate and complicated issues revolve around topics like acculturation to the health system, previous medical interventions or lack thereof, and personal and cultural beliefs regarding healthcare needs (Morris, et al, 2009; Adams, Gardiner, Assefi, 2004). Specific acculturation challenges also impact resettled refugees' confidence in their physician. Some of these issues include a lack of culturally appropriate services, separation from family for large periods of time, non-culturally specific health promotions, and familial challenges (Makwarimba, Stewart, Simich, Makumbe, Shizha, & Anderson, 2013; McKeary & Newbold, 2010; O'Donnell, Higgins, Chauhan, & Mullen, 2007).

Trust

Stigmatization and discrimination are also significant obstacles to access and care for resettled refugees (Szajna & Ward, 2015; Harris & Telfer, 2001). Seven studies reviewed in a 2015 dynamic analysis by Szajna and Ward confirmed the impact that the fear of disrepute or rejection can have on resettled refugees, particularly in relation to Islamic dress, seeking medical care for particular health conditions (especially mental health), HIV diagnosis, deportation fears, and a general lack of trust in providers (Omeri, et al, 2006; de Anstiss & Ziaian, 2010; Ellis, et al, 2010; Othieno, 2007; Asgary & Segar, 2011; Palmer, 2006; Herrel, et al, 2004). Oftentimes,

this distrust stemmed from previous experience with patient abuse at the hands of government authorities, health care providers, and those in the medical community (Sharpe, 1997; British Medical Association, 2001; Hadgkiss & Renzaho, 2014).

Lack of Provider Training

Several studies noted that many health professionals lacked sufficient training or cultural knowledge regarding issues specific to refugees, particularly in providing reproductive health care to women or cultural practices (Murray & Skull, 2005; McKeary & Newbold, 2010; McKelvey, et al, 2002).

Lack of Health Insurance Coverage

Lack of health insurance coverage can prove troublesome in some countries, including the United States (Caulford & Valie, 2006; McKeary & Newbold, 2010). After their first eight months in the U.S., refugees' initial health insurance is discontinued. Refugees must then re-apply to Medicaid, purchase health insurance through the federal marketplace, or obtain health insurance from their place of work (Morris, et al, 2009). Few studies have been conducted about the insurance coverage challenges refugees face after this initial eight-month period, though financial issues and a lack of knowledge about the health insurance marketplace have been cited in previous studies related to health insurance coverage for refugees.

Overburdened Health Systems/Lack of Resources and Capacity in the Medical Care System

Recent studies of Syrian refugees who fled to Turkey and Lebanon have demonstrated the challenges health systems face when they have reached their capacity limits (Zencir, Davis, 2014). Hospitals in Turkey have faced issues of overcrowding and personnel complaints, and refugees have expressed frustration at the lack of available services in these health facilities (Sleiman, Atallah, 2016). Though the Turkish government has allowed hospital access for refugees and even provided hospitals funding for this population, hospital access has still been noted as a challenge by the Turkish Medical Association, and has been compounded by the number of new refugees for whom hospitals must provide care. The generally robust health care system in Turkey has faced major obstacles in providing treatment to Syrian refugees, including difficulty achieving desired rates of vaccination for polio and measles, language barriers in hospitals and primary care centers, and difficulties and shortages with chronic disease treatment. (Mirza, Luna, Mathews, Hasnain, Hebert, Niebauer, & Mishra, 2014).

Financial Barriers

Financial barriers have been cited in several studies. These financial barriers can include lack of employment, insufficient income, inadequate government financial assistance, insufficient funds to obtain safe housing, or any housing at all, (Makwarimba, et al, 2013; Morris, et al, 2009). Financial barriers to dental problems and medication have also been noted (McKeary & Newbold, 2010). Lack of financial resources to pay for medical services, transportation, and services not covered by insurance have also been found to be problems. (Lamb & Smith's 2002).

Transportation

Many refugees face significant barriers in accessing transportation to attend medical appointments (Morris, et al, 2010; Morris, et al, 2009; Allotey, 1999; Harris & Telfer, 2001). For newly resettled refugees who do not own or lease cars, learning to navigate the public transportation system is also a reported obstacle.

Geographic Isolation and Lack of Access to Providers

Geographical isolation and lack of access to providers has been noted as an obstacle in several studies, particularly a lack of health care facilities in rural areas. (Grant, Mayhew, Mota, Klein, & Kazanjian; Lamb & Smith, 2002).

Prior Lack of Care

All refugees resettled in the United States must undergo a health assessment within their first 30 days of resettlement. In these assessments, refugees are rarely screened for mental health problems, and the short duration of the examination does not generally allow for sufficient screening for non-specific illnesses that are targeted by the Public Health Department, such as tuberculosis and malaria (Sheikh-Mohammed, et al, 2006).

Section 4
Background on Resettlement History, Process, and Health Programs for Refugees

Refugee Health in the United States

Refugee health legislation has been evolving for decades in the United States. A variety of international and national laws govern health care for resettled refugees in the U.S., including:

- **The United Nations 1951 Declaration** and **1967 amended protocol**: refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to "[T]he highest standards of physical and mental health" (UNHCR, 2018). The Convention outlined the basic right of health for all refugees and set an international standard of health care and medical access for all nations who endorsed the resolution
- **The Refugee Act of 1980** set important legal rights for refugees rehoused in the United States, chief among them domestic resettlement and assistance through the Office of Refugee Resettlement including grants, cash assistance, English training, and funding for state health programs under the Department of Health and Human Services (ORR, 2012).
- Refugees' status changed in the eyes of the law following the passage of the Refugee Act, which automatically enrolled them in a medical benefits plan, usually Medicaid, or Refugee Medical Assistance (Rao, 2013). This legislation gave the first important distinction between immigrants (who do not qualify for these federal health plans until they live in the country for five years) and refugees (who were allotted these unique protections) (Rao, 2013).

This act gave the Director of the Office of Refugee Resettlement a variety of responsibilities in regard to refugee health care, including the authority to:

- implement methods for monitoring and assessing the quality of medical screening and related health services provided to refugees awaiting resettlement in the United States.
- make grants to, and enter into contracts with, state and local health agencies for payments to meet their costs of providing medical screening and initial medical treatment to refugees.
- make grants to, and enter into contracts with, public or private nonprofit agencies for projects where specific needs have been shown and recognized, including health, mental health, social services, educational and other services.
- provide assistance, reimbursement to states, and grants to and contracts with, public and private nonprofit agencies, for the provision of child welfare services, including foster care maintenance payments and services and health care, furnished to any refugee child.

United States Refugee Resettlement Process

In total, the resettlement process can take up to two years and involves eight U.S. government agencies, six different security databases, five separate background checks, four biometric security checks, three separate in-person interviews, and two inter-agency security checks (UNHCR, 2018). The U.S. Refugee Admissions Program (USRAP) is the largest resettlement agency in the world and is managed by the Department of State, but also involves the Department of State's Bureau of Population, Refugees, and Migration Refugee Admissions program; the U.S. Citizenship and Immigration Services; the Department of Health and Human Services' Office of Refugee Resettlement; and the Department of Homeland Security's Refugee Affairs Division (United States Department of State, 2017).

After this intensive vetting process and once a refugee has been approved for resettlement in the U.S., the State Department assigns them to one of nine RRAs, all funded by the U.S. Department of State's Bureau of Population, Refugees and Migration, with 350 affiliate offices nationwide (UNHCR, 2018). The nine RRAs help to resettle refugees in locations based on their specific needs and the resources which are available in a given community (U.S. Department of State, 2018). Priority is given to regions with a large population from the same home nation or region of the U.S. in which a refugee has any family members (AIC, 2017). Each RRA is responsible for providing a basic set of services for each refugee under their care for the first 90 days of their time in the U.S. (AIC, 2017). These services include arrangements for food, basic housing, clothing, employment counseling, medical care, and other basic services, mostly funded by the federal government (AIC, 2017). Obtaining a Social Security card, enrolling children in local schools, studying local public transportation schedules, acquiring medical appointments, teaching grocery shopping styles, and helping refugees with language service groups are all basic responsibilities of RRAs and some of the many tasks refugees must complete within three months of their arrival in the U.S. (U.S. Department of State, 2018). RRAs are given a lump sum per refugee to help cover these expenses, most of which goes to rent, food, and the cost of RRA staff members.

In certain cases, refugees can apply for a Special Immigrant Visa (SIV), a Congressionally-authorized program that allows people from certain countries who are personally affiliated with the U.S. to receive the same benefits as refugees. Currently eligible recipients are Iraq and Afghanistan citizens who worked for the United States' government within their native countries (Travel.State.Gov, 2018). Iranian religious minorities, former religious minorities from the Soviet Union, select Cubans, and Central American Minors also

qualify for similar refugee programs (U.S. State Department, 2017). These programs have grown in size and popularity over the last few years, especially on the West Coast of the United States, and are responsible for a substantial portion of Middle Eastern refugees resettling in the country.

United States Refugee Health Program Model

All refugees are covered under a basic health program on a national basis, at least for the first 8 months in the U.S. Table 1 shows the major public assistance programs for which refugees are eligible.

Medicaid**:** Most newly arrived refugees receive Medicaid health coverage for up to seven years if they meet federal income eligibility requirements as part of the Affordable Care Act (U.S. Centers for Medicare and Medicaid Services, 2018). As "qualified non-citizens," refugees are exempt from the standard five-year waiting period for new immigrants for Medicaid eligibility and are eligible for the same protections and benefits under the Affordable Care Act as other U.S. citizens (Refugee Health Technical Assistance Center, 2018). Medicaid is a joint federal-state program that varies on a state-by-state basis. States are required to cover certain population groups at certain income levels and have discretion to cover other groups. States must provide certain mandatory health services and have the option to cover certain other services. States are responsible for designing and administering their own Medicaid programs, within certain federal guidelines, including deciding what population groups to cover. Certain groups must be covered, including children, pregnant women, adults in families with dependent children, the aged, blind, and/or disabled, and individuals who meet certain minimum income eligibility criteria that vary by category. Medicaid is also responsible for the Children's Health

Insurance Program (CHIP), which covers health care for children under 19 in families whose incomes are too high to qualify for Medicaid (Wang, 2017; Rudowitz, 2018).

Refugee Medical Assistance: If a resettled refugee's income level makes them ineligible for Medicaid coverage, they will qualify for short-term health insurance called Refugee Medical Assistance (RMA) for the first eight months of resettlement (Refugee Health Technical Assistance Center (RHTAC), 2011). Medicaid and RMA provide the same basic health benefits in each state, but RMA coverage expires at the end of the initial eight-month period while Medicaid recipients may reapply for Medicaid coverage at the end of that time period.

Table 1. Refugee Eligibility for Major Means-Tested Federal Public Assistance Programs, as of May 2017

Program		Description	Refugee Eligibility Time Limit
Cash Assistance			
Either/or	Temporary Assistance for Needy Families (TANF)	Time-limited cash assistance and other support services for qualifying low-income individuals with dependent children.	Up to 5 years, then depends on state rules*
	Refugee Cash Assistance (RCA)	Program similar to TANF for refugees who do not qualify for TANF.	Up to 8 months
Supplemental Security Income (SSI)		Cash assistance to low-income individuals who are aged, blind, or disabled.	Up to 7 years
Medical Assistance			
Either/or	Medicaid/State Children's Health Insurance Program (SCHIP)	Health care coverage for qualifying low-income individuals.	Up to 7 years, then depends on state rules**
	Refugee Medical Assistance (RMA)	Program similar to Medicaid for refugees who do not qualify for Medicaid.	Up to 8 months
Other Benefits			
Supplemental Nutrition Assistance Program (SNAP)		Food assistance for qualifying low-income individuals.	No time limit

* States can set their own time limits on TANF receipt by curtailing federal TANF funds before the five-year limit or extending services beyond five years for the most vulnerable families through state TANF funds. Families without an adult recipient are not subject to this five-year limit.
** Children under the age of 18 continue to be eligible for SCHIP beyond these time limits.
Sources (citations available in full in the Works Cited): Social Security Administration (SSA), "Supplemental Security Income (SSI) Overview;" SSA, "Supplemental Security Income (SSI) for Noncitizens;" Center on Budget and Policy Priorities (CBPP), "Policy Basics: An Introduction to TANF;" U.S. Department of Agriculture, Food and Nutrition Service, "Supplemental Nutrition Assistance Program (SNAP);" Medicaid, "Eligibility;" CBPP, "Policy Basics: Introduction to Medicaid;" U.S. Department of Health and Human Services, Office of Refugee Resettlement (ORR), "About Cash & Medical Assistance;" Hooper, Zong, Capps, and Fix, *Young Children of Refugees in the United States*, 7.

(Fix, Hooper, & Zong, 2017)

Following the expiration of RMA coverage, if refugees do not qualify for Medicaid in their state, they must obtain insurance coverage through the nongroup/individual marketplace,

through employer-sponsored insurance, or become uninsured. Although Medicaid and RMA provide essential coverage for resettled refugees, they were not designed to be long-term care models for resettled groups. Very few programs have been developed to help ensure that refugees have other coverage when their eligibility for RMA or Medicaid ends.

Section 5:
Methodology

Analytical Approach

The goal of this project was to examine perceived barriers to health care access for refugees in three specific geographic areas by conducting interviews and surveys with key informants in each area. The analysis had eight major steps:

- selection of specific geographic areas to study
- review of background information on each area
- review of the existing literature on refugee health care (summarized above)
- development of interview guides
- obtaining approval from the Harvard Chan IRB
- recruitment of key informants and survey participants
- conducting of interviews
- analysis of results.

Selection of Areas to Study

As noted earlier, the three areas selected for the study were Los Angeles, Tucson and Seattle/King County. These areas were chosen because:

- Each has recently resettled a large number of refugees (based on the number of refugees per overall state population);
- Each region is located in a state that enacted a Medicaid expansion as a result of the Affordable Care Act (ACA) (so more health coverage options are available for refugees);
- Each has diverse refugee populations that differs somewhat from the other areas;

- Each has a distinct refugee resettlement model; and
- Each location is in the western part of the U.S., which made it easier to travel to conduct interviews.

Some comparative information on each area is shown in the table below.

Table 2. State Refugee Comparison Table

Region/State	State refugee Population (2001-2016)	Major countries of origin	Number of Refugee Resettlement Agencies	Centralized refugee health system
Seattle, Washington	13,636	Ukraine, Myanmar, Somalia, Iraq	5	Yes
Los Angeles, California	102,614	Iran, Iraq, Somalia, Ukraine	7	No
Tucson, Arizona	39,031	Iraq, Somalia, Myanmar, DRC	3	Somewhat

**Centralized refugee health system refers to how closely the state's Office of Refugee Resettlement and Departments of Public Health work with RRAs and nonprofit health care facilities for refugees*

Each of the three regions in Washington, California, and Arizona has a somewhat unique mix of refugees and provides health care using a different model. In each region, a large and diverse refugee population has formed communities, nonprofit health organization and refugee groups had been formed, and, as noted above, Medicaid expansion has increased health insurance coverage options for low-income people living in these three states. Seattle/King County, Los Angeles, and Tucson each have distinct refugee populations from different parts of the world, with different health needs, and the regions have adopted different approaches to refugee health care and service provision.

Development and Approval of Interview Guides and Protocol

Using the background on each area, and the literature review, a guide was developed to use during the key informant interviews (see appendix for interview guide). A study proposal, including the interview guide, was submitted and approved by the Harvard Chan Institutional Review Board (see appendix for IRB approval letter).

Recruitment of Key Informants

A potential list of key informants in each area was developed using internet research, referrals from key contacts, media publications, social media, and inquiries with academics in each area. The goal was to identify key knowledgeable individuals who frequently engage with refugees, either those receiving services within the health system or those who are attempting to access the health system. Among the key target groups were individuals who worked at RRAs; university departments of medicine, public health, law, social science, government, and public policy; hospitals; community health centers and nonprofits; other health facilities that accept Medicaid; state and local Departments of Health; local health boards; nonprofits created by resettled refugees; nonprofits tailored to refugees; and public health working groups (see charts below).

The key informant interviews were conducted in two stages:

Stage 1: **Initial detailed interviews**

These in-depth interviews, ranging in length from 30 to 90 minutes were completed in the three regions. As shown in Table 3, a total of 15 interviews were completed. The questions in the interview guide were based on key topics from the literature review. Using the Edberg Trajectory Model, the interview transcripts were then analyzed in order to get a clear understanding about

the main topics present in the data (2010). This framework uses the social determinants of health to delineate different factors of health and how they impact health access (Edberg, Cleary, & Vyas, 2010). The Edberg model helped establish a clear picture of perceived refugee health needs, improvements, challenges, and barriers to care. Those four topics were made into the survey questions for Stage 2.

Stage 2: Shorter survey

Based on the analysis of the detailed interviews, a shorter more focused survey was developed to explore a smaller number of key themes that emerged from the initial interviews (Medicaid, health system improvements, barriers to health care access, and gaps in services). As shown below, a total of 35 surveys were completed. This survey results were then analyzed using Morris' framework from a previous study of refugee health in San Diego, California (2009). The model breaks down survey responses into six main categories for deeper analysis.

Table 3. Number of Key Informant Interviews in Each Area

Region	Initial Detailed Interview	Shorter Email Survey	Total
Seattle/King County	7	8	15
Los Angeles	3	13	16
Tucson	6	14	20
Total	**16**	**35**	**51**

Table 4. Number of Key Informant Interviews by Type of Occupation/Organization

Profession/Organization	Initial Detailed Interviews	Survey	Total
RRA Management	2	2	4
RRA case workers	0	11	11
Physicians/Clinicians	2	1	3
Dept. of Public Health	1	1	2
Academics/researchers	1	7	8
Resettled refugees	4	0	4
Nonprofits	4	8	12
Miscellaneous	1	5	6
Total	**15**	**35**	**50**

As shown in Table 4, only 4 of the key informants were themselves resettled refugees, and none was a recently resettled refugee. Almost all of the key informants were facilitators and providers of refugee health care. Thus, the results of the interviews must be viewed as identifying *perceived* barriers to health coverage and care, rather than actual barriers as reported by refugees themselves.

Analysis of Results

Two researchers independently evaluated each interview and survey response and coded these data, using Morris' six groups and subgroups depending on the issues and barriers that had been discussed by each respondent. The results from the two independent reviews were compared and any differences were discussed and resolved. The consensus results were then analyzed to identify themes and key findings across the areas, which are presented in Section VI.

A case study, or summary of the situation and findings, for each of the three regions was also prepared. (See Appendix) A discussion of the findings, and some policy considerations and next steps are presented in Sections 7-10.

Section 6:
Findings

A number of perceived barriers emerged from the key informant interviews. Some of these barriers were the same in each of the three regions, while others were more significant in some areas rather than others. Many of the perceived barriers were consistent with previous studies (e.g., language, culture, mental health), while others were new and unexpected (e.g., health system complexity, migration experiences, dental care). This section summarizes the key themes from the interviews, and uses quotes from key informants to illustrate the major findings.

Acculturation challenges and lack of access to culturally appropriate care was the most frequently cited barrier to care in each region and for most refugee groups. The complexity of the U.S. health care system contributed to making this issue even more difficult. Respondents noted that refugees from non-Western cultures faced substantial challenges to finding care providers who could tailor care to their needs and social traditions in each of the three regions. For female refugees, especially Islamic women who were victims of female genital mutilation (FGM) or sexual assault, acculturation challenges were viewed as more challenging because of the need to remove clothing for medical examinations or a need to find a female provider. One respondent in Tucson gave a powerful example of this challenge in his own family:

> *"(Local hospital) is the number one in mother and child care; they have the best centers, and they have no clue about FGM. Those are the places I want the money to go so that they know more about refugees so that my wife does not die there when she's giving birth. Because I'm not only a former refugee, I'm a member of this community and I'm a citizen."*
>
> *– Resettled refugee and nonprofit director in Tucson*

Finding culturally appropriate mental health care was viewed as a particular challenge:

"If you are trying to provide mental health services to somebody who did not grow up in the United States, who has not had the same journey or history as an American, and you haven't got that understanding or that knowledge base, it would be very hard to do it in a culturally appropriate way and a way that would be accepted by our refugee clients, and that is important to us."

– Former refugee and current medical interpreter in Seattle

The key informants provided many examples of the types of access, quality, and safety concerns that arise from a lack of culturally appropriate care. Many of these concerned hospitalizations and other adverse events that occurred because of misunderstandings about medication. For example, one refugee assumed that his mother's heart medication was aspirin, the only medicine he had ever been exposed to in his home country, and took it for his headaches. Another respondent gave an example of a medical provider in the Tucson area who assumed their patients understood how a bottle of lotion was to be used when they gave it to a patient, but the instructions were not understood by the patient:

"I remember having two cases where a doctor described a skin lotion or a skin medication and they both drank that and ended up hospitalized. But whoever was given that prescription never realized that someone can make that mistake."

– Former refugee and current medical interpreter in Tucson

Medication mistakes were viewed quite common, even when refugees were given directions in their native tongue by physicians.

The key informants noted that that some cultural concepts most native-born Americans understand mean something specific was actually a confusing topic to those not raised in this country and who were not exposed to services provided in the same ways. One example given in Tucson involved refugee parents did not want to call an ambulance for their son during a medical emergency because they believed calling emergency services meant they were calling the police:

"Finally, someone told them, "Call 9-1-1." And what that person meant was for that child to get help, the child is in his twenties, but then the mother said, "Why would I call 9-1-1 for my child? Why would I call the police for him?""

– Former refugee and current medical interpreter in Tucson

Many key informants noted that providers' ignorance about their refugee patients' cultural and religious beliefs caused access and care challenges for their community members. A physician in Seattle gave the following example of the need for cultural competence in caring for Muslim refugees:

> *"If you have a lot of Muslim patients and Ramadan is coming up and there is a lot of diabetes in those patients, figuring out how you would talk to your fasting diabetic patients about Ramadan is important."*
> *– Hospital physician, Seattle*

Culture and cultural beliefs were often cited by respondents as perceived barriers to care, even when they gave no specific examples or more detail. This is consistent with previous studies, which often find that the cultural beliefs and norms of refugees are often much different than those in the United States, including in areas like clothing, religion, dietary choices, education, communication styles, and social mores. Previous research, and the respondents in this project, noted that these cultural beliefs are often not in line with the Western medical model, including in areas such as when to seek treatment, perceptions of mental health care, the distinction between acute and chronic illnesses, and beliefs on suffering. Many refugee groups fear the medical model in the US, with its heavy reliance on drugs and intervention. A number of respondents, including several physicians, noted that that their patients would sometimes say they were taking medication when they really were not because of their apprehension about the effects of the medication on their body. (This often changed once the provider and patient developed rapport and trust.)

Language and communication challenges were regarded by most key informants as among the most significant barriers to access. Not surprisingly, one of the biggest perceived barriers to refugee access to care was language and communication, a major challenge cited in previous

studies about barriers to health care for refugees. In each region, almost every key informant said that communicating with refugees – even with professional interpreters – could be a difficult task, and a barrier to ensuring refugee clients understood and received accurate information. In the words of one key informant in Tucson:

> *"Even with the translation services, I look at patients and think, "I'm pretty sure you didn't understand that." I have patients that are more established and now understand English better and they tell me, "She's not saying it right. That's not what I said," from the translator, so I know that there's a lot lost in translation as half of the time, we're not confident that they're understanding their care plan because of the language barrier. So the providers don't feel comfortable making a change in the care plan because they don't even know if the refugees understand what needs to happen."*
>
> *– Nonprofit professional in Tucson*

Several physicians and case workers noted how poor and inaccurate translation impacted care in many ways, including medication compliance, linguistic misunderstandings about patient symptoms, the inability of patients to ask informed questions about treatment or medical concerns, and failure to seek follow-up care because of lack of comfort with the initial clinical encounter. Even though most health facilities in the U.S., including hospitals and community health centers, are required under federal law to provide qualified interpreters, several respondents indicated that many clinics could not afford to provide interpreter services and so did not do so. Lack of interpreter services at pharmacies was noted as a particular issue by several providers, leading to concerns about misunderstandings regarding medication schedules and dosages. One provider in Seattle noted:

> *"Oftentimes, I think in reality, people are not getting interpreters when they're going to the pharmacy to pick up their medications even though I think the pharmacies are supposed to provide them. But they really have no financial incentive to or maybe even financial support to do so."*

Most respondents in Seattle and Tucson mentioned lack of interpreter services as a major concern. However, this was not perceived to be a major barrier in Los Angeles, perhaps because it has a less diverse and more homogenous refugee populations.

> *"I think that the populations in Los Angeles are very different from somewhere like San Diego, which gets more of a mix of different refugee groups. Whereas, LA is predominately these religious minorities coming from Iran. About 90% of the refugees that we have resettled, and have resettled for some time, have been Armenian Christians from Iran."*
>
> *– Academic Researcher, UCLA*

Lack of communication and collaboration between RRAs, health facilities and providers are perceived to create access barriers. This was a common theme in all three areas. Most respondents noted that many entities, both public and private, are involved in refugee health care, and communication and collaboration among so many different parties is challenging. Even when interpretation is provided, it is often provided over the telephone and not in person, which causes logistical challenges, particularly within the context of short, 20-minute medical appointments. Patients often do not have time to ask questions of their provider. These communication problems are often exacerbated by literacy concerns. For example, follow-up medical instructions may be given to patients in writing rather than translated in person, and so are not understood by patients who cannot read.

A lack of mental and behavioral health care was cited by nearly all key informants as a gap in services, with several even calling the issue a "crisis." Like most of the country, these three areas have an acute lack of mental health providers for refugees. Many patients with mental illnesses will not seek treatment due to financial costs or other reasons (e.g., stigma). For refugees in cities with a high prevalence of SIV refugees or others who were exposed to war

zones or terrorism – especially from the Middle East – a higher than usual prevalence of undiagnosed PTSD and severe depression and anxiety issues were noted by respondents. One RRA in Los Angeles shared:

"*But with respect to health, we simply inquired after resettlement agencies' and their clients' experience of health issues, and what we found was the Syrian refugee community has experienced high rates of PTSD and other mental illnesses and accessing care has been a great challenge. And that frankly, thus far, there have been no good answers as to how to improve either access to care or the quality of that care."*

In Seattle/King County, where trauma and torture counseling programs for refugees have been nationally recognized, nearly 90% of respondents noted mental health care was still a gap in service provision and not available for most refugees. The need for more and better mental health services for refugees was mentioned more than virtually any other issue. Some health experts believe that lack of adequate mental health services poses an immediate threat in the lives of refugees.

> *"…It's a life-or-death situation because someone has PTSD and then there are other issues that could trigger some other type of depression and if it's not taken care of, the consequences can be worse. A major gap in health services is people not having a mental health provider to express their feelings or thoughts to safely."*
>
> *– Tucson nonprofit employee*

The need for mental health care was cited as a significant concern in every region and across all refugee groups.

> *"Every refugee that comes here, they've been exposed to some sort of trauma. Especially those that are coming from war zones, those that are coming from refugee camps. So the rates of folks with PTSD is higher than other segments of the population or other immigrant groups. And then children tend to have a lot of behavioral issues because of all the trauma and the hard life they've been exposed to. And so there is some increased number of children with autism. So these are some of the things we see every day."*
>
> *-Tucson nonprofit employee*

Gender issues were noted by many informants. This issue was almost always raised in regard to 1) women in their role as their family's main caretaker or 2) Islamic women who were not comfortable with male providers. Among the perceived barriers for women were lack of childcare, shortages of culturally appropriate and/or competent female providers, and the fact that women were almost always the primary caregivers in newly arrived refugee families and did not often feel comfortable speaking or expressing discomfort in appointments with new providers or interpreters. Religious standards were also viewed as a particular problem for women (as discussed above).

A pressing challenge noted by many key informants was the complexity of the American health care system. Navigating this system can be challenging for many native-born citizens, but when combined with additional linguistic and financial issues, a task as simple as scheduling an appointment with a cardiologist a refugee had been referred to by their primary care provider can become nearly impossible. Several providers described the health system as "fragmented" and one noted that health insurance was the most challenging aspect of the medical system for her personally, let alone for refugees:

> *"I think just learning the system of how things work is probably the biggest issue for folks who aren't accustomed to being here and weren't raised here. The fragmented health care system here is also a huge, huge issue. These people are coming from somewhere that had a medical home where they were accessing all their medical services. And they come here, and they have five different conditions, so they have to see five different specialists to take care of that, in addition to their primary care physician. I'm a physician in this country and I can't even figure out health insurance. I get confused when I get my insurance bills, so I think when you don't speak English and haven't lived in this country and haven't gone through this system, you don't understand how it works. It's really overwhelming for most folks to just navigate the system."*
>
> *-Former refugee and current hospital physician in Seattle*

Several respondents noted that the requirement in many health plans to get a referral to a specialist was a feature of the U.S. system was often confusing to refugees:

> *"That doctor wants you to go to a different specialist. But you can't just go to them, it has to be a referral. The insurance has to be approved beforehand and after, but you have to call about seeing a specialist. And I see a gap there. So many times I go to homes and somebody has a pile of paper and it's like, "Oh, I have seen my doctor two months ago, but I don't know what happened. I don't know why I'm not seeing a specialist." But when you look, they never even went through the referral system and they ask you, "What's a referral? What am I supposed to do? Why can't this doctor send me to the next person and this be done?""*
>
> *-Former refugee and current medical interpreter in Tucson*

Stigma and discrimination were perceived as barriers to care. Many respondents viewed stigma and discrimination as obstacles to care for many refugees. They noted that this issue had become more acute because of the current political climate in the U.S., including the proposed refugee ban and its impacts on refugees already in the United States.

Migration experiences influenced refugees' health needs. Respondents often used the term "culture shock" to describe the experience of migrating to the United States and that refugees are overwhelmed by the major changes they are forced to endure. Some respondents (including former refugees) described the "triple trauma" faced by refugees. One Seattle/King County behavioral health provider described this part of the refugee experience:

> *"The 'triple trauma' paradigm or concept is just a way to really think about the refugee journey and to recognize that each part of the journey has traumas associated with it. When people flee or leave their homes, that generally is the most violent time for a refugee. Because what makes them leave their home is fear for their life in almost all cases. So this is the part in time where bombs drop, where soldiers come into a village or to a town, where houses are burned down, people are raped, children are abducted. It's a very perilous time, and then the journey often to cross a border also has significant trauma associated with it. Then there's the period of time where you're encamped or you're really a refugee in another country in your host country. And both of those have significant deprivation and trauma and uncertainty associated with it. When somebody's*

crossed a border and they're a refugee, they don't know if they'll be able to return home. And then, there's resettlement, and they count resettlement as part of this journey for refugees that are, you know, resettling to a third country because it's a significant trauma. They might have reached a destination that is safer than where they were, but they have to rebuild their lives in a new community, in a new culture with a new language. They've often left significant others behind. There's a very pressured adaptation where they have to learn a lot in a short period of time. And so all of these have significant repercussions on a refugee's mental health."

According to these health experts, the 'triple trauma' was the most daunting aspect of migration for many refugees, and a significant reason for the challenges associated with acculturation.

"*There's coming to their new country. And that, in and of itself, really is a trauma. And I think that the process for people when they arrive here is very stressful; learning to navigate the medical system, the financial system, the housing system, food security. All of these things can be really overwhelming. There are some caseworkers and different people to help navigate that, but it's daunting for people."*
-Former refugee and hospital physician, Seattle

This issue was not mentioned by any key informants in Los Angeles, which one RRA staff member attributed to the fact that most of the city's refugees are Iranian and spend six months to two years in Vienna once they leave Iran. As a result, many refugees in Los Angeles may not have been exposed to as much immediate stress to relocate to their new nation of resettlement.

Educational needs of refugees and providers were perceived to be a significant barrier, and discussion of this issue exposed some issues not described in previous studies. Some of the surprising perceived barriers were educational needs. While a lack of service awareness was expected to be a perceived barrier, several informants noted a need for education classes around domestic violence, family planning, homelessness prevention, and financial management. Respondents expressed a need for refugees to develop a stronger educational background in health, and gave a number of specific examples of lack of health education having an adverse

effect on refugee health. One topic that was repeated by several informants was the need for better Western-style nutritional education:

> *"I think one of the biggest problems of health care in general is education. We do not have enough education on diet, our choices of food, we are a sedentary culture. I think that for citizens to get involved with any type of assistance for refugees, illegals, or just the community in general is just to be a good example. It's to be a good example, to live healthy lifestyles, and to promote those healthy lifestyles."*
>
> *– Provider, Tucson nonprofit*

These interviews indicated that some resettled refugees lack a basic understanding of human biology, the methods by which communicable diseases are spread, and the importance of preventative care. Among refugee groups with higher education levels, there was a perceived need for other type of health education, including about the types of specialty care in the United States, new treatment methods, and a general understanding of the U.S. health system.

Respondents also noted a need for provider education, which is related to the previous theme of culturally appropriate care:

> *"More education for the service providers would help them to really do the work that they are all about. We understand that what they do is making sure they help people. But the lack of understanding of the people that they are helping makes it harder for them to succeed in what they want to do."*
>
> *- Seattle RRA employee*

Providers often lack the education and knowledge necessary to provide effective care to many refugees, especially in places like Seattle's Harborview Medical Center where over 80 languages are spoken and interpreted every day. Many noted the challenges faced by organizations of needing to train providers and others about health practices in places that have a broad and diverse range of refugee groups, with a wide variety of cultural differences and health beliefs.

Lack of transportation was a notable barrier cited by a majority of the informants.

Seattle/King County, Los Angeles, and Tucson are all cities where the majority of residents rely

on cars as their means of transportation. Although there are other public transportation options like buses, trains, ferries, and light rails, navigating these systems can be difficult, expensive, and time-consuming. One case worker at an RRA in Seattle said that some refugees there must travel for more than two hours on a city bus in some areas to get to the health facility.

> *"Transportation is a bit of a barrier. We try, the resettlement agencies I should say, try their best to show everybody how to take the bus, how to get around. Some people are lucky; they have friends with cars who can get them around. But oftentimes, especially for the elderly population, transportation seems to be a big barrier to getting to appointments and to getting to specialty care appointments. "*
>
> *- Seattle/King County Department of Public Health employee*

The geographical locations of RRAs and public health clinics in the center of the city exacerbate this challenge, especially in Seattle and Los Angeles, where refugees must live far from their service provider.

> *"If they're being serviced through the welfare office in the Glendale area, or through medical clinics in the Glendale area, which are more familiar with the refugee population, there is a lot of difficulty in just transportation and getting there. The size of the city makes transportation really difficult."*
>
> *– Los Angeles RRA employee*

Loss of health coverage after the initial eligibility period for RMA or Medicaid was perceived to be a major problem. Though all resettled refugees are entitled to free health insurance during their first eight months in the country, and refugees receive at least 90 days of services from their case worker at their assigned RRA, as noted earlier, there is no guaranteed health coverage for refugees who do not qualify for Medicaid assistance after their first 3 months in the United States. This short time period for RRA coverage causes challenges for refugees, providers, and RRAs alike in terms of meeting the long-term health needs of resettled refugees:

> *"We know that many health conditions don't present within those 90 days. But even those that do, we're not going to respond to after 90 days. So if we have a refugee who has a health condition who is dragging her feet in getting care, past the 90-day point? We know*

she still needs it; how are we going to make sure she gets it? And I know the response would be, "You can't call after 90 days". You have to remember we have a 90-day window to work with refugees. So what happens is refugees will stop seeking medical care. What we see in other parts of the country with extended case management - the continuum of care and the ancillary effect - is the direct effect of health care that insures people over a much longer period of time so that they don't fall off the cliff and risk not getting the care that they need. I think that one of the things that isn't recognized enough is that our time with newly-arrived refugees only last 90 days. So what happens to those refugees after 90 days and their health care? We often don't know."

– Los Angeles RRA Manager

Until 2000, refugees were eligible for RRA services for three years, and some resettlement agencies have struggled to provide all the necessary services to refugees within the much shorter 90-day time frame, much less help refugees achieve "self-sufficiency" within that time frame (U.S. Office of Refugee Resettlement, 2000):

"*I think in the past when we started refugee resettlement in the USA, we used to give people 3 years to learn how to figure things out, to take buses, to take care of their children before they went to work. We went from 3 years to 90 days. And you can imagine, there are some people who are just not doing that well, but they make it, anyway, everybody makes it somehow, anyway, but imagine making their lives a little easier and making that process just more comfortable for them."*

– Seattle nonprofit employee

This issue was cited in Los Angeles and Seattle, but was surprisingly not mentioned by key informants in Tucson, likely due to the strong refugee communities of support which exist in the region and provide guidance and information to newly resettled refugee families.

Housing is viewed as a major contributor to the health and well-being of resettled refugees, but lack of affordable housing is perceived to be a major barrier—even a crisis—for many refugees in Los Angeles and Seattle. The cost and availability of housing was a critical perceived barrier in Los Angeles and Seattle/King County, but not in Tucson where the cost of housing tends to be much lower. In both areas, housing is not just a crisis for refugee families; Seattle and Los Angeles continue to struggle with housing costs and rising homeless populations.

However, the lack of affordable housing options can be particularly challenging for resettled refugees.

For refugee families struggling to start their new lives in a new region, housing was critically connected to their children's education, public transportation, and their own health. In the words of one Seattle RRA employee:

> "*Housing is the biggest crisis that we're in when it comes to resettling refugees. Everything starts with housing. In order to get the kids to school, they need to have a permanent housing address somewhere. In order to connect the families to a private care provider, they need to know where they will be living so that we can find a primary care provider around their living area. Unfortunately, to rent an apartment, in this country, you have to have some requirements met. Things like: having rental history, for at least six months, or being able to show that you have a steady job--a secure job--that you're going to pay the rent. Not only that, but they want you to have an income that is at least two and a half times more than the rent. All of these criteria, no refugee can validate those criteria and requirements. It makes it hard for them to rent apartments. Those requirements put them out of the market of renting an apartment and makes it very difficult. Though, refugees are the best tenants that anyone can have. If you are an investor, and you want your place to be filled, refugees are the best tenants you can have. They come in without any criminal background because they have been vetted by the federal government, so you shouldn't be worried about giving a background check before giving the apartment to them."*

Long commute times, living long distances from medical facilities or workplaces negatively impact refugee health, and may hinder the integration of refugees into local communities:

> "*I think that the most pressing issue is housing. How housing is connected with everything else in terms of integration and their well-being, so being able to rent a house in an area of the city that is close to their job, close to their kids' schools -- it's oftentimes impossible. So they end up living very far away, having to commute for hours, and that has an impact on their health as well."*
>
> *– Los Angeles nonprofit employee*

Funding challenges for RRAs and other organizations that serve resettled refugees are perceived to be having a significant impact on refugee. The RRAs are funded by a per capita model, in which the amount of funding depends on the number of refugees served by each RRA.

As a result of the recent reduction in the cap on refugee admissions into the U.S., RRAs have experienced a drop in funding. Several RRAs in the three regions have experienced layoffs, and others have closed.

> *"Whereas President Obama planned to have 110,000 refugees admitted this fiscal year, president Trump reduce that immediately to 50,000. The U.S. Refugee Admissions Program is a per capita program. The nine agencies that resettle refugees [in the country] don't get paid if there are no refugees. So effectively by cutting by more than half the number of refugees admitted this year, that has had a deleterious economic impact on all nine agencies. Several of the other agencies have closed not only many offices, but have reduced staff all over the country. The Voice of America (VoA) did a study of this that was released about a month ago, and they found that over 300 positions had been cut from 7 of the 9 agencies (only 7 of the agencies responded to the VoA inquiry). So they realize that that was not a comprehensive survey of the number of positions cut, but still represented very serious cuts for resettlement agencies. And that didn't take into account positions that existed but had their hours reduced or open positions that weren't going to be filled."*
>
> *– Los Angeles RRA manager*

The per capita funding model creates serious problems for agencies during a period in which the national government is resettling the lowest number of refugees in 15 years:

> *"The refugee agencies receive $2,025 per person. Out of the $2,025, $900 of it is taken directly by the [refugee resettlement] agencies for the office, to pay the staff, and so forth--to pay for the services they provide. $1,125 will be spent on the refugee families, per individual, of course. The $1,125 is what the refugee agencies use to rent the apartment for the families, to furnish their apartments, to get them the bus tickets to move around, to buy groceries for them during the first couple of days and months that they are in the country. Everything that we do for them is out of that $1,125 per person. Anything that is remaining, after the ninety days period that we are supposed to work with them is given back to the refugee families."*
>
> *– Seattle RRA Manager*

While the RRAs are not directly responsible for health care, most key informants noted that the RRA case workers were pivotal components of a refugee's health team, and provide support such as coordinating initial appointments, arranging transportation to that appointment, and assisting with Medicaid enrollment. With fewer case workers at every RRA due to a reduction in

funding, resettled refugees have lower levels of support for health care, housing, education, and food needs, during the critical first 90 days, and no services after this initial period.

In Tucson, respondents noted an additional funding challenge, which was lack of adequate state funding for refugee health-related services. One perceived challenge is underfunding of the state's Medicaid program – AHCCCS. Medicaid pays relatively low rates to providers, which has caused many private providers to stop contracting with the program, which causes particular problems for refugees, who are heavily reliant on Medicaid.

> "[T*]here's not a lot of private clinicians that take AHCCCS health care. And when they do take AHCCCS health care, it's kind of a limited number because they have a busy practice to run and AHCCCS doesn't pay well, so you always have to take that into consideration. And so you have the clinician that's seeing the patient and it's like, "Okay, 'AHCCCS isn't paying me anything, okay. I'm seeing you," and you have that constant pressure as a clinician to keep moving throughout your day and that can be another obstacle for them or that can be another detriment that visit isn't maximized for the patient."*
>
> *–Tucson nonprofit provider*

Several non-profits, funded primarily by grants and donations, have been formed to try to fill in these gaps in Tucson. For example, **Clinica Amistad provides free care for low-income or undocumented people, including** refugees, through a system of volunteer providers and interpreters around the region. The organization works with a local church and various nonprofit health organizations to treat all patients with culturally appropriate, sensitive health care.

Several other nonprofit health facilities in Tucson are also committed to filling the care gap for refugees who are uninsured or cannot find providers who accept Medicaid:

> *"…[M]ainly we're supported by private donations. And as far as the volunteers go, there's a lot of in-kind donations. People don't know this, but we have 22 providers, clinical providers. These are physicians, PAs, Nurse Practitioners, nurses. Those are volunteers that work with us. We have cardiologists, endocrinologists, pulmonologists. I specialize in dermatology. We have another dermatologist that comes in and helps us once a month. Our clinical staff support is by a lot of the public health students here at the University of Arizona. And we have a lot of pre-med, pre-PA, pre-nursing students that volunteer with us as well. So the in-kind donations also are given through big*

companies such as LabCorps. So we have patients that need lab work. So LabCorps actually gives us, allows us to order labs at a significantly discounted rate to help us provide better care for our patients. There's an organization called Radiology Limited; they also reduced their fees so, therefore, we can patients for x-rays or ultrasounds or CT scans."

– Tucson nonprofit provider

Although not specific to refugees, the out-of-pocket costs of accessing health care are a financial challenge for many refugees. The most frequently mentioned out-of-pocket costs were: the costs of traveling to and from medical appointments; the costs of missing work and paying for childcare; and medication costs, particularly when there is no generic medication available or insurance will not cover the prescribed medication.

Many other gaps in services and barriers to access were mentioned; these varied somewhat by region. These included: dental care; vision services; long-term tuberculosis care and control in each region; the need for better outreach and health promotion; better care coordination and case management; the need for a patient-friendly approach to care; materials written in refugees' native languages; more effort to collaborate with refugees to empower them to articulate their own health needs and how to address them; and the need for a system of universal health coverage, so that so many refugees would not be without coverage.

Despite many perceived barriers and challenges, several exemplary models of care for refugees were noted during the interviews. In Seattle, many respondents talked about several refugee health programs that are regarded as models of care. These included:

- **Refugees Northwest,** an organization in Seattle that provides trauma-focused care for victims of torture, famine, genocide, conflict, and violence

- **The International Medicine Clinic** at Harborview Medical Center was viewed as a model of care, particularly its Caseworker Cultural Mediator Program, which employs mediators who come from refugee communities themselves and speak many languages:

  "They provide service to providers, their community's patients through medical interpretation, cultural mediation, community outreach -- they're really the liaisons between the institutions and their communities. They will refer patients to provide some case management and really work closely with their part of the medical team."
  -Seattle nonprofit employee

A physician in the clinic noted:

> *"The cultural navigators are part of my medical team. I really view them as somebody who works alongside me in providing medical care to the patients here. They not only serve as interpreters, but they really kind of help provide a conduit between me and the patient and what our goals are, helping me understand in some ways what's going on at home. They really are an extension of the care. It's noticeable when we don't have that extra person to help navigate between our biomedical culture -- which is a strong culture -- and whatever culture that individual patient is coming from that's informed by their language and their country of origin."*

These and several other models are described in more detail in Section 8.

Section 7:
Discussion

The previous sections have detailed the range of perceived barriers to refugee health that exist in the Seattle/King County, Los Angeles, and Tucson regions. Many, if not most, of these perceived barriers, such as lack of coverage, transportation challenges and funding gaps, are consistent with those found in previous studies of refugee health.

One useful way to think about these barriers is that some are "demand side" barriers and some are "supply side" barriers (Aran, Aktakke, Gurol-Urganci, & Atun, 2015). Demand side barriers are factors that operate at the level of the individual, and, in this case, affect the ability of refugees to access the care that they need. Supply side barriers require interventions at the health system or more general system level.

Using this framework, the barriers discussed in the previous section can be characterized in the following way:

Demand side barriers

- Acculturation challenges and lack of access to culturally appropriate care
- Language and Communication challenges
- Gender issues
- Stigma and discrimination
- Migration experiences
- Educational needs of refugees
- Loss of health coverage after the initial eligibility period for RMA or Medicaid
- Out-of-pocket costs of accessing health care

Supply side barriers

- Lack of communication and collaboration between RRAs, health facilities and providers
- A lack of mental and behavioral health care
- Complexity of the U.S. health care system
- Stigma and discrimination
- Educational needs of providers
- Lack of transportation
- Lack of affordable housing
- Funding challenges for RRAs and other organizations that serve resettled refugees
- Gaps in services and barriers to access

Demand side barriers are more difficult to address than supply side barriers, and require sustained multi-sectoral interventions to address health system issues and social determinants of health.

Although the access barriers detailed in this project, both on the demand side and the supply side, are complex and inter-related, three emerged as particularly pressing barriers and warrant further discussion: 1) mental health care; 2) language challenges in settings other than hospitals and physician offices, and 3) acculturation challenges.

Mental Health Care

Mental health was mentioned as the most significant barrier by the majority of respondents, including nearly every respondent in Seattle/King County. The problems of the mental health system in the U.S. are well-known; however, the situation for refugees is intensified and exacerbated by stigma related to mental health care among many refugee groups,

a fear of Western forms of medical treatment, and a lack of culturally competent providers. Trauma-informed care for PTSD and torture survivors is a particularly acute gap. As one mental health provider in Seattle noted:

> *"They've all faced persecution. They've all had to leave their country and start over in the United States. Most of them have faced significant trauma: War trauma or torture. They've all certainly had tremendous loss. Many have had tremendous deprivation including food shortages. They're trying to rebuild their lives here."*

Another Seattle/King County provider noted that without first addressing the grave mental health symptoms affecting PTSD victims, their general health issues may never fully resolve due to the substantial weight of their mental health conditions:

> ***"****I think when you work in this field, you hear a lot of tragic stories. And I think what's surprising is that you don't really work with many tragic individuals. Their stories are tragic but they're deeply resilient, strong people. I have had the pleasure to work with people who unfortunately, have seen their children killed in front of them because of bombings, had their children kidnapped. In one case, their son's decapitated head was placed on their doorstep. People who were tortured because of their political beliefs, kept in cages that were too small to stand up in, naked, and in the hot sun without food. People who've been electrocuted, who have been hung from their ankles and dropped on their head repeatedly, beaten with sticks, beaten with steel rods, urinated on, used as sex slaves for armies, subsequently getting HIV. You know, people flee for very significant reasons; they flee for their lives, and what they've endured is unimaginable."*

Providing long-term, efficient mental health care to these refugee patients is a necessity in order for them to live healthy, productive lives and find some release from the pain and mental anguish they have endured. When combined with the "triple trauma" paradigm for refugees entering their third country the moment they step foot into the United States, the severity of existing or potential mental health issues might even increase.

One refugee group that was highlighted by several respondents in discussions of mental health are asylum seekers and refugees who are currently being held in detention centers. Respondents noted that this group often have mental health needs that are related to significant trauma, but little or no access to trauma-trained providers familiar with torture-based care and

the warning signs of PTSD. While there are physicians at these detention centers, who are hired as independent contractors, they do not provide baseline psychological evaluations that are usable in immigration hearings. Instead, volunteer clinicians are relied upon at detention centers to perform the psychosocial assessments that are needed to support and strengthen the case of refugees seeking asylum. The Tacoma Detention Center, which is a privately-run facility, has a history of complaints of human rights violations, including the physical abuse and delays in providing medical care for mentally ill refugees. Thus, these concerns are of great importance to the health and safety of refugees in detention centers (Walters, 2017).

Language and Communication Needs

Language and communication is a commonly cited barrier in refugee health care. However, this issue is far more complex than a lack of translation, and "language" is often used as a term to describe a wide range of challenges, including issues such as:

- Poor or inaccurate translations between provider/case worker and refugee;
- Poor or no literacy on the part of the refugee;
- Poor or no communication between RRAs and its refugee clients; and
- A lack of communication between all members of a patient's health care and resettlement team

One of the most interesting communication barriers identified in this study was language problems in pharmacies. As described earlier, this barrier results in a range of safety, quality and health consequences for refugee patients, from the inability of refugee patients to understand directions, warnings, and side effects to taking the medication of family members. Respondents are concerned that pharmacies often did not have the time or incentives to use the telephonic translation services that are available, especially if they were unable to identify the patient's language of preference at the time of service. In hospital pharmacies where refugees often wait

for their prescriptions to be filled with their families, the wait times needed for pharmacists to obtain translation services are frequently prohibitive and some experts noted that even though refugee patients might say they understand the instructions for a particular medication, they are often being polite or agreeable due to their personal cultural and social standards. One expert explained:

> *"Somalis are very polite. So many times, Nepalese, too, I've seen that. They know their head. They might not be comfortable with something, but they will agree with you."*
> *-Tucson nonprofit professional and resettled refugee*

Although pharmacies are required under federal law to make interpretation available, the issues identified in this study suggest that there is more work to do in this area.

The findings also suggest that it is not sufficient to talk about a general "language barrier" or "language gap" because this often does not provide a sufficiently detailed or nuanced understanding of the underlying problems, or of the approaches that are needed to address them. Policymakers and others should devote more time and effort to understanding these "language" barriers in more detail so that the root cause of problems that are often characterized as "language gaps" can be addressed effectively.

Acculturation Challenges

Acculturation challenges emerged a third major topic in this study. As with language, respondents often used "culture" to describe a range of complex barriers. The complicated structure of the U.S. health care system, including referral processes, are not logical or easy to understand or navigate, especially when language, communication, and logistical challenges abound. Health insurance might also be an entirely new domain of health care for resettled

refugees where co-pays and provider networks add another layer of difficulty to an already overwhelming system.

Diet and nutrition are also a major issue in terms of acculturation. Programs like EthnoMed (described below) exist to help providers understand the traditional foods and nutrition backgrounds of their patients, and also allow patients to have photographic information that demonstrates the Western equivalents of many traditional foreign foods, while also providing nutritious suggestions for refugee families. Nevertheless, few patients or providers have been exposed to this type of system, and, given the financial limitations of most newly resettled refugees, adopting a Western diet of cheap and processed food is one of the most pressing medical issues mentioned by survey and interview respondents. This acculturation challenge is one of the foundations of a family's overall health and requires a much more substantial analysis.

EthnoMed is a program at Seattle's Harborview Medical Center to address this need, though informants in King County still noted nutrition education as a major challenge for both refugee patients and providers. This program serves as a tool for people looking to learn more about the cultural backgrounds, traditions, and foods associated with each patient's national or religious origin and has helped alleviate the barriers in education for some refugee health providers:

> *"EthnoMed is a website and it is a resource for healthcare providers and the patients and communities they serve. It's a resource for providers who see refugee and immigrant patients and want to learn more about their cultural background, have information about what a community's experience with Western medicine might have been in their country of origin, it has resources about the communities that are here locally. It has developed out of real relationships that our bilingual, bicultural staff, through the community house calls program in our International Medicine Clinic providers and others here have with community-based organizations. Our original content for the site is developed through gathering input from community members, through focus groups and interviews, through review processes. It's really an iterative process in developing content to make sure we*

have the clinical perspective and the cultural perspective brought into our pieces. If you want to learn about traditional medicine that might be used or have a sense of what may be the history of the refugee experience that this person is coming out of potentially."
-Seattle EthnoMed Director

Culturally competent care has been identified in prior research as a major gap or barrier in care, but the nuances and details of what type of" cultural competence" is necessary have been largely understudied. For instance, several prior studies identify a need for more "culturally appropriate" mental health practitioners, but do not specify whether this refers to trauma-informed care, clinical diagnostics, torture rehabilitation, pharmacological complications, or PTSD in minors. Although this project did not explore these issues extensively, it does shed light on issues that have not been adequately addressed in previous research on refugee health.

Finally, health education emerged as one of the most interesting aspects of this study. Not only did health experts note that refugees faced a lack of education about the current health system, an understanding of Western medicine and practices, services and programs available to them, and an understanding of virology and biology (in some populations), they also identified other specific areas of health education that need more attention. Domestic violence, financial management, homelessness prevention, and family planning education were all mentioned as specific education gaps for resettled refugees. As cultural standards on the West Coast of the United States are quite different than the traditional social standards in other countries refugees fled before arriving here, concepts like intrauterine devices, mortgages and home equity loans, and emotional abuse might be unfamiliar subject matters. Just as English-speaking Americans might be overwhelmed with the social, political, cultural, and medical structures in the Middle East, Southeast Asia, or Northern Africa, these factors must be considered when designing health care and public health programs and strategies to help refugees acclimate to the models and infrastructure that exist in in Washington, California, Arizona, and the United States in general.

Section 8:

Policy Considerations

Most of the perceived barriers to care detailed in the previous section are systemic, serious, long-standing, and in many cases, not unique to resettled refugees. Some could be addressed with additional funding and the development of new programs, although most do not lend themselves to simple or short-term solutions, even with additional investments.

However, there are policy actions that could be taken to address some of the most significant barriers that were identified in this project. This section identifies three priority areas for policy action: expansion of Medicaid; a national board and program of culturally competent interpreter services; and the dissemination and replication of exemplary models of care for resettled refugees.

Policy Option 1: *Medicaid Expansion*

Nearly every respondent in the project emphasized the need to expand Medicaid in each state in the country as a way to improve access for resettled refugees. Most noted the benefits that the Medicaid expansion in their states, enabled by the Affordable Care Act, had significant and long-term benefits for refugees and the health system in general:

> "*We've seen a huge number of people get insurance that never would have health insurance before under the Affordable Care Act. I've known a lot of these patients for over 20 years and they have not had health insurance and people now are having their diabetes taken care of, they're not losing their toes or their feet, they're not getting heart attacks, they're able to take care of their health problems and work, take care of their families so that they can actually work and be part of our society, and contribute as tax payers. So, the more that we can keep people out of the emergency rooms, and working and healthy, it's going benefit the whole. Everyone, it's going to benefit the whole United States."*
>
> *– Tucson nonprofit provider*

As of the writing of this paper, 18 states have yet to expand Medicaid under the ACA. As a result, most refugees living in those states do not have access to longer-term Medicaid coverage and will likely be unable to afford health insurance for themselves and their families. Decades of research has documented that lack of insurance has profound health and financial consequences for individuals, families and communities. (Freeman, Kadiyala, Bell, & Martin, 2008). Beyond the moral and health reasons to provide health coverage to all resettled refugees, such coverage is a good investment for the country because refugees make a strong and positive contribution to the U.S. economy. One recent study found that, over the past decade, refugee families paid $63 billion more in taxes than they cost the nation in public benefits. On a per person basis, refugees contributed more during this period than U.S.-born citizens. (Popay, 2008; Breene, 2018). Expanding Medicaid in every state should be a top policy priority to address barriers to care for refugees.

Although attempts to repeal the ACA were unsuccessful in 2017, depending on results of the 2018 election, they could be tried again. Any attempt to reduce or eliminate the Medicaid expansion through a repeal of the ACA, or to undermine Medicaid through other legislative or executive actions, would have devastating effects on refugees:

> *"If the ACA is removed, in most cases within the first couple [of] months [refugees] would have insurance, but once they start working and they are getting some income, they would be taken away from that program. They wouldn't have access to healthcare, they wouldn't have access to health insurance, which means they would either have to buy their insurance on the private market, or through their employers. If their employer is offering, and we have somebody who is working two different jobs part-time, which means the person wouldn't be qualified for any insurance assistance, they wouldn't be able to afford to buy their own either. It would really affect people either here in Washington state, or nationally, what we would really see the impact on refugee families, or on the individuals coming."*
>
> *-Seattle nonprofit employee*

So defending the Medicaid expansions that have occurred must also be a policy priority for refugee health.

Policy Option 2: ***National Board and Funding Mechanism for Medical Language Interpreters/Translators***

Language was identified as a significant barrier to care in every location. One policy approach to addressing this barrier would be to create, a federal certification program for refugee medical translators. Such a program would be a means of promoting self-sufficiency and employment within the refugee community, ensuring medical translations are accurate, and creating a more uniform and standardized system for basic health care interpretation.

No such program currently exists on the federal level. Some states and national associations have certification programs, but providers are not required to use these programs. If a federal program were created, certain types of providers (e.g., federally qualified health centers) could be required to employ only certified translators, and their payment rates could be adjusted to take these costs into account. Several respondents noted that current funding for interpretation services is inadequate or non-existent:

> *"From a structural perspective, adequate means of funding interpretation so that federally qualified health clinics or mental health clinics are already under financial pressure and then if they are losing money because they're already providing interpreter services, it often disincentivizes them from embracing this population as part of their client population. I think, again from a structural perspective, providing significant opportunities for people who come from a refugee/asylum background to get educated and placed in these fields, this creates ways that we can diversify our linguistic access as well as our cultural responsiveness within the medical and mental health field."*
>
> *– Seattle nonprofit provider*

Thus, the financial burden of translation often falls on health facilities who are least able to absorb these costs. Establishing a federal board to certify interpreters, with an adequate and

sustainable funding mechanism, would help to encourage greater usage of translators for refugees and create more self-sufficiency options for refugees seeking jobs.

Policy Option 3: Identify and Replicate *Best Practices of Caring for Refugees*

As discussed in the previous section, several exemplary models of care for refugees were identified during the interviews. More widely disseminating information about these programs. and trying to replicate them in other areas would likely improve refugee health access, improve refugee satisfaction, and help to bridge gaps that exist between what refugees currently receive and what they actually need. Some of the models of care that warrant further examination are described briefly below.

- **The International Medicine Clinic, a partnership among** the University of Washington, King County Health Centers, and HealthPoint: This program, which was originally supported with funding from the Bill & Melinda Gates Foundation has had success in reducing the costs of caring for refugees, improving health outcomes, increasing patient retention, and, by employing refugees, helping increase self-sufficiency among this population. The clinic's Caseworker Cultural Mediators and EthnoMed program allow community members to receive training as interpreters, provide advocacy on behalf of patients to providers and insurance companies alike, help physicians explore the cultural complexities of their patients, and serve as a trusted health system navigator for their refugee clients. These support services are seen as a critical component of care at the medical center. Los Angeles and Tucson would both benefit from piloting this type of approach.
- **The Seattle/King County model of care for refugee victims of torture or trauma**: Firmly rooted in evidence-based interventions and established from an RRA in the county, this program has produced a handbook for counselors providing torture-informed behavioral health care. It uses community tools and cultural aspects of each patient to achieve the most effective results possible. Other mental health care organization that serve refugees could benefit from learning more about this effective model of care for this very complex group of refugees.
- **Clinica Amistád in Tucson**: was created out of the need for greater health care options for low-income, undocumented, and linguistically diverse people in the area. Though this model relies solely on grant funding, donations, volunteers, and a community partnership among churches, RRAs, health care organizations, law enforcement, and local nonprofits, it can be tailored to cater to any local populations based on its ability to obtain high-quality care providers. This clinic has helped refugees unable to find language services in

other medical clinics, refugees who cannot afford copays to specialists, and refugees whose Medicaid or insurance coverage may have lapsed. Expanding this type of health facility in the Los Angeles or Seattle/King County region might help address some of the perceived barriers of communication, financial hardships, insurance coverage, and logistical challenges with specialists.

Section 9:
Conclusion and Next Steps

Through this project, many themes emerged about the current state of refugee health care. As expected, language and mental health were perceived to be major areas for improvement in the three regions examined in this project and among the particular refugee populations resettling in those areas. Acculturation, logistic, and communication challenges were also identified as urgent needs. Addressing these barriers would help improve access to care, which could help to alleviate years of suffering and trauma, and lead to improvements in health. The US needs to make additional investments in refugee health as both an ethical imperative and to ensure health access and health for resettled refugees as a basic human right.

Following the completion of this initial phase of the project, I would like to continue the work with resettled refugees in the three areas in order to determine whether or not the perceived barriers and gaps noted by key informants are the same as the actual barriers and gaps experienced by resettled refugees. I intend to see grant funding through Harvard and private foundations to support this work. I would like to try to publish some of the findings of the project in health policy journal.

Given the current political and social climate regarding immigrants and refugees, I would also like to write opinion pieces for local and national news outlets about the realities of refugee resettlement, the intense vetting process each refugee must endure, and the necessity of helping this population of people integrate into American society and communities, including our health systems. There has never been a greater need for accurate information about vulnerable populations and those of us in the fortunate position of having knowledge and privilege need to use it to try help improve the lives refugees, who have faced such adversity.

My original intention when I began this project was to produce a film about resettled refugees. I intend to pick up this project again, as a means to support the work of the excellent organizations participated in this project. I have dozens of hours of recorded interviews, location shots, and the powerful and touching moments with refugees, and I hope to produce a film for each organization that participated in this project that they can use in fundraising, policymaking, and awareness campaigns.

Section 10:
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Section 11:
Appendix

1. Refugee Resettlement Process into the United States
2. Background information and case study of each of the three areas
3. Interview Guide
4. IRB Approval Letter

Refugee Resettlement Process

The initial step in the resettlement process is that the United Nations High Commissioner for Refugees (UNHCR, the UN refugee agency) screens and interviews applicants to discern if they qualify as refugees and then as resettlement candidates. The group then decides the next best solution for the refugee: safely returning them to their home country (called voluntary repatriation), integrating them within their new local community or country (also called the country of first asylum), or resettling them in a third country that is typically farther from conflict and is considered "more developed" (United States Department of State, 2018; United States Department of State, 2017). Generally, the most vulnerable and those at the greatest risk - less than one percent of all refugees - will be resettled in a new nation (UNHCR, 2018). (While most refugees will receive in-country support from the country they fled to after leaving their own, the goal is to be able to return to their home nation once it is deemed safe for them to do so.)

For refugees who are selected for consideration to be rehomed in the United States (the nation resettles two-thirds of the world's resettled refugees) the U.S. government completes additional vetting processes like biometric analyses and Homeland Security interviews to determine whether to allow the refugee to be resettled within the country (UNHCR, 2018). Nine overseas Resettle Support Centers (RSCs) run by the State Department oversee case files for every applicant, and these offices are tasked with completing initial interviews, taking photos, reviewing applications, obtaining fingerprints, collecting new information, and generating biographic information for the security clearance process by a Department of Homeland Security (DHS) officer (U.S. Department of State, 2018). These support centers are located in Jordan,

Thailand, Nepal, Cuba, Turkey, Russia, Kenya, Austria, and Ecuador and have several sub-offices throughout several surrounding regions (U.S. Department of State, 2018).

Refugees who advance in the process as qualified refugees are subject to an "intensive security screening" according to the Department of State, and each security check must be approved before this department and DHS submit the application to a US security screening process (2018). Refugees and their families then must pass medical examinations and attend a cultural orientation (generally a three-day class about the customs and procedures that occur within the U.S. and the assistance they can expect to receive from resettlement agencies) to move forward with their applications (U.S. Department of State, 2018). After these steps are all completed, the applicant is issued a "sponsorship assurance" from a resettlement agency and the Department of State's Reception and Placement Program helps them start the moving process.

Once a refugee has been approved for resettlement in the U.S., the State Department assigns them to one of nine refugee resettlement agencies (RRA), all funded by the U.S. Department of State's Bureau of Population, Refugees and Migration, with 350 affiliate offices nationwide (UNHCR, 2018). These RRAs are:

- Church World Service
- Episcopal Migration Ministries
- US Committee for Refugees & Immigrants
- Lutheran Immigration and Refugee Services
- United States Conference of Catholic Bishops
- World Relief Corporation
- HIAS, International Rescue Committee, and,
- Ethiopian Community Development Council.

The RRA hold weekly meetings to review each applicant and determine where they will be resettled, by which agency, and in which state (U.S. Department of State, 2018). Refugees are then notified of where they are to be settled, and are prioritized in the following categories:

- Priority One. Individuals with compelling persecution needs or those for whom no other durable solution exists. These individuals are referred to the United States by UNHCR, or they are identified by a U.S. embassy or a non-governmental organization (NGO).
- Priority Two. Groups of "special concern" to the United States, which are selected by the Department of State with input from USCIS, UNHCR, and designated NGOs. Currently, the groups include certain persons from the former Soviet Union, Cuba, Democratic Republic of Congo, Iraq, Iran, Burma, and Bhutan.
- Priority Three. The relatives of refugees (parents, spouses, and unmarried children under 21) who are already settled in the United States may be admitted as refugees. The U.S.-based relative must file an Affidavit of Relationship (AOR) and must be processed by DHS." (American Immigration Council (AIC), 2017).

Refugees can be denied entry into the U.S. for a variety of reasons, including health issues that might have developed during the application process, and are required to pass a further medical examination upon entrance to the U.S. (AIC, 2017). Resettlement candidates are placed in locations based on the specific needs of each refugee and the resources which are available in a given community (U.S. Department of State, 2018). Priority is given to regions with a large population from the same home nation or region of the U.S. in which a refugee has any family members (AIC, 2017). Travel is arranged by the International Organization for Migration, in partnership with RSCs, and refugees are a United States government loan for transportation costs

(for which they must sign a promissory note that requires repayment within five years of resettlement in the country). (U.S. Department of State, 2017). When refugees arrive at the airport, the refugee resettlement agencies arrange for local transportation and housing in one of 180 refugee communities in the U.S. (U.S. Department of State, 2017).

Each RRA is responsible for providing a basic set of services for each refugee under their care for the first 90 days of their time in the U.S. (AIC, 2017). These services include arrangements for food, basic housing, clothing, employment counseling, medical care, and other basic services, mostly funded by the federal government (AIC, 2017). Obtaining a Social Security card, enrolling children in local schools, studying local public transportation schedules, acquiring medical appointments, teaching grocery shopping styles, and helping refugees with language service groups are all basic responsibilities of RRAs and some of the many tasks refugees must complete within three months of their arrival in the U.S. (U.S. Department of State, 2018). RRAs are given a lump sum per refugee to help cover these expenses, most of which goes to rent, food, and the cost of RRA staff members. Fortunately for the resettled refugees, the Office of Refugee Resettlement often provides cash and medical assistance for a longer period than ninety days, which helps many refugees obtain jobs within six months of entry into the U.S., though often at much lower skill levels than each refugee might possess in terms of their prior experience or education (U.S. Department of State, 2018). Finally, after residing in the U.S. for one year, a refugee is able to apply for Lawful Permanent Resident Status, and five years after this status is granted, they may apply for naturalization as a U.S. citizen (AIC, 2017).

In certain cases, refugees can apply for a Special Immigrant Visa (SIV), a Congressionally-authorized program that allows people from certain countries who are

personally affiliated with the U.S. to receive the same benefits as refugees. Currently eligible recipients are Iraq and Afghanistan citizens who worked for the United States' government within their native countries (Travel.State.Gov, 2018). Iranian religious minorities, former religious minorities from the Soviet Union, select Cubans, and Central American Minors also qualify for similar refugee programs (U.S. State Department, 2017).

Background Information and Case Study on the Three Areas

Seattle/King County

(Region with strong, centralized services and abundant nonprofit and political support)

Key Quotes

"Washington State has played a historical role in refugee resettlement. It's pretty much always taken a stand to be open and welcoming to refugees. But more than that, it's considered them an asset to the community. And the state services really reflect that. It has a vast array of services here, and I don't think every state has that. The state has really embraced the resettlement of refugees and seen it as an asset. And so I think that that support is felt on the ground."

-Nonprofit director

"The cultural navigators are part of my medical team. I really view them as somebody who works alongside me in providing medical care to the patients here. They not only serve as interpreters, but they really kind of help provide a conduit between me and the patient and what our goals are either in that visit or beyond that clinic visit. Really helping to be that advocate for the patient. Also helping me understand in some ways what's going on at home. They really are an extension, I think, of the care. Or Farsi speaking, or whatever. But it is noticeable when we don't have that extra person to kind of help navigate between our biomedical culture -- which I definitely think is a strong culture -- and whatever culture that individual patient is coming from that's informed by their language and their country of origin."

-Harborview physician

"I think that the value of EthnoMed is not only kind of culture-specific or country-specific information, but it's also topic-specific. It's kind of a repository of information, reference material for people that work with refugee, immigrant, non-English speaking patients. It provides just a wealth of information and a number of different ways to navigate that information. There's literally nothing quite like it."

-International medicine physician

"Fortunately, I do not have a lot of obstacles in providing refugee care. We are very fortunate to be working in a clinic like this and I think that this clinic does provide a unique service to refugees in the way that it's modeled and the structure that it has. I think that I am very fortunate. I think that our collaborative scheme really helps us focus and identify medically complex refugees and can get them the care that they need in a supportive way, in the best way that we can, definitely."

-Harborview physician

Overview of Seattle/King County's Refugee Health System

With one of the most diverse refugee populations in the country, Seattle (and the greater King County region) is home to a plethora of nonprofits specializing in culturally specific health and daily living needs in both health and general resettlement. The Pacific Northwest state of Washington ranks number eight in the nation for resettled refugees, with five RRAs responsible for resettling new refugees in King County as they acclimate to their new regions:

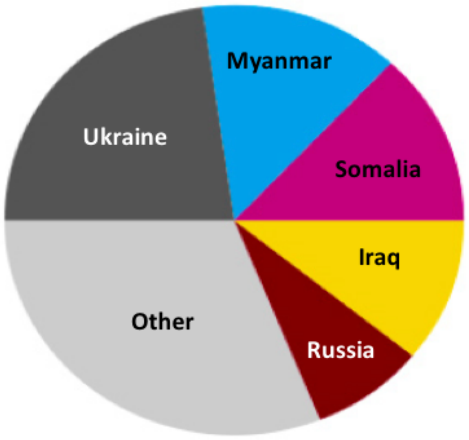
- International Rescue Committee
- World Relief
- Lutheran Community Services Northwest
- Diocese of Olympia, Refugee Resettlement Office (formerly Episcopal Migration Ministries)
- Jewish Family Services

These groups helped resettle roughly two-thirds of all refugees welcomed to Washington in 2016 (McDermott, 2016). The majority of refugees who resettled in Washington in 2016 are from 1) Ukraine, 2) Afghanistan, and 3) Iraq, while most of the last two populations came to the U.S. as part of the Special Immigrant Visa program for people who worked with the U.S. government in those countries. This influx of recent visitors has caused a need for an increase in Ukrainian and Russian, Pashto and Dari, and Arabic and Kurdish translators for medical offices. Washington has had a strong Islamic community for many years as Somali refugees have been resettled in the state since the early 1990s.

However, from October of 2001 – the end of 2016, Washington's refugee population primarily stemmed from 1) Ukraine, 2) other (including Afghanistan), 3) Myanmar (formerly Burma), 4) Somalia, and 5) Iran (see Table 13) (Hussein, 2017). Washington has one of the nation's most varied refugee populations with a variety of medical issues, religious backgrounds, and unique demographics.

Table 13.

2001 – 2016 Top National Refugee Origins



2001-2016 Top Nations of Origin

1. Ukraine
2. Other (including Afghanistan)
3. Myanmar (formerly Burma)
4. Somalia
5. Iran
6. Russia

2016 Top Nations of Origin

1. Ukraine
2. Afghanistan
3. Iraq

**The breakdown in each state is limited to nationalities with at least 500 people*

(Hussein, 2017)

Refugee Intake

All new refugees to King County must go to the Downtown Refugee Health Center (DRFC) located in downtown Seattle and run through the King County Department of Health within 30 days of arriving. Working with the five RRAs, the DRFC refers all new community members to specialists or notes particular issues to follow up with their primary care provider throughout greater King County. Refugee population health varies greatly by home country, especially considering the rural and urban differences in the resettled population in King County and their exposure to war zones and refugee camps. During long-form interview with health experts, the most cited medical issues of newly resettled refugees were common adult ailments like hypertension and diabetes, but also significant amounts of PTSD, depression, and mental health issues. Many refugees to the Seattle/King County region are victims of torture and sexual assault, while many children faced malnutrition issues, according to experts. During this initial health screening, refugees are also screened for tuberculosis; hepatitis A, B, and C; HIV; varicella; lead; and are tested for basic vision and basic hearing issues.

King County's refugee services are highly integrated and are highly familiar with each organization and services they provide, offering refugees a well-connected, integrated system of referrals and communication. In terms of health facilities, Seattle/King County has crowded but accessible public hospitals, including Harborview Hospital's International Medicine Clinic which caters to those who do not speak English. Most general health services are located outside of Seattle and within greater King County due to housing costs. The public transportation system

can be challenging, but does offer transportation between smaller cities and Seattle in general. The King County Department of Health and Mayor of Seattle both refer to Seattle as a Welcoming City for refugees, and the state and local Office of Refugee Resettlement provide strong coordination and resources to the community. Seattle and Washington's politicians are progressive in comparison to the rest of the nation, according to the health experts interviewed there, and pose strong support to refugees and the service organizations working with them.

Strengths in Refugee Health Care

- The International Medicine Clinic at Harborview Medical Center/University of Washington (UW) Medicine specializes in care for refugees. This unique program has dozens of highly trained staff members trained in a variety of cultural methods, including in-house staff members who are fluent in Amharic, Cantonese, Chao Jo, Mandarin, Hmong, Khmer, Laotian, Mien, Oromo, Somali, Tigrinya and Vietnamese. The clinic also provides charity care for patients with no insurance and was started by one of Seattle's most devoted and active refugee physicians, Dr. Carey Jackson.
- Harborview employs nine cultural navigators full-time called Caseworker Cultural Mediators (CCMs). The CCMs are former refugees who live and work in the communities which they represent, which often involves them speaking several languages fluently. The CCMs fill major gaps in services, according to providers within the hospital, not just as interpreters, but as cultural experts, health educators and trusted confidants with local community members. CCMs help explain Western medicine to patients, help them navigate the complex health care system in the U.S. (including minor issues such as explaining the meaning of medication labels and how to follow up on a referral), and are considered vital parts of the care team at Harborview.
- UW also created a program called EthnoMed (www.ethnomed.org) meant to integrate culturally specific information into clinical practice for providers. This grant-funded program presents community cultural profiles on its website, including traditional medical practices in that culture or county, religious customs, country torture profiles, and refugee health profiles. Additionally, as cross-cultural health involves many elements, the website offers health topics from a cultural perspective (such as asthma among Cambodian migrants), patient health education information and tools for each culture, and a huge variety of nutritional slides for both providers and patients on options and traditions in home country and Western food based on religions and regional food selection. EthnoMed produces a weekly refugee health newsletter that is widely read and distributed among both providers and refugees around the region.
- Refugees Northwest, a program created by Lutheran Community Services Northwest and directed by Beth Farmer, provides counseling, complex health case management, and asylum and torture assistance for refugees. In her time as a therapist for torture victims, Farmer authored a handbook for service providers in mental health providing counseling for victims of torture. Given the high population of resettled SIV refugees in the region, this in-demand and highly regarded program has been hailed by other organizations across the country and serves as a model for compassionate, culturally appropriate care. Even the DRHC began screening for mental health and emotional trauma issues during

its initial screening with patients a few years ago. This made the center and Department of Public Health one of the first regions in the country to have a basic mental and emotional health assessment tool for refugees.
- Many of Seattle/King County's refugee health professionals worked with various refugee groups throughout the region to create an organization called New Arrivals Working Group. This group collaboratively approaches problems that arise within the refugee health system, improves access to care, and works with providers to improve culturally-tailored care and transportation challenges. This 200-member group advocates at local, state, and national levels for refugee rights and benefits in general, but specifically for refugee health improvements.

Weaknesses in Refugee Health Care

- Considering the majority of refugees have to live outside the city of Seattle, and this is where most health services are provided, transportation is a major challenge in Seattle as the bus system can be difficult to navigate and the public health transportation service company, HopeLink, only offers three free rides per refugee. Getting to the DRHC or Harborview, let alone the Department of Economic Security or Department of Public Health, can cost a significant amount of money for newly arrived refugees and up to two hours of travel each way. Considering the costs of child care and other opportunity costs, this can be a significant challenge for many residents.
- Housing costs in Seattle and the greater King County are some of the most expensive in the country, despite the fact that all refugees across the U.S. receive the same financial assistance (given to their RRA) when they first arrive. As a social determinant of health, housing is pivotal to health for all populations, but can be a major issue for families or single adults who arrive in the region. As a Director at a local RRA in King Country recently stated, *"Housing is the biggest crisis that we're in, when it comes to resettling refugees. Everything starts with housing. Most refugees, for the last couple of years, no longer live in Seattle. Just because of the cost of living in Seattle, the rent is pretty expensive, so they don't really live in Seattle."*
- Due to the large diversity of refugee groups present in Seattle/King County, finding appropriate translation services can be difficult, despite being federally mandated. A frequent concern of several providers and nonprofits was finding interpretation services with qualified, effective translators.
- Multiple service locations for lab work, primary care, gynecology, and pediatrics can be up to 40-50 miles from each other and a refugee's home (outside of Harborview, community health centers, and the HealthPoint Clinic in the Southern part of the region).

Barriers to Health Care Access for Refugees

- In Seattle/King County, the largest barriers to care were based on language and communications, and acculturation challenges. Language was a major issue in facilities

outside of Harborview's International Medicine Clinic, with nearly half of all experts noting that no interpretation services served as a significant obstacle to care for many refugees, while one quarter of respondents noted that poor interpretation was as issue and nearly 40% noted general language and communication issues posed as barriers to care. Several experts blamed this on the geographical distribution of care facilities while others noted the sheer amount of diversity within the refugee population of Seattle/King County made finding qualified translators in every language a major challenge.

- The complicated health system in the United States was seen as one of the biggest barriers to health as more than 50% of health experts cited it as a major obstacle. Along with a lack of culturally competent providers, these two acculturation challenges accounted for nearly one-fourth of all total responses about potential barriers to health care access.
- Transportation, discrimination, and general logistics and health insurance coverage were also marked hindrances to health care access in the Seattle/King County region. The reasons for these hurdles may be numerous, though several respondents noted that a lack of community integration impacted both non-refugees and refugees in terms of misperceptions and discrimination.
- While not a cited as a direct gap in health care services, a majority of respondents discussed housing as a pivotal challenge for resettled refugees, and one that likely impacted their ability to access health care. More than one participant noted that the social determinants of health should be strongly considered when conducting any health barrier research, and especially when designing health programming and interventions for refugees or low-income populations.

Gaps in Health Care for Refugees

- Undoubtedly, the most significant gap in health care cited by health experts was a lack of mental health care and providers, with nearly 90% of respondents citing this need a major chasm in health care for refugees.
- Dental services were also noted by half of survey participants as a health care gap, as most recognized that Medicaid and publicly funded health insurance options do not offer comprehensive dental care in their coverage.
- No health experts cited educational gaps or RRA needs in their responses. This lack of concern about these potential issues may serve as a testament to the health promotion and awareness campaigns, variety of educational classes and opportunities, and quality of staff members at RRAs in the King County area.

Threats in Refugee Health Care

- Local housing costs and rates of homelessness are expected to continue rising in the foreseeable future in King County. Unless other housing options are presented to newly arrived refugee families, the housing crisis among them will worsen.

- Rates of latent tuberculosis are increasing in King County. While all patients are screened for the ailment at the DRHC, no follow-up is required, so if patients are unable to continue seeking treatment, their TB may become active and spread.

Los Angeles Case Study
(Region with decentralized services and decreasing resettlement agencies)

Key Quotes

"Within the Los Angeles Area, I'd say, 70-80% of refugees who are resettled are coming from Iran. And they're religious minorities who qualify for the Lautenberg Program. That's actually why the majority of refugees who are coming to the LA area are coming with US ties, because the cost of living is too expensive for what are called "free cases." I think that, alone, makes the LA population somewhat different, because they do have more of a support network than in other places where they don't have these US ties. In terms of characteristics and challenges, might be very different from some others."

-UCLA Sociology Department

"Particular to LA, the geography of the city is one obstacle. Refugees who are resettled through agencies in Glendale don't necessarily live in Glendale. If they're being serviced through the welfare office in the Glendale area, or through medical clinics in the Glendale area, which are more familiar with the refugee population, there is a lot of difficulty in just transportation and getting there. One of them would be, the size of the city makes transportation really difficult."

-Volunteer, Refugee Forum of Los Angeles

"Whereas President Obama plan to have 110,000 refugees admitted this fiscal year, president Trump reduce that immediately to 50,000. The U.S. Refugee Admissions Program is a per-capita program. The nine agencies that resettle refugees here don't get paid if there are no refugees. So effectively by cutting buy more than half the number of refugees admitted this year, that has had a deleterious economic impact on all nine agencies. Again, this is a per-capita program, it is paid on the basis of arrivals, so when we get arrivals, we get paid, and when we don't get arrivals, we don't get paid."

-RRA Director

"I typically call our Refugee population middle income, middle class, middle age. So we have issues with hypertension, diabetes. But all of that said, I think our refugee population is probably among the healthiest. Remember, these are not people who have spent years & years in refugee camps or living hand-to-mouth in communities where they are not able to work or maybe even access health care. These are people who are coming from a cosmopolitan country with a good health care system to Vienna, where they spend 3 to 6 to 12 months, where they also can access health care. Glendale is the center of the Iranian diaspora, which is why we're here."

-RRA Employee

Overview of Los Angeles' Refugee Health System

Los Angeles' refugee population is different than any other region in the country as it boasts the largest Persian population in the world outside of Tehran (Amirani, 2014). A majority of newly settled and more established refugees resettled in the region came to the country as part of the Lautenberg Amendment, a 1990 amendment proposed by Senator Frank Lautenberg of New Jersey that gives Jewish and Christian minorities from Southeast Asia and the former Soviet Union legal eligibility for refugee status (Bruno, 2015). In this program, refugees do not have to prove a well-founded fear of persecution like other refugees, but this program has been a lifesaving instrument in the past for bringing Jews, Bahai, and Christians from Iran to safety who do face a greater risk of persecution than Christians from Ukraine (who are resettled in high rates as well). One key element of the Lautenberg Amendment that differs from traditional refugee resettlement policy is its application process. While most refugees generally live in camps, obtain refugee designation by the UNHCR, then begin the resettlement process in very few cases, a relative or close friend from within the United States submits and application for a refugee in another country. In Los Angeles, extended family members tend to apply for refugee status for their family members still living in Iran. Those family members then spend three months to one year in Vienna awaiting a medical exam and processing.

Due to this major influx of Iranians in the Los Angeles area, the IRC believes roughly 90% of its resettlement cases are from Iran and nearly all of its clients applied through the Lautenberg Amendment. This poses substantially fewer challenges for refugees who are resettled in the area (which is traditionally in Glendale, which is North of downtown Los Angeles and on the Eastern part of the San Fernando Valley) as this group has strong community ties, numerous friends and family members, and often "blocks and blocks of housing dedicated to Iranians," according to Martin Zogg, the Director of IRC in Los Angeles. Given that most refugees to Los Angeles come directly from two countries with strong health systems and do not suffer the same exposures to war zones of famine, the health status of most refugees is strong, with few communicable diseases.

The five RRAs that service the Los Angeles area are also accompanied by these additional two in Glendale:

- Catholic Charities
- Glendale Episcopal Diocese of Los Angeles Interfaith Refugee & Immigration Service (IRIS)
- International Institute of Los Angeles
- International Rescue Committee
- Jewish Family Services of Los Angeles
- U.S. Conference of Catholic Bishops
- HIAS

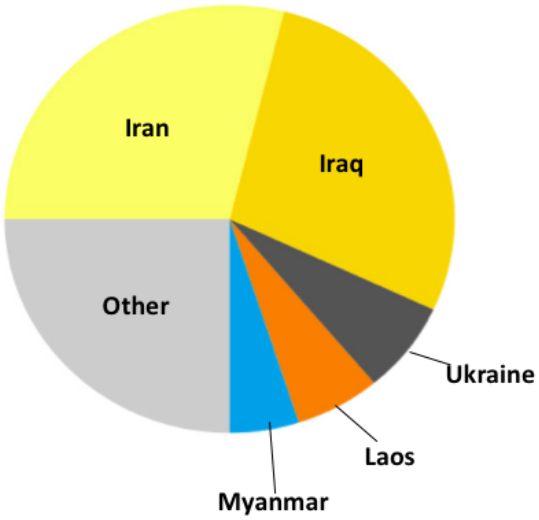
However, several of the RRAs serve more than Los Angeles County, with IRC serving the majority of Southern California. In terms of refugee populations, California takes in the most every year, followed by Texas and New York. Of the counties in California, Los Angeles took in the most from FY 2015-2016, followed very closely by Sacramento and San Diego (the latter of

which houses the state's largest refugee population) (Office of Refugee Health, 2016). The highest populations in 2016 were from: 1) Iran, 2) Iraq, and 3) Afghanistan, many of whom entered through the SIV program.

From a more historical perspective, from October of 2001 – the end of 2016, California's refugee population stemmed from 1) Iran, 2) Iraq, and 3) a mix of other countries in the following order: Russia, Laos, Ukraine, Somalia, Bosnia & Herzegovina, Myanmar, Belarus. Though Los Angeles' intake of refugees is primarily of Middle Eastern and Asian descent as of late, the refugee population is relatively homogenous in most parts of the city and Glendale due to the large number of Iranian refugees.

Table 14.

2001 – 2016 Top National Refugee Origins



2001-2016 Top Nations of Origin

1. Iran
2. Iraq
3. Others (including Russia, Laos, Ukraine, Somalia, Bosnia & Herzegovina, Myanmar, Belarus)
4. Ukraine
5. Laos
6. Myanmar

2016 Top Nations of Origin

1. Iran
2. Iraq
3. Afghanistan

**The breakdown in each state is limited to nationalities with at least 500 people*

(Hussein, 2017)

Refugee Intake

All new refugees to Los Angeles must undergo a health screening within 30 days of arrival. While the major clinic most screenings take place in is a Department of Public Health clinic in Glendale, other provides may perform the assessment. Refugees are referred to Medi-Cal primary care providers following their two health assessment visits. The first visit is composed of a pre-screening and involves answering general questions, allowing the clinic to obtain copies of the patient's International Organization for Migration overseas screening and vaccination

records, and answering general questions. The second visit include a visit with a physician, lab work, and chest x-rays when needed. Several tests are performed, including tests for tuberculosis, hepatitis B, and schistosomiasis, as well as brief screenings for mental and emotional wellness, a lifestyle assessment, and a general physical exam.

For resettled refugees in the Glendale area, the continuum of care can be easier to access than for those outside the area. If a specialist, primary care physician, or further testing is required outside the area, transportation can be a challenge, though most Lautenberg refugees have a wide array of family and friends who may help transport or accompany refugees to their appointments. For those refugees residing in the city of Los Angeles, getting to Glendale for initial exam may be a challenge and require roughly two hours for transportation. Housing costs within the major cities are among the highest on the West Coast, so for the majority of refugees with family or friends already in the country, cohabitation with more than one family is common, according to one refugee health expert in the area. Luckily, Los Angeles is one of the nine funded counties in Los Angeles where a screening center specifically for refugees has been established, so no co-pays or extra costs are associated with the primary visits. The most commonly diagnosed ailment in Los Angeles' refugee population is dental caries, with obesity in a distant second. In comparison to other regions of resettlement in U.S. with high rates of malnutrition from famine-stricken countries or cancers caused by radiation exposure, the Los Angeles refugee population is considered relatively healthy. As more SIV refugees begin to enter the country, though, the demand for more mental health care related to war zones has only increased, as has the need for more Arabic, Kurdish, Pashto, and Dari translators and an increase in culturally appropriate and sensitivity trained providers for Islamic families.

Strengths in Refugee Health Care

- Due to Los Angeles' relatively homogenous refugee population, most services are tailored around this Iranian refugee group and provides a high quality of services to patients. Given that the majority of patients in Los Angeles do not present with major health issues, this community-based care model is helpful for most refugees.
- The University of Southern California and University of California, Los Angeles employs a large number of physicians who serve as faculty members in the Department of Medicine and Department of Public Health as well as appointments at regional hospitals and health clinics. Given that most of these physicians who work with refugee populations also conduct research, a large amount of care provided to these populations is built on evidence and is culturally specific to this group. New assessment tools and emerging trends are often seen first by this group and allows for rapid assessments and the undertaking of new research based on these issues. When combined with the full array of services offered by the California and Los Angeles Departments of Health, the holistic approach to health for refugees can lead to better health outcomes for this population.
- The Program for Torture Victims near Koreatown in downtown Los Angeles is a behavioral health organization that uses a multidisciplinary approach to help rehabilitate torture survivors. These services included medical, case management, psychological, and

legal services for refugees and asylum seekers and are targeted towards people who have fled traumatic situations. As all staff members are well-trained in providing torture and trauma care, the group has a stellar reputation among academics, clinicians, and RRAs in Los Angeles.

- St. John's Well Child provides free and low-cost clinics to low-income community members, regardless of documentation status. Unlike most health clinics, St. John's provides podiatry, dental, homeless health, HIV/AIDS, and transgender health services and its support programs offer case management and a medical legal partnership in addition to health education, case management, and environmental health assessments for its clients. This progressive clinic is federally-funded and serves as a safe haven for refugees and asylum seekers.
- The Public Health Department's Annual Refugee Health Report provides an excellent snapshot of the health issues currently posed to many refugees, foreseeable challenges, and interventions designed to target specific populations. This report details significant demographics and could easily be used as a model for grant writing and cost-benefit analyses for providers and refugee health nonprofits in the region.

Weaknesses in Refugee Health Care

- The decentralized nature of the health system in Los Angeles can be difficult to navigate, with little information provided for refugees on the county and state department websites. Navigating this health system can be challenging, especially given the increased caseloads many RRAs are currently seeing.
- Wait times can be much longer than expected for refugees, particularly for referrals to specialists, often taking weeks or months. Several Medi-Cal provider websites urge patients to arrive to their appointments 30 minutes ahead of time and encourage them to bring books or other entertainment as this wait time in clinics has been thoroughly documented. The opportunity costs and other associated costs (like childcare) that are expended during these long wait times may be a reason for resettled refugees to not follow up with appointments or not schedule them in the first place. One university research noted that even federal and state identification and health insurance cards can take a disproportionately long amount of time to arrive:

  > *"Things like, if you don't get your medical insurance cards in the mail for four weeks after you arrive, you might not know if, during that time, you can seek healthcare. For example, one father of two young kids was very concerned that, since he didn't have his medical cards in hand, if his children had a medical emergency, he would be turned away from the hospital."*

- Due to the annual cap in refugee allowance set forth by the Administration, several RRAs in California have already closed, which has forced other agencies to embrace their caseloads while they must lay off some of their own staff members as well. As the resettlement system works on a per capita basis, the fewer refugees who enter the system, the less money available for the resettlement agencies. This has lead, according to one RRA director, to a decrease in service quality and provision among case workers, and confusion and stress among newly arrived refugees. Given the initial 90-day acceptance period, this crucial time to help refugees complete all their health exams and begin

treatment on their roads to self-sufficiency is vital, and any lack of support will make maneuvering Los Angeles' complicated refugee health system even more difficult.

- Mental health care has become an increasingly important need in Los Angeles with the arrival of more SIV refugees, Syrians, and URM refugees from Central America. One RRA director noted:

  > *"But with respect to health, we simply inquired after resettlement agencies' and their clients' experience of health issues, and what we found, and we didn't get any great detail on this, is something we already suspected, which was the Syrian refugee community, which is the only refugee community we are inquiring after, has experienced high rates of PTSD and other mental illnesses, that accessing care has been a great challenge. And that frankly, thus far, there have been no good answers as to how to improve either access to care or the quality of that care."*

  Providing care for a population that is emerging in a city dominated by one to two refugee groups has proved to be a challenge for the region.
- Housing and transportation are challenges for anyone in Los Angeles, let alone refugees who do not have prior U.S. ties. As a social determinant of health, housing is crucial to the well-being of a refugee, and being able to afford to rent a house or apartment in a vicinity close to a workplace, health center, and easily accessible transportation is a luxury. Most non-Middle Eastern refugees have had to live a long distance from one of these crucial locations, which has caused long commute times and a lack of follow up to health care because of the effort, money, and time required.

Barriers to Health Care Access for Refugees

- Language and communication challenges were noted by most health experts as the most considerable barriers to health care access, despite more respondents citing more obstacles within the acculturation challenges category due to the large category size. 57% of all respondents noted that unspecified language issues were major challenges, particularly for non-Spanish speaking translators. The quality of translation services was noted as a barrier for health access, while many experts stated that providers – especially specialists – often neglected to offer or provide interpretation services, sometimes illegally.
- Health education was considered a large obstacle by 28.6% of health experts. A general awareness of services and health programming was the major reason for this selection, and highlights an important field in which health services can be improved.
- Unspecified cultural beliefs were frequently noted as an obstacle to accessing care for many refugees, especially outside of the Glendale area. Non-Iranian refugees were more likely to experience this challenge, according to health experts.

Gaps in Health Care for Refugees

- 25% of health experts in the Los Angeles area believe that health insurance advocacy was a major gap for resettled refugees in the region. Most respondents felt this gap should be filled by RRAs, especially to advocate on the behalf of refugee patients for uncovered services, medication, or health supplies.
- A commonly cited issue about respondents was the needs for more health promotion and awareness as well as more service awareness for refugees from both health facilities and health insurance plans. Interestingly, RRA case workers with knowledgeability of health programming and services was not cited frequently by health experts as a gap in care.
- Mental health care was noted as a major gap by 53.87% of respondents. As many new refugees to the Los Angeles area arrive through the SIV program and were living in active war zones, this need is not surprising.
- Roughly one-third of respondents noted that improve collaboration and communication among RRAs, health care providers and facilities, and Departments of Health posed a significant rift in services. Gaps were noted between the California Department of Health's initial assessment in Glendale to treatment at primary care and specialists and testing/lab work.

Threats in Health Care for Refugees

- As fewer refugees are being allowed entry into this country, and more refugees from non-Lautenberg countries begin to become the dominant population in a global city like Los Angeles, fewer RRAs will exist with even fewer staff members than they initially employed, which can be troubling for some refugees and per capita-based health financing systems.
- Additionally, newer refugee populations in the Los Angeles area requires a new cadre of providers and public health professionals with cultural knowledge and awareness of their health needs. Considering public health budgets are already shrinking in this field, affording to recruit and hire new professionals or fully train current staff members may prove to be impossible.

Tucson Case Study

(Smaller, somewhat centralized region with varied refugee populations, many pro bono services, and several political challenges)

Key Quotes

"It was started in 2003 to provide free health care services to Tucson's low-income and uninsured. If you don't have health insurance, we welcome anyone who needs health care. And we just provide any type of health services that are necessary. For a lot of people, health insurance is not accessible. And sometimes when you do need to go see a doctor, the cost is too high for someone to afford so they basically go without they end up in the ER. [We] don't do any real intense outreach services. It's word of mouth. So we've situated ourselves in an area that the poor population lives. We used to keep it real quiet because we take care of the undocumented. They know we're seeing undocumented people, but they don't really care because they know we're taking care of them."

-Clinica Amistad Volunteer Medical Professional

"Even with the translation services, I look at patients and it's like, "I'm pretty sure you didn't understand that." And I even have patients that are more established and now understand English better and they tell me like, "She's not saying it right. That's not what I said," or something like that from the translator, so I know that there's a lot lost in translation so half of the time, we're not confident that they're understanding their care plan because of the language barrier. So the providers, rightfully so, don't feel comfortable making a change for the care plan because they don't even know if they understand what needs to happen."

-Medical Clinic Employee

"There's not a lot of private clinicians that take AHCCCS health care. And when they do, it's kind of a limited number because they have a busy practice to run and AHCCCS doesn't pay well. You have the clinician that's seeing the patient and it's like, okay, 'AHCCCS isn't paying me anything, You have that constant pressure as a clinician to keep moving throughout your day and that can be another obstacle for them and that visit isn't maximized for the patient."

-Nonprofit Director

"…[I]f we talk about mental health programs, there are communities like the Somalis that there's a stigma, and for someone to get assistance, it will take a lot of work and someone who already worked with certain groups will know how to help them navigate the system. I remember having two cases that a doctor described a skin lotion or a skin medication and they both drank that and ended up hospitalized. But whoever was given that prescription never realized that someone can make that mistake."

-Refugee & Health Care Worker

Overview of Tucson's Refugee Health System

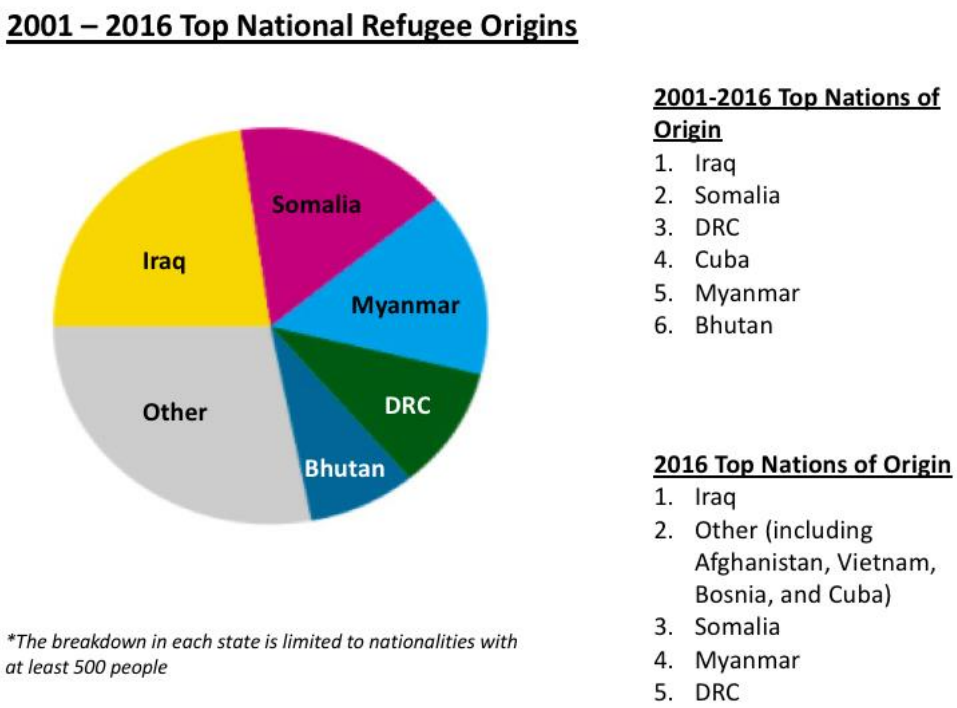
Nestled in the Southeast corner of the state, Tucson is a progressive community with a welcoming cultural environment for refugees and immigrants, despite being in largely conservative state. Along with California and Washington, Arizona is one of the top 10 states to resettle refugees in the nation, and the city works with these three RRAs on refugee resettlement:

- International Rescue Committee
- Refugee Focus (Lutheran Social Services of the Southwest)
- Catholic Community Services of Southern Arizona

Pima County settles the second most refugees in the state outside of Maricopa County, home of the Phoenix metropolitan area (Arizona Refugee Resettlement Quarterly Meeting, 2017). In recent years (2014-2015), most refugees to Arizona have been representative of the national refugee migration trend in terms of country of origin, with the following five countries sending the most refugees to the state: 1) Iraq, 2) Somalia, 3) Democratic Republic of the Congo, 4) Cuba, and 5) Myanmar (Stern, 2015). This influx of recent visitors has caused an increased need for medical interpretation for the following languages: Arabic, Nepali, Somali, Spanish, Myanmar, Karen, Farsi, Kirundi, and Swahili. Arizona has had large Somalian and Mexican/Central American communities for years, but recent increases in Middle Eastern and Central/East African refugees has caused a need for more interpretation and cultural awareness rooted around these cultures.

However, from October of 2001 – the end of 2016, Arizona's refugee population primarily stemmed from 1) Iraq, 2) other (including Afghanistan, Vietnam, Bosnia, and Cuba), 3) Somalia, 4) Myanmar (formerly Burma), and 5) Democratic Republic of the Congo (see Table 14) (Hussein, 2017). Arizona's nationally representative refugee populations have a variety of medical issues, religious backgrounds, and unique demographics.

Table 14.



(Hussein, 2017)

Refugee Intake

All new refugees to Pima County must undergo a mandatory refugee health screening funded through the Refugee Medical Assistance Program. The screenings take place through the Banner Medical Center's Infectious Disease Unit (Pima County Department of Health, n.d.). During this initial health assessment, refugees are screened for tuberculosis, hepatitis b, HIV, syphilis, chlamydia trachomatis, neisseria gonorrhoeae, and women must undergo a pregnancy test. Providers also look for undiagnosed chronic ailments during this initial assessment, and a screen refugees for potential communicable diseases or major mental illnesses. Referrals for obstetrics and gynecology, infectious diseases, and other services are immediately made with additional providers at Banner Medical Center.

Banner Medical Center is centrally located in Tucson, making it accessible by public transportation, and also houses a variety of medical clinics, so follow-ups and referrals to specialists are not as challenging as they might be in larger cities. Refugee health care is also relatively centralized in the Tucson area with several known providers and clinics that are frequented by refugee patients. As many new refugees to the Tucson area come from areas where endemic rates of tuberculosis are high, hundreds of patients test positive for treatment upon their initial health screening in Tucson. Additionally, HIV/AIDS rates are higher than in other areas in the state given that a large proportion of refugees come from countries where HIV prevalence rates are significantly higher than in other countries.

Though Pima County's refugee health services are easily accessible through the use of case management and RRAs, research about clinic locations, communication with providers and offices, and general AHCCCS questions are challenging due to a restricted web presence for some state and county offices who have recently undergone layoffs (as a result of refugee admission rates being reduced over the past two years). Significant health access options exist in Tucson, ranging from hospitals like Banner Medical Center/UMC to Tucson Medical Center, with many public health centers and clinics being located in parts of the city where large refugee communities are based. St. Elizabeth's Health Center provides refugee-specific services, and El Rio Community Health Centers are highly visible and present throughout the region. The Petersen HIV Clinic – run through the University of Arizona Department of Medicine/Infectious Diseases – works collaboratively with the Southern Arizona AIDS Foundation and El Rio Infectious Disease Clinic to serve newly resettled refugees who are HIV-positive with medical care, housing, behavioral health care, and medication counseling. The strong health activism community in Tucson helps refugees find a sense of community and has advocated for more accessible health care for this population.

Strengths in Refugee Health Care

- Due to Tucson's centralized, accessible refugee health system, combined with a smaller number of key stakeholders, collaboration between organizations and providers occurs frequently and allows for more consistent treatment along the continuum of care. Several providers in Tucson are noted as refugee specialists and are frequently referred to by patients, RRAs, and Pima County Health Department officials alike. Given that these providers and clinics have a robust knowledge base with numerous refugee groups from assorted nations, patients are more likely to feel comfortable and follow through with appointments and treatment, according to some health experts.
- Tucson's Clinica Amistad provides free care for all who enter the clinic's doors, regardless of documentation status. Providers familiar with refugee health care frequent the clinic as it is known as a "safe" location for asylum seekers and undocumented people to receive treatment. Immigration officials do not visit or stop by the clinic as part of a tacit agreement with the neighborhood and the Catholic Priest who began the clinic. Often, refugees with lapsed health insurance can obtain specialty care from a number of volunteer physicians several nights a week. Tucson is a low-cost, low-income city, and many residents are reliant on the services of Clinica Amistad for their family's health needs.
- Tucson's Arizona Language and Transportation Services (ALTS) is a medical transportation and language services provider started several years ago by Sahra Hirsi, a Kenyan refugee who spent 15 years in a refugee camp before being resettled in Tucson. Mrs. Hirsi and her husband, Abdullahi Omar, a Somalian immigrant who also spent most of his life in a refugee camp, now run the organization together after having experienced a difficult transition as new community members in Tucson when they were resettled. Seeing a clear need for culturally competent, trained interpretation services as well as community navigators caused Mrs. Farsi to start the company so young women who

underwent trauma like female genital mutilation (FGM) would always have an advocate by their side and someone who understood their unique care needs. The team now involves a wide variety of linguists and trained interpreters who assist in refugee health cases daily.

- The Petersen HIV Clinic is performing excellent research studies including refugee populations in the greater Tucson area. Not only does the clinic provide health and medication coverage to HIV-positive refugees if their health insurance lapses, they also include non-HIV related medication that is not required as part of their antiretroviral therapy. Ensuring consistency with medication and provider appointments with medical case management will likely continue to improve refugee health outcomes in the region.
- Several organizations, like Tucson Refugee Ministry and Iskashitaa Refugee Network, work to provide some basic services for refugees after their time with their RRAs has finished. Some of these services include community integration, the harvesting of fruits and vegetables in Southern Arizona for food or sale, and English as a Second Language classes. In addition to Tucson's abundant progressive activism community, many community organizations offer additional support to refugee families and work to form long-term relationships and health advisory groups to better serve this population.

Weaknesses in Refugee Health Care

- Several health experts noted that culturally competent RRAs could be difficult to work with for new refugees. Additionally, staff turnover at RRAs was noted as particularly high by more than one respondent. Working with untrained and newer staff members at these organizations had been a major complain among some refugees. One expert noted:

  "Are you meeting with a case worker who just got hired and has no clue about the culture or you know, experience working with refugees? Because I did home visits with people who really, the questions they were asking were not appropriate and it wasn't culturally sensitive."
- Despite the strong support for health care and the resettlement of refugees in the Tucson area, the state's conservative Legislature and Governor have posed legislation at least three times attempting to prevent refugee resettlement throughout the state. Republican Senator Judy Burges from Sun City West proposed a law that would charge nonprofits $1000 a day for aiding refugees in addition to preventing the state's Department of Economic Security from partaking in refugee resettlement (Fischer, 2017). Governor Doug Ducey also proposed immediately stopping refugee resettlement in the state in 2015. This political environment has made it challenging to expand refugee health care despite pressing needs based on studies run by state health groups which advocated strongly mental health care funding. Despite this civic discourse, Arizona continues to settle more refugees per capita than over 85% of other states.
- Many private clinicians do not take AHCCCS due to the low cost of reimbursement. This has led to several providers taking on a larger share of these patients who are publicly insured, including refugees. Some health experts noted that this has caused a decrease in quality care with shorter appointment times and bigger waiting times to see providers.

- Mental health was cited as a major service issue in the Tucson area, specifically around Middle Eastern and Somalian refugees who had faced traumatic issues like war zones, famine, and displacement. Several health experts noted that diagnosing and referring patients with previous exposure to trauma was a challenge. A lack of culturally competent mental health care providers as well as funding provisions for these services were noted as the biggest obstacles in the city by several experts.
- Culturally competent providers were found to be lacking in the Tucson area, according to three health experts, particularly for women of non-Christian religious groups. These experts also stated that new providers were frequently unaware of non-Western medical, cultural, and social belief systems, making providing care like gynecology or psychology a challenge.

Barriers to Health Care Access for Refugees

- In Tucson, the most commonly cited barrier to health care access for refugees was three-fold: unspecified language challenges, health education, and transportation. With many new refugees arriving in the area from Somalia, Democratic Republic of the Congo, and Myanmar, finding appropriate language services in sufficient numbers can be a major challenge, in addition to communication about transportation and presenting health information to refugees unfamiliar with Westernized health systems.
- Several experts noted acculturation challenges as a major obstacle to care for refugees. A complicated health system, medication issues, and a lack of culturally competent care were all cited numerous times, particularly for those refugees with inexperienced case managers or those facing language challenges.
- As some health providers noted, most new refugee families to Tucson have several children, so childcare serving as a barrier to care is unsurprising in this region. The barrier of stigma is related to mental health care in the region, another issue cited by several providers below.

Gaps in Health Care for Refugees

- By far, the most frequently cited gap in health care for refugees in Tucson was mental and behavioral health. Several in-depth interviewers noted a lack of providers, specifically those familiar with trauma-informed care and the needs of refugees, and a lack of assessment and referrals for this gap.
- Funding was noted as a main gap and major need in Tucson. Considering that many private providers refuse to take AHCCCS due to low reimbursement rates, many Department of Health employees losing their jobs due to budget cuts, and a reduced rate of case workers from RRAs and local hospitals, this need speaks to the under-funding of public health programs in Arizona, which some experts cited as a political issue.
- Respondents also noted that service awareness, holistic and integrated care, and greater communication and collaboration among agencies were major gaps in health care for

refugees. Despite having a somewhat centralized health system for refugees, high staff turnover and languages challenges which impact the scheduling of specialty and case management appointments may be responsible for this gap.

Threats in Refugee Health Care

- Turnover rates continue to rise among RRA case workers in the area, which has caused many refugees to lose trust with their case workers before completing their initial medical screenings, and especially before follow-up appointments with specialists. One health expert noted that many case workers are young and unaware of cultural customs, making refugees hesitant to engage in communication about health needs with the staff member. This has led to some loss to follow-up and probable missed diagnoses for chronic conditions.
- Tuberculosis and HIV rates in the Tucson area are increasing in some foreign-born, minority populations, including refugees. If more aggressive health promotion campaigns and treatment follow-up protocols are not applied, widespread infections could occur in the greater Tucson area.

Key Informant Interview Guide

- Please state your name and organization.

- Please tell me about what the landscape of refugee health looks like in [state] in terms of population number and refugee nations of origin.

- Can you tell me about how the funding system works for refugee health and who the major players are?

- If Medicaid expansion to the states under the Affordable Care Act is removed, can you tell me what that would mean for funding for refugee programs in [your state]? Nationally (or if it's on a state-by-state basis)?

- Can you tell me some of overall demographics of [your state] resettled refugees and where they live?

- Are there any particular health issues that have emerged in health screenings that require long-term care?

- What are the most common issues you see in refugees here? Does it differ by region? What about in children?

- Can you tell me what the most basic obstacles are in providing refugee health care?

- Can you tell me what you think was the biggest change/improvement to the refugee health care system has been since you've worked in it the past ten years?

- Do you think any gaps exist between refugee treatment needs and what is provided? How can we improve that? (This can be national, local, state; greater communication among agencies, more professionals, greater awareness of the programs, etc.)

- For refugees who are here without the proper documentation or who are still in the approval process for their applications, what tools do they have for accessing healthcare? What kind of burden might this put on the system?

- Is there anything that concerned citizens can do to help refugees gain access to healthcare or support the work that is already being done?

- Why do you want to work with refugees in health?

IRB Approval Letter

HARVARD
Human Research Protection Program

Harvard T.H. Chan School of Public Health
Office of Human Research Administration
90 Smith Street, 3rd Floor
Boston, MA 02120
Federalwide Assurance FWA00002642

Notification of Initial Study Exemption Determination

February 21, 2018

Christin Gilmer
ceg167@mail.harvard.edu

Protocol Title:	Converting Film Interviews Into Research Interviews and a Short Survey for Refugee Health Gap Analysis and Unmet Needs Analysis
Principal Investigator:	Christin Gilmer
Protocol #:	IRB18-0281
Funding Source:	None
IRB Review Date:	2/21/2018
IRB Effective Date:	2/21/2018
IRB Review Action:	Exempt

This Initial Study submission meets the criteria for exemption per the regulations found at 45 CFR 46.101(b)(2). As such, additional IRB review is not required.

The determination that your research is exempt does not expire, and you will not file annual renewals. If changes to the research are proposed that would alter the IRB's original exemption determination, they should be submitted in ESTR by using the Modify Study button. If unsure, contact the Harvard T.H. Chan School of Public Health IRB office.

The IRB made the following determinations:

- Research Information Security Level: The research is classified, using Harvard's Data Security Policy, as Level 2 Data.

If you have any questions, please contact me at 617-432-7434 or kserpico@hsph.harvard.edu.

Sincerely,

Kimberley Serpico

Kimberley Serpico, MEd, CIP
Assistant Director of IRB Operations