



STUDY OF DOMESTIC CAPACITY TO PROVIDE MEDICAL CARE FOR VULNERABLE REFUGEES

A survey and policy study examining medical case management and healthcare accessibility for refugees

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TABLE OF CONTENTS

Acronyms	4
Glossary	7
Charts and Tables	10
Executive Summary	11
Introduction	11
Challenges of Providing Care.....	12
Affordable Care Act (ACA) and Medicaid Expansion	15
Service Models: A Cost-Benefit Analysis.....	17
Summary of Policy Recommendations	20
Challenges of Providing Care	20
Cost.....	20
Impact of Medical Conditions	20
Flow Of Refugee Health Information.....	20
Refugee Access to Medication	20
Affordable Care Act (ACA) and Medicaid Expansion	21
Effect of the ACA.....	21
Impact of Medicaid Expansion.....	21
Service Models: A Cost-Benefit Analysis	21
Model Cost-Benefit Analysis	21
Methodology	23
Timeframe	23
Eligibility and Definitions.....	23
Survey and Guide	25
Sites and Partners	26
Data and Research Limitations	28
Introduction	30
Overview and Purpose	30
Case Study.....	31
Research Questions	32
Analysis	38
Challenges of Providing Care	38

Cost.....	38
Impact of Medical Conditions	41
Flow of Refugee Health Information.....	44
Refugee Access to Medication	46
Affordable Care Act and Medicaid Expansion	49
Effect of the ACA.....	49
Impact of Medicaid Expansion.....	51
Service Models: A Cost-Benefit Analysis	57
Policy Recommendations.....	83
Challenges of Providing Care	83
Cost.....	83
Impact of Medical Conditions	83
Flow of Refugee Health Information.....	84
Refugee Access to Medication	84
Affordable Care Act (ACA) and Medicaid Expansion	85
Effect of the ACA.....	85
Impact of Medicaid Expansion.....	86
Service Models: A Cost Benefit Analysis.....	87
Future Studies	89
Acknowledgements	90
Appendices.....	91
Appendix A – USCRI and Refugee Health.....	91
Appendix B – RMA Data for Participant States	92
Appendix C – Historical Arrival Data for Participating Resettlement Affiliates	94
Appendix D – Clients with Mental Health Conditions	98
Appendix E – List of Forms Related to Medical Conditions.....	99
Appendix F – Companion Guide for PRM Domestic Refugee Health Capacity Study	100
Appendix G – Participating Resettlement Affiliate Structured Interview	109
Appendix H – Other Local Resettlement Affiliates Structured Interview	112
Appendix I – State Refugee and Refugee Health Coordinator Structured Interview	115
Appendix J – Bibliographic References	117
Appendix K – Prescription Medication Management Resources	120



Acronyms

ACA	Affordable Care Act
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CSI	College of Southern Idaho, Twin Falls, Idaho
CWS	Church World Service
DPH	Department of Public Health
ECBO	Ethnic Community-Based Organization
ECDC	Ethiopian Community Development Council
ECHOS	Epiphany Community Health Outreach Services
EMM	Episcopal Migration Ministries
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent Employee
HIAS	Hebrew Immigrant Aid Society
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration, U.S. Department of Health and Human Services
IIMN	International Institute of Minnesota, St. Paul, Minnesota
IINE	International Institute of New England, Boston, Massachusetts

IOM	International Organization for Migration
LCSW	Licensed Clinical Social Worker
LEP	Limited English Proficiency
LIRS	Lutheran Immigration and Refugee Services
LTBI	Latent Tuberculosis Infection
MA	Medical Assistance
MAA	Mutual Assistance Association
MAGI	Modified Adjusted Gross Income
MBHP	Massachusetts Behavioral Health Partnership
MCM	Medical Case Manager
MDH	Minnesota Department of Health
MG	Matching Grant
MORI	Massachusetts Office of Refugees and Immigrants
MSW	Medical Social Worker
NSC	Nationalities Service Center, Philadelphia, Pennsylvania
ORR	Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Services
PC	Preferred Communities
PCP	Primary Care Providers
PPA	Participating Provider Agreement
PRM	Bureau of Population, Refugees, and Migration, U.S. Department of State
PRHC	Philadelphia Refugee Health Collaborative
R&P	Reception and Placement
RCA	Refugee Cash Assistance

RHA	Refugee Health Assessment
RHP	Refugee Health Program
RHS-15	Refugee Health Screener - 15
RMA	Refugee Medical Assistance
RMCAC	Refugee Medical Care Advisory Committee
RSC	Resettlement Support Center
SMC	Significant Medical Condition
SRC	State Refugee Coordinator
SRHC	State Refugee Health Coordinator
SSI	Supplemental Security Income
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
USCCB	U.S. Conference of Catholic Bishops
USCRI	U.S. Committee for Refugees and Immigrants
USRAP	U.S. Refugee Admissions Program
WR	World Relief

Glossary

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (PPACA) 2010 HR5390, or Affordable Care Act (ACA), is the healthcare reform law that expands Medicaid coverage to millions of low-income Americans and promotes expanded health insurance coverage, lower health care costs, and more health insurance programming options.

Affordable Care Act (ACA) Subsidies: The ACA establishes a system to provide assistance for low and middle-income families and individuals who are trying to purchase health insurance. The amount of assistance, or subsidies, varies based on location, family structure, and income level.

Assistance-Based Approach: The method used to determine a refugee’s eligibility for this study. Considers refugees eligible if they receive medical case management services that fell outside the standard assistance involved with ensuring timely access to initial refugee health assessments. A more detailed explanation is available in the “Methodology” section.

Bio-Psychosocial Assessment: Refers to a series of questions asked at the beginning of treatment of an individual that obtain information about the major physical (biological), psychological, and social issues of the individual.

Biographical Data Form (Biodata): The Biographical Data form is generated for each arriving refugee by the overseas Resettlement Support Center. The form includes information on each member of the case including name, date of birth, education, employment history, and health history.

Community-Based Organization (CBO): Civil society non-profits operating within a local community.

Complex Medical Condition: A descriptive term for conditions that qualify a refugee for inclusion in this study based on the **assistance-based** approach to eligibility. For the purposes of this study, a complex medical condition is any medical condition that requires additional medical services beyond what is required for a healthy refugee in a refugee health assessment (RHA). This is the broadest category of eligibility in this study, and includes severe medical cases.

Coverage Gap: Refers to a situation where a refugee is not eligible for state, subsidized federal health insurance plans or employer plans and cannot afford to purchase private insurance. This individual would fall into a coverage gap.

Ethnic Community-Based Organization (ECBO): A community-based organization that provides services for a specific ethnic group(s).

Federally Qualified Health Center: Health Centers that are federally operated through the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) to provide services to low-income adults.

Hard Cross Reference: Cases that are almost always interviewed overseas together, allocated together, scheduled to travel together, and resettled together.

Health Exchange (or Exchange): See definition for Health Insurance Marketplace.

Health Insurance Marketplace (or Marketplace, Health Exchange or Exchange): A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources to pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Plan (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. Also known as "Health Exchanges".

Matching Grant: A grant administered by ORR that is an alternative to public cash assistance. It enables eligible populations (including refugees) to become economically self-sufficient within 120 to 180 days of program eligibility. Participating agencies agree to match the ORR grant at a 50% rate with cash and in-kind contributions.

Medically Vulnerable: Used in the report when discussing refugees with medical issues in general terms. It includes a larger universe of refugees with medical conditions.

Mutual Assistance Association (MAA): Ethnic Community-Based non-profit organization that provides linguistically and culturally sensitive services to members of a locally-based ethnic community.

Navigator or Healthcare Navigator: An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms.

Preferred Communities: A grant administered by ORR that supports programming focused on early employment and sustained economic independence. In addition, the program supports special needs populations including medically vulnerable refugees.

Reception and Placement (R&P): The Department of State’s Reception and Placement program provides assistance for refugees to settle in the United States. It supplies resettlement affiliates a per capita amount to provide refugees with basic necessities and core services during their first three months (90 days) in the United States.

Reception and Placement Period: The Department of State’s Reception and Placement program is limited to the first three months (90 days) after arrival.

Refugee Health Assessment: The initial post-arrival health assessment, generally performed by local health departments or clinics. Assessments vary in scope and are informed by CDC guidelines.

Refugee Health Screener-15 (RHS-15): The RHS-15 is a tool to screen refugees for emotional distress and mental health status. This tool was developed by Pathways to Wellness and has not been tested for validity of use with individual ethnic groups.

Refugee Medical Assistance (RMA): RMA is a 100% federally funded program that provides up to eight months of health care coverage for refugees and other eligible persons.

Refugee Resettlement Agency: An agency that has a cooperative agreement with the Department of State to provide R&P services through a network of affiliates and field offices. In FY2014, there were nine such organizations.

Resettlement Affiliate: A local resettlement agency field office or an independent non-profit that has an agreement with a refugee resettlement agency to provide R&P services.

Severe Medical Condition: A descriptive term used to identify a subgroup of refugees in this study who have the highest level of need due to their medical condition(s). This is the narrowest category of eligibility in this study, and is a subset of complex medical conditions. Eligibility criteria for this subgroup can be found in the “Methodology” section.

Significant Medical Condition Form: The Significant Medical Condition (SMC) form is designed to collect and transmit advance information on refugees’ post-arrival follow-up, placement or additional assistance needs to receiving affiliates in the country of destination. The form is used by IOM panel physicians for approximately 15% of U.S. bound refugees diagnosed with significant medical conditions requiring additional assistance from the resettlement affiliates and/or local health care providers. IOM panel physicians conduct assessments for about 70-80% of U.S. bound refugees.

State Refugee Coordinator (SRC): The State Refugee Coordinator implements the State Plan for Refugee Resettlement, oversees federal grants for refugee services, and may administer

medical and social assistance programs. The SRC collaborates with federal, state, and local partners in the private and public sector to design and implement policy related to refugee resettlement in their state.

State Refugee Health Coordinator (SRHC): The State Refugee Health Coordinators are responsible for administering refugee health programs in their state or territory. Refugee health programs focus on linkage with health care services and care coordination, refugee health assessments and immunizations, health education, and reducing health disparities.

U.S. Tie: A U.S.-based relative or friend of a refugee.

Wilson-Fish: The Wilson-Fish program is an alternative to traditional state-administered refugee resettlement programs for providing assistance (cash and medical) and social services to refugees.

Charts and Tables

1. USCRI Refugee Arrivals and Study Participants in the Five Study Locations (pg. 25)
2. Per Refugee Cost by Type of Medical Condition (pg. 39)
3. Costs of Management of Mental Health, Mobility Issues and Hospitalizations (pg. 40)
4. Clients Needing Assistance at 90 Days Post-Arrival (pg. 45)
5. Comparison of Medicaid Options by State (pg. 53)
6. Income Eligibility Limits for States Included in Study (pg. 54)
7. Refugees Aged 19-64, Unmarried, Without Private Insurance (pg. 55)
8. The State-Based Collaborative Model (pg. 58)
9. The Affiliate-Based Collaborative Model (pg. 59)
10. The Independent Center Model (pg. 60)
11. The Single Agency Model (pg. 61)
12. Model Costs and Benefits (pg. 80)

Executive Summary

Introduction

The United States resettles more refugees than all the other countries of the world combined. This achievement is possible through strong partnerships between the U.S. Government, the United Nations High Commissioner for Refugees (UNHCR) and domestic and international non-governmental organizations. Identifying and addressing challenges to successful resettlement is critical to the success of the U.S Refugee Admissions Program (USRAP).

Refugees who are resettled in the United States face many challenges that are part of building their new lives in a new country such as learning a new culture, language and overall adjustment. Some of these refugees arrive with medical conditions that add to the challenge of resettlement and become an obstacle to early self-sufficiency.

One of the challenges to successfully assisting medically vulnerable refugees is the lack of evidence regarding the cost of managing the medical conditions of resettled refugees. The intent of this multi-disciplinary study is to provide a concrete assessment and recommendations to address the U.S. domestic capacity to resettle refugees with medical conditions during the resettlement process and specifically for the initial 90-day Reception and Placement (R&P) period.

This study assesses the capability, impact, and service models implemented in resettlement communities to resettle medically vulnerable refugees during the 30 to 90 days after arrival in the U.S. The research was implemented at five resettlement sites: Boston, Massachusetts; Houston, Texas; Philadelphia, Pennsylvania; St. Paul, Minnesota; and Twin Falls, Idaho. Data generated by this project in the five study sites shows a need for additional post-arrival support for the medically vulnerable, particularly for those with mental health conditions and mobility issues, as well as for those requiring hospitalization shortly after arrival. Through this study, the U.S. Committee for Refugees and Immigrants (USCRI) provides research findings based on qualitative and quantitative data that are used to support policy recommendations. The recommendations generated by this report offer options for providing this additional support, as well as some critical health-related issues to consider in the resettlement of these refugees. Further, this study considers national variations in the accessibility of health services and provides options for service provision.

The findings and conclusions of this study are organized considering the following four study areas:

1. To analyze the challenge of providing care when resettling medically vulnerable refugees;
2. To assess the impact of the Affordable Care Act and efforts to expand Medicaid coverage on medically vulnerable refugees;
3. To evaluate the various resettlement models utilized at the five research project sites and highlight models that reduce the challenge of providing care in resettling medically vulnerable refugees; and
4. To provide relevant policy recommendations.

CHALLENGES OF PROVIDING CARE

Cost

Findings

- Data shows that refugees with complex medical conditions (as defined by this study) require, on average, an additional 5.13 hours of case management and 27.27 miles driven by case management staff per refugee during the 90-day post-arrival period. These hours and miles indicate an investment beyond what is required for the medical case management of a healthy refugee who only needs the general services provided by resettlement staff to coordinate a Refugee Health Assessment (RHA).
- Data shows that refugees with severe medical conditions (as defined by this study) require on average an additional 7.69 case management hours and 63.76 miles during the 90-day post-arrival period.
- This translates to an average of approximately \$164.19 in additional investment by resettlement affiliates for refugees with complex conditions and \$258.95 additional investment for refugees with severe conditions per refugee.

Conclusions:

- The R&P program Cooperative Agreement requires resettlement affiliates to provide assistance in accessing health screenings and appropriate health services. Resettlement affiliates are covering additional costs for the case management of medically vulnerable refugees, with a particularly high investment required for refugees with severe medical conditions.
- These additional expenditures for refugees with severe medical conditions are typically not covered by the R&P funding provided to resettlement affiliates for resettlement, but come from either privately-raised funds or affiliate reserves. Although services for the medically vulnerable are required under the Cooperative Agreement, the disparity in the

amount of investment required by resettlement staff warrants further funding for these specific types of medical conditions and situations.

- The per capita discretionary amount of \$200 is specifically for direct assistance to the refugees, and does not cover the additional administrative and medical case management costs of resettling medically vulnerable refugees.

Impact of Medical Conditions

Findings:

- The level of resettlement affiliate outlay varies based on the type of condition a refugee has, even within the subset of severe medical conditions as defined by this study. Certain medical conditions require a much higher level of resettlement affiliate support than others.
- Although many conditions fall under the category of severe, two conditions were found to require the most management and support from resettlement affiliates. These conditions are mental illness and mobility issues. Data shows that mental health issues require an average investment of 9.19 hours and 11.25 miles per refugee by resettlement affiliates during the 90-day post-arrival period. This translates into an additional cost of \$273.09 per refugee to support refugees with this specific condition. Similarly, mobility issues require an additional average investment of 9.23 hours and 85.53 miles per refugee during the 90-day post-arrival period, resulting in an additional \$315.85 per refugee for refugees resettled with these kinds of conditions.
- Emergency hospitalizations require a significant amount of investment from resettlement affiliates. Emergency hospitalizations, or hospitalizations that occur within the first two weeks of arrival, require an average investment of 19.81 hours and 139.25 miles per refugee by resettlement affiliates during the 90-day post-arrival period. This translates into an added investment of \$652.92 per refugee.

Conclusions:

- On average, resettlement affiliates in this study invested more resources providing services for refugees with mental illness and mobility issues than any other conditions.
- Emergency hospitalizations, or hospitalizations that occur within the first two weeks of arrival, require significant support from resettlement affiliates.
- Resettlement affiliates do not have consistent or dependable funding mechanisms to support refugees with these specific conditions.

Flow of Refugee Health Information

Findings:

- Pre-arrival information on specific medical conditions is critical in determining whether a medically vulnerable refugee will continue to need assistance from the resettlement affiliate in order to manage their medical needs after the 90-day R&P period ends.
- Resettlement affiliate staff expressed a desire to understand how specific errors in pre-arrival information were addressed by the Bureau of Population, Refugees, and Migration (PRM), U.S. Department of State and to improve the system that supplies pre-arrival information about a refugee to the resettlement affiliate.

Conclusions:

- Incomplete or inaccurate pre-arrival medical information creates an additional challenge for resettlement affiliates engaged in pre-arrival planning. This is because it limits affiliates' ability to make appropriate arrangements for the management of these conditions in advance of arrival.
- Resettlement also suffers when medical information is not shared appropriately within resettlement affiliate offices, as well as between resettlement staff, state refugee officials (when appropriate) and medical service providers. Notification of local medical service providers and health officials on the medical status of a refugee, and ensuring this information is accurate, are critical components of a resettlement community's capacity to build relationships that will help provide appropriate health services to refugees.
- Information should be shared in a timely manner, appropriate to a refugee's medical needs (may be pre-assurance, pre-arrival, or post-arrival), and in accordance with recommended timeframes found in biodata and other medical forms, in order to ensure quick access to medical services.

Refugee Access to Medication

Findings:

- Medical Case Managers (MCMs) reported that refugees sometimes arrive without critical medications, having given them away prior to travel, and assuming that either replacement pharmaceuticals would be available upon arrival or that traveling with pharmaceuticals was not allowed.
- Resettlement affiliates reported that assisting refugees in accessing essential medication post-arrival often requires additional resettlement staff time. Resettlement affiliates may also need to pay for medication in situations where a lag in accessing health coverage prevents refugees from acquiring medication.

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- Texas, one of the five research sites, limits recipients to three prescriptions per month. Many refugees with severe medical conditions require more than three prescriptions to manage their medical needs.
 - A study conducted in 2012 identified 16 states that put some sort of limit on the number of prescription medications that an individual could receive through Medicaid.

Conclusions:

- For medically vulnerable refugees in certain states, there are obstacles to accessing essential medications. These obstacles can result in medical conditions being untreated, and lack of compliance with medical care providers' treatment protocols. Resettlement affiliates draw upon staff and financial resources to overcome these obstacles.
- Obstacles include insufficient orientation to managing prescriptions, both overseas and domestically, and state-specific Medicaid policies regarding medication coverage and payment.
- Refugees in 16 states may face prescription medication limits imposed through Medicaid policy, impacting their ability to address medical needs.

AFFORDABLE CARE ACT (ACA) AND MEDICAID EXPANSION

Effect of the ACA

Findings:

- State policies related to the ACA are still in a transitional phase and state officials remain actively involved in managing this transition.
- Healthcare Navigator programs are useful for informing refugee populations on options for health insurance coverage and providing education and orientation regarding the enrollment process.
- The ACA promotes Healthcare Navigator programs through grant funding. A Health Navigator program in Boise, ID, showed a dramatic decrease in missed medical appointments after the engagement of Health Advisors via this program.

Conclusions:

- Given the current status of the implementation of the ACA, it is not possible to measure the full impact of the new law on the resettlement of medically vulnerable refugees.
- In resettlement areas (counties) with large ethnic communities (10% of total population) advocacy and outreach should be conducted by resettlement affiliates to ensure that medical interpretation services are provided by federally funded healthcare providers.
- Healthcare Navigator services should be pursued by resettlement affiliates and community stakeholders to ensure that refugee populations have the information needed to access and utilize health insurance programs. These services include linking refugees

to appropriate health insurance options and providing education on appropriately utilizing this programming.

Impact of Medicaid Expansion

Findings:

- Refugees who are ineligible for Medicaid and do not live in a Medicaid expansion state are still able to access health coverage through Refugee Medical Assistance (RMA) during their first eight months post-arrival.
- If a refugee is no longer eligible for RMA (eight months post-arrival) and s/he is not able to access health insurance through the health insurance marketplace, through an employer, or by purchasing private insurance, the state of residency plays a large role in whether health coverage is accessible.
- If a refugee is resettled in one of the 24 states not expanding Medicaid, s/he has a much smaller chance of gaining health coverage via Medicaid in the post-RMA period due to restrictive eligibility criteria in those states. Note that at the time of this study, there were 24 states without expanded Medicaid. This number remains fluid, and in January 2015 (outside the confines of this report), Pennsylvania will join the ranks of the states that have expanded Medicaid, lowering the number of non-participating states to 23.
- Benefits of Medicaid expansion include continuity of coverage for refugees beyond the eight-month period, greater flexibility in programming, and a simplification in billing medical costs.
- State Refugee Coordinators (SRCs) interviewed for this study, who operate in the two Medicaid expansion states, report that they expect their RMA costs to drop significantly, if they are not eliminated entirely.
- Technical glitches in some new state health exchanges (including Minnesota) have prevented refugees from enrolling in expanded Medicaid in a timely manner.
- In cases where a refugee is unable to meet eligibility criteria to access affordable insurance options after the initial eight-month period through subsidies or traditional Medicaid in non-expansion states, resettlement affiliates try to link refugees with alternative federally or locally funded healthcare services such as free or low-cost clinics or federally Qualified Health Centers (FQHCs) to ensure that critical health services are accessible. This can occur either during the R&P period or after.

Conclusions:

- Adoption of Medicaid expansion has allowed participating states to enroll most refugees in state Medicaid programs in lieu of RMA.
- New Medicaid expansion states that do not account for refugees in the planning and implementation of healthcare exchanges may face issues when enrolling refugees into Medicaid.

- Because of the limitations posed by the length of the study it was not possible to track refugees' insurance status after the initial eight-month RMA period.
- Refugees over 18 and under 65 years of age, with no children, and in a state without expanded Medicaid, may have difficulty meeting strict eligibility standards.

SERVICE MODELS: A COST-BENEFIT ANALYSIS

Findings:

- The models examined can be placed in one of three categories:
 1. **Community-Based Collaborative Model:** This model serves the entire local resettlement community in which it operates, and functions with a centralized structure dedicated to the medical case management of medically vulnerable refugees across resettlement affiliates. The cost of this model is shared across affiliates, as are the benefits of sharing a coordination function across affiliates. Considering that the costs of programs that serve the communities utilizing this approach are moderate and that the client base is larger, these models (currently operational in St. Paul, Minnesota and Philadelphia, Pennsylvania) are more cost effective than the other models studied. The other models, however, are effective for the provision of medical services and referrals for their refugee populations.
 2. **Independent Center Model:** This model is managed by an individual agency in a multi-affiliate resettlement community. Affiliates operating under this model function independently of each other. All medical case management services occur within the confines of the independent affiliates. Costs are not shared between sites in these locations. The two affiliates considered operating within the confines of this model are those located in Boston, Massachusetts and Houston, Texas.
 3. **Single Agency Model:** This model is found in settings that contain a relatively small resettlement community consisting of a single affiliate and healthcare provider. In these type of cases, which can be found in Twin Falls, Idaho, the size of the refugee community does not lend itself to centralized coordination. This also precludes the possibility of collaboration between resettlement affiliates.
- Each of the five research sites works within different models to manage the additional challenge of providing medical services to medically vulnerable refugees. These models are supported by a variety of funding mechanisms, which vary significantly between sites. Funding for the positions that support these models are from private organizations, R&P, local grants (such as City of Boston's Community Block Grants), and various Office of Refugee Resettlement (ORR) grant programs. Funding sources are time-limited and sustainability of programming and their funding sources requires regular and continued attention by resettlement affiliate personnel.

- Models used at sites are adapted to existing local infrastructure, including the region's population density, number of resettlement affiliates present, engagement of state officials, and level of participation of Community Based Organizations (CBOs) and Mutual Assistance Associations (MAAs).
 - In **Boston**, services are provided by numerous stakeholders with little inter-organizational coordination, but with a concentration on robust provision of mental health services at the International Institute of New England (IINE). The model employed by this site uses dedicated medical case management, with associated personnel costs of \$105,651 (1.75 FTEs).
 - In **Houston**, YMCA International Services centralizes the management of care within the affiliate, with little engagement by other local stakeholders. The model employed by this site uses dedicated medical case management personnel, with associated personnel costs of \$120,744 (2.0 FTEs).
 - In **Philadelphia**, The Nationalities Services Center (NSC) and the Philadelphia Refugee Health Collaborative (PRHC) work collaboratively with other local resettlement affiliates, but with little engagement from the SRC and the State Refugee Health Coordinator (SRHC). The model employed by this site uses dedicated medical case management, with associated personnel costs of \$102,558 (2.5 FTEs).
 - In **St. Paul**, the International Institute of Minnesota (IIMN) and other local resettlement affiliates work closely with the Minnesota Department of Health (MDH) to develop a medical services management plan with a strong focus on pre-arrival planning. The model employed by this site uses dedicated medical case management, with associated personnel costs of \$90,558 (1.5 FTEs).
 - In **Twin Falls**, the College of Southern Idaho (CSI) is the only resettlement affiliate within that community, and all medical case management is managed by that affiliate. The model employed by this site uses dedicated medical case management, with associated personnel costs of \$60,372 (1.0 FTEs).
- Two of the sites (Boston, Massachusetts and Twin Falls, Idaho) considered in this study are located in Wilson-Fish states. The affiliate receiving Wilson-Fish funds may prioritize their allocation to address the special needs of medically vulnerable refugees. Funds utilized in Wilson-Fish states serve a roughly equivalent purpose to Preferred Communities (PC) funds available in non-Wilson-Fish states.
- The Wilson-Fish program does not provide dedicated support for medical case management for medically vulnerable refugees, although it does provide additional case management support that can be utilized to support medical case management at the discretion of the administering affiliate. ORR is currently implementing regulations to



ensure that no state can accept both PC and Wilson-Fish funding for extended case management.

Conclusions:

- Communities should consider many variables when determining which model would be most appropriate for the provision of medical case management. These variables include the size of the resettlement population, the engagement of other local community organizations, including CBOs, MAAs, and other resettlement affiliates, the relative level of engagement of the SRC and SRHC, and available funding from various sources.
- In locations where there are multiple resettlement affiliates and robust state engagement, the model practiced in Minnesota’s Twin Cities region is efficient for the provision of services to medically vulnerable refugees. In locations where there is limited state-level engagement, the PRHC is a robust model to ensure that refugees receive needed care in an efficient manner.
- In all localities, resettlement affiliate staff can assist refugees in acquiring emergency medical services before the RHA or initiation of primary care.
- Findings show that the varying administrative procedures related to Wilson-Fish do not affect medical case management of arriving refugees. A refugee resettled in a Wilson-Fish state will receive the same medical insurance coverage as one resettled in non-Wilson-Fish state.

Summary of Policy Recommendations

Challenges of Providing Care

COST

1. PRM should increase the administrative component of the per capita funding for a subset of medically vulnerable cases identified pre-arrival, on a per-capita basis. The conditions to be considered for additional per capita assistance should include mental health, cases with mobility issues and those requiring hospitalization within two weeks of arrival, as these require a level of investment far exceeding that of an average medically vulnerable case. This study found those conditions and situations to cost on average an additional \$273.09, \$315.85, and \$652.92 respectively over the 90-day post-arrival period. In addition, ORR should continue to support extended case management for medical cases (including those with conditions identified above) through the PC and Wilson-Fish programs.

IMPACT OF MEDICAL CONDITIONS

2. The Centers for Disease Control and Prevention (CDC) should convene a working group and review multiple mental health assessment tools (such as the RHS-15), selecting the most appropriate tool for post-arrival mental health screening. The CDC mental health guidelines currently used should be assessed by this working group. The goal of this assessment would be to determine whether greater guidance could be provided to states and clinicians regarding the provision of mental health services to refugees.

FLOW OF REFUGEE HEALTH INFORMATION

3. Resettlement affiliates should continue to develop and improve information sharing and coordination related to Significant Medical Condition (SMC) and other medical forms, especially during the pre-arrival planning phase of resettlement of refugees with severe medical conditions. The recommendations in the biodata concerning when treatment should be received, as well as other medical forms, should be utilized to determine when medical information should be shared with medical service providers and local health officials. Information should be shared, where applicable, through secure, electronic channels.

REFUGEE ACCESS TO MEDICATION

4. Where possible, PRM, International Organization for Migration (IOM), CDC, UNHCR, and other pertinent agencies, should coordinate to provide two months' worth of critical medications in a sealed package to refugees immediately prior to departure.

5. PRM should reinforce orientation on medication and prescription management with Resettlement Support Centers (RSCs) overseas by incorporating the topic into Cultural Orientation where offered. National resettlement agencies should promote adoption of best practices for prescriptions management post-arrival and reinforce it through Community Orientation delivery across affiliate sites.

Affordable Care Act (ACA) and Medicaid Expansion

EFFECT OF THE ACA

6. Resettlement affiliates should participate in Health Navigator and Health Advisor programs by engaging in partnerships with organizations that provide these services, accessing existing programs, or seeking grant opportunities.
7. The ACA requires robust and professional medical interpretation services when a county has a particular language group represented at levels higher than 10% of the total population of the county. SRCs and resettlement affiliates should identify local communities who meet eligibility requirements and advocate to ensure established ethnic communities receive mandated language support. These advocacy efforts should include educating federally-assisted local medical service providers in regards to their obligation to provide accordant access to programs and activities for limited English proficiency individuals, as required by title VI of the Civil Rights Act.

IMPACT OF MEDICAID EXPANSION

8. Resettlement affiliates, SRCs and SRHCs should strengthen partnerships to address any possible gap in coverage by focusing on federal and local health options in locations without Medicaid expansion.
9. In states pursuing Medicaid expansion, SRCs and SRHCs should incorporate refugees' unique circumstances into the planning and implementation of new policy.

Service Models: A Cost-Benefit Analysis

MODEL COST-BENEFIT ANALYSIS

10. Use external organizations to support resettlement services. SRCs and resettlement affiliates should identify local MAAs and CBOs and build partnerships with them to promote successful resettlement of the medically vulnerable.
11. Build a collaborative model. Three categories of service model were identified during this study. Resettlement affiliates should consider the models presented and determine which have characteristics or functions that would be appropriate for their site. In cases where characteristics of a collaborative community-based model are appropriate, local

resettlement stakeholders should build partnerships to manage the implementation of a centralized coordination structure.

Methodology

This report was developed using the collection and analysis of qualitative and quantitative data. The research was implemented at five resettlement sites: Boston, Massachusetts; Houston, Texas; Philadelphia, Pennsylvania; St. Paul, Minnesota; and Twin Falls, Idaho. The data gathered over the course of this study was captured via a survey administered at the five resettlement sites and extensive structured interviews with local refugee officials and other local resettlement affiliates.

The quantitative aspect of the research was implemented to capture information on medically vulnerable refugees and the impact that specific medical conditions have on the resettlement of these refugees. The qualitative data captured information from resettlement affiliates in each city as well as from SRCs, and SRHCs, and was gathered to contextualize the quantitative data. All data gathered pertained to costs and resources utilized in the case management of medically vulnerable refugees, community engagement, coordination of care, the overall impact of providing these services, and related variables that could affect long-term access to medical services.

Timeframe

The **timeframe of this study** was from September 1st 2013 through December 30th, 2014. The **eligibility timeframe** for arriving refugees to be included in the quantitative data collection portion of this study ran from January 6th, 2014 to April 21st, 2014. The quantitative **data-gathering period** for the study occurred from January 6th 2014 to July 21st, 2014. All eligible refugees resettled by USCRI affiliates in each research location were monitored for the first 90 days post-arrival, the full R&P period.

Eligibility and Definitions

Each data-gathering site, USCRI affiliates in each research location, was responsible for identifying eligible refugees for the study.

This study utilized an **assistance-based approach** for the identification of refugees so as to capture data on refugees with study-eligible medical conditions. The assistance-based approach considered medical case management services that fell outside the standard assistance involved with ensuring timely access to initial refugee health assessments. This approach ensured refugees met the eligibility requirements identified for the study.

Identification of eligible refugees occurred either pre-arrival or post-arrival. Affiliates identified refugees, pre-arrival, based on notification from the national headquarters. Cases were also identified post-arrival based on resettlement affiliate and medical providers' identification of medical needs.

Complex Medical Conditions

Eligible refugees for inclusion in this study were those who required one or more of the following services:

1. Appointments with medical care providers for chronic or ongoing medical needs and related coordination (not including initial refugee medical screening and routine follow-up);
2. Acquisition of needed medical supplies such as wheelchairs and home-based care items;
3. Management of housing needs, such as the identification of handicap accessible housing;
4. Planning for the management of a medical condition.

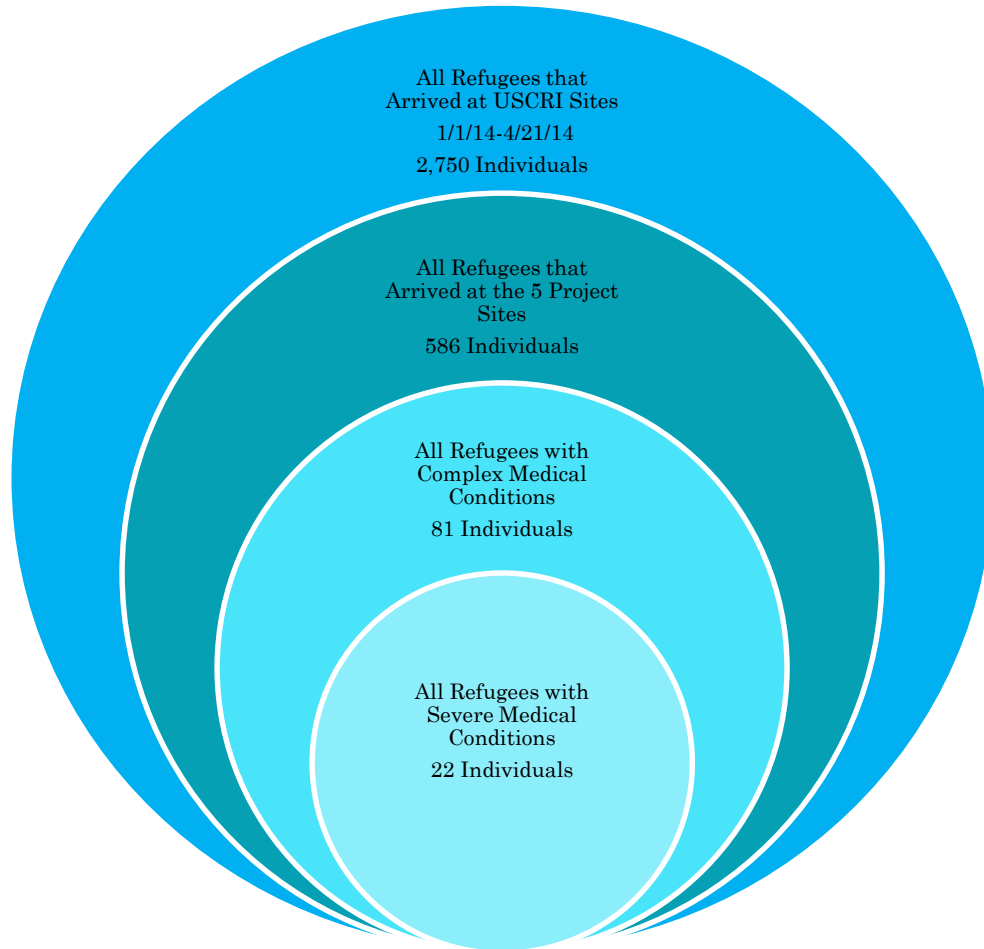
Severe Medical Conditions

A subset of the criteria was created in an effort to identify the most severe cases among those eligible for the study. Refugees who meet one or more of the following criteria were classified as having a **severe medical** condition:

1. Require urgent/lifesaving medical interventions;
2. Require hospitalization upon arrival and continued care;
3. Require assistance for daily living activities such as refugees with physical disabilities (amputation, paralysis, cerebral palsy, etc.);
4. Mental health issues such as schizophrenia, bi-polar disorder and/or history of attempted suicide;
5. High-risk pregnancy;
6. Congenital heart defect requiring surgery;
7. Chronic conditions such as cancer, renal failure, and blood disorders.

The relationship between severe and complex medical conditions can be seen visually in Figure 1.


Figure 1: USCRI Refugee Arrivals and Study Participants at the Five Study Locations



Survey and Guide

A survey was developed to capture data on medically vulnerable refugees who required additional assistance post-arrival. The participating resettlement sites provided the data that pertains to the health needs of incoming populations and the subsequent impact on resettlement affiliates. Specifically, the survey focused on affiliate-based resources, and provided affiliate research personnel with a platform on which to record utilized local resources, including insurance coverage and the source of this coverage, and local programming designed to support refugee health services. Further, the data gathered through the use of this survey provides information on the number of refugees resettled at a given site with complex medical conditions.

USCRI convened a group of experts on refugee health issues to form an advisory committee to provide guidance on all aspects of the study, including study design, definitional issues, and current research. This group, the Refugee Medical Care Advisory Committee (RMCAC),



consisted of individuals representing international organizations, state refugee officials, representatives from resettlement agencies, and federal staff.

The survey was tested and piloted prior to the initiation of the data-gathering period. Drafts of the survey were circulated for comment to participating research sites and to members of the RMCAC. Research sites piloted various versions of the survey to test question validity and saliency. A workshop was held in December 2013 to finalize the survey. Attendees at the workshop included all research site personnel and members of the RMCAC. The finalized survey was made available for use to sites on January 6, 2014.

During the December workshop, site-based researchers were trained on the project data gathering methodology. A detailed session was conducted to ensure methodology was standardized among selected sites, and a companion guide was introduced to the group. This guide provided detailed information on every individual question within the survey. This guide can be found in **Appendix F**.

The survey was set up on an electronic platform. Sites entered data as it became available. Data management was a component of the platform selected, and it provided secure, cloud-based storage for data security. In addition to providing data security, the electronic platform allowed for real time collaboration and technical assistance, reduced the potential for communication difficulty, and allowed for a robust approach to monitoring and providing technical assistance throughout the data-gathering period of the study.

The survey questions are organized into a variety of modules based on chronological development of cases. Certain modules repeat as needed to capture all information on medical and case management services accessed in the first three months post-arrival. Survey modules include case data, demographic information, health information, treatment plan, and medical services and case management.

Sites and Partners

Five resettlement sites were selected to participate in this study. These sites were:

1. Boston, Massachusetts: Wilson-Fish state, **expanded** Medicaid coverage in 2014
 - a. Founded in 1924, IINE helps immigrants and refugees successfully integrate in New England. The state of Massachusetts is the 16th largest resettlement state and where 2.34% of the incoming refugee population was resettled over the past six years.

2. Houston, Texas: **did not expand** Medicaid coverage in 2014
 - a. YMCA International Services started serving refugees in 1978 and has resettled refugees from more than 40 countries. The state of Texas is the 2nd largest resettlement state and where 10.27% of the incoming refugee population over the past six years was resettled.

3. Philadelphia, Pennsylvania: **did not expand** Medicaid coverage in 2014
 - a. NSC has provided services to refugees and immigrants since 1921. The state of Pennsylvania is the 10th largest resettlement state and where 3.58% of the incoming refugee population was resettled over the past six years.

4. St. Paul, Minnesota: **expanded** Medicaid coverage in 2014
 - a. IIMN has provided services to refugees and immigrants since 1919. The state of Minnesota is the 12th largest resettlement state and where 2.98% of the incoming refugee population over the past six years was resettled.

5. Twin Falls, Idaho: Wilson-Fish state, **did not expand** Medicaid coverage in 2014
 - a. CSI has been in existence since 1978 and involved in the USCRI R&P program since its early inception. The state of Idaho is the 23rd largest resettlement state and where 1.47 % of the incoming refugee population over the past six years was resettled.

These sites were selected for their diversity of health programming. Factors considered in the development of this site list include overall refugee arrival numbers into the state, the state's process of administering the refugee program (and specifically whether it is a Wilson-Fish state), plans to expand Medicaid, and the current capability of the affiliate to provide medical case management to newly arrived refugees.

Structured Interviews

A variety of structured interviews were conducted with stakeholders located in the research sites' operating areas. For each participating city, interviews were conducted with state refugee officials, local officials (if applicable), and representatives from surrounding resettlement affiliates, who were also engaged in the resettlement of medically vulnerable refugees. The purpose of these interviews was to gain a better understanding of local factors that might play a role in affiliates' abilities to facilitate appropriate treatment and promote successful resettlement. State refugee officials included the SRC and SRHC. Resettlement affiliate personnel who were interviewed represented Church World Service (CWS), Episcopal Migration Ministries (EMM), World Relief (WR), Ethiopian Community Development Council (ECDC), Hebrew Immigrant

Aid Society (HIAS), Lutheran Immigration and Refugee Services (LIRS), USCRI and the U.S. Conference of Catholic Bishops (USCCB). A full list of questions administered over the course of the interviews are in **Appendices H, I, and J** of this report.

A total of 31 interviews were conducted over the course of this study. Of the 31 interviews conducted, 19 were with resettlement affiliate staff and 12 were with state and local officials.

Interview questions focused on specifics of the model used in each city to provide medical services, how costs for care were managed, the role of state policy in the management of those costs, and the process of coordination of care with local providers. Further, questions were asked regarding coordination and collaboration with local resettlement affiliates and health centers, potential barriers to acquisition of care, and program continuity.

Confidentiality

This project was developed to maintain strict confidentiality of data. Over the course of this study, no identifying information was gathered on the refugees for whom data was considered. Partners at research sites were trained on the submission of data without identifying information during the December workshop, and USCRI national headquarters did not receive any identifying information over the course of the study.

Data and Research Limitations

The quantitative data-gathering period was completed after every refugee eligible for the study had reached their 90th day in the U.S. The data set includes every medical appointment for every refugee in the data set, and resettlement affiliate costs associated with each medical visit outside of the standard health assessments. Although the survey included questions on monetary values associated with each medical service (whether it be an appointment or hospitalization), due to concerns regarding the ability to access this information, queries on time spent and miles driven per refugee were also included as proxies for monetary costs. Costs associated with medical services are not shared with resettlement affiliate staff. Individual medical providers directly bill Medicaid or RMA based on the client's insurance coverage. At the end of the data-gathering period, information on 314 medical appointments had been gathered.

National RMA costs and changes to those costs associated with the ACA were also explored over the course of this study. In an effort to gain dollar figures for gross RMA expenditures, USCRI contacted ORR and the Centers for Medicare and Medicaid Services (CMS), both within the Department of Health and Human Services. However, neither agency tracks this data, nor was any other agency identified as being responsible for tracking this data. However, USCRI did

gain information on enrollment by state for the five focal states of this study from ORR. That data and additional information on RMA is presented in **Appendix B**.

At the conclusion of the data-gathering period, USCRI conducted an analysis of the data set. Data showed that the distribution of cases across sites was randomized in a manner that did not lend to cross-site analysis. For example, in most instances specific medical conditions were clustered at the individual sites. Philadelphia, for example, had a larger cohort of refugees with complex medical conditions than other sites in the study. However, the majority of the medical conditions were Tuberculosis (TB) cases, which require relatively little resettlement affiliate assistance. Conversely, the St. Paul research site resettled many fewer study-eligible refugees, but the medical conditions associated with those refugees were severe and required much higher investment from the resettlement affiliate. Thus, although the cases flowed in a randomized manner, the variability in the types of cases resettled across sites did not allow for direct comparison of practices across sites.

Further, social factors impacted the ability to compare services for identical conditions across sites. Treatments for identical conditions monitored in the database differed significantly as a result of the specific situations of the individual refugees. To illustrate this point, consider the following scenario:

Two refugees arrived at different research sites with the identical condition of valvular heart disease, and both required surgery. By the end of the monitoring period, the first refugee had 15 medical services, including open-heart surgery and prescriptions for numerous medications. In contrast, the second refugee had received two medical services, neither of which included specialist services or medication. Resettlement staff working with the second refugee stated the lack of services acquired by this refugee was related to his family situation. He considered his wife to be in much greater need of medical care for her multiple conditions, which included mobility issues and pain related to degenerative disc, uterine fibroids, hypertension and depression. As primary caregiver to his wife, he felt unable to invest the time required to address his own health concerns. At the end of this study, caseworkers were still endeavoring to have him initiate treatment.

Models illustrating the process of resettlement and the provision of medical services were developed for each of the five sites participating in the study. A cost-benefit analysis of each model is presented in the report. The data to develop this section of the report was based on more than 30 interviews with local stakeholders in refugee resettlement, including all locally-based resettlement affiliates.

Introduction

Overview and Purpose

This study of Domestic Capacity to Provide Medical Care for Vulnerable Refugees assesses domestic capacity to care for medically vulnerable refugees and applies research findings to policy recommendations and best practices. In the assessment of domestic capacity, this study considers national and state level changes to health insurance programming that affects refugees' ability to access healthcare, changes in accessibility related to the Affordable Care Act, an assessment of the challenges placed on resettlement affiliates in the resettlement of medically vulnerable refugees, and strategies for the management of these challenges.

The health status of refugees can vary based on numerous factors, including country of origin, length of time spent as a refugee prior to resettlement, and the residency situation of the refugee. Despite these varying obstacles, a unifying characteristic for refugee populations is the difficulty in obtaining healthcare services pre-arrival. In a 2011 report to Congress, ORR noted an increasing number of medically vulnerable refugees due to limited access to medical care and poor nutrition pre-arrival (Bruno). Many refugees arrive here with health concerns because of poor nutrition from living in refugee camps or other unstable conditions for protracted periods of time. As a result, medical conditions can significantly affect self-sufficiency for refugees who are not properly treated pre-arrival.

It is of critical importance to ensure that medically vulnerable refugees arriving in the United States are able to access health care services upon resettlement. Successful resettlement is linked to the capacity to achieve self-sufficiency, and the inability to function as a result of health concerns is a solid barrier to the acquisition of self-sufficiency. Resettlement affiliates must be prepared to assist new arrivals with the provision of medical services and guide them through their individual state-specific programming options. This process of identifying appropriate medical services and connecting those services to refugees is complicated by the heavy dependence of this population on language and cultural services, particularly medical interpretation services and health orientation needs.

USCRI explored the various models being used by resettlement sites and assessed their effectiveness in resettling medically vulnerable refugees. The project developed assessment tools to track the experience of medically vulnerable refugees, and provided guidance on reducing the impact of financial costs associated with the resettlement of medically vulnerable refugees on resettlement communities.

Refugees who are resettled in the United States face many challenges that are part of building their lives in a new country such as acclimation to a new culture, finding employment, and navigating the various governmental, social, and economic systems that exist in the U.S. Some refugees arrive with medical conditions that require additional support from resettlement affiliates. This support includes coordinating and assisting with access to healthcare, as well as auxiliary services such as acquiring accessible housing, transportation, and benefits.

Stakeholders in the resettlement process regularly discuss the difficulties of resettling medically vulnerable refugees, and the added costs associated with the resettlement of these cases; however, these discussions are anecdotal, and evidence-based research in this field is extremely limited. Through this study, USCRI provides research findings based on qualitative and quantitative data that are used to support policy recommendations.

Case Study

A five year-old refugee from Somalia was resettled in Minnesota during the course of this project. This client arrived with two severe conditions which required immediate treatment, acquisition of handicap-accessible housing, and procurement of medical equipment. Significant affiliate-based family support services were also required. Robust pre-arrival planning and significant community support promoted efficient management of these severe conditions.

The client was resettled in the U.S. with his mother and his two year-old sister. While still in the refugee camp, he was diagnosed with encephalocele (a neural tube defect) and a cleft palate. He was resettled in Minnesota in close proximity to numerous large healthcare facilities, all of which regularly provide healthcare services to members of the refugee community. As a result of his medical condition, he required a wheelchair for mobility as well as accessible housing.

This case had no U.S. tie, meaning there was no family or friend already in the U.S. to be resettled near. The family was very dependent upon the resettlement affiliate to provide support and to help manage the stresses placed on family members supporting this small child throughout this process. Resettlement staff noted that the mother was struggling to manage the needs of her toddler while attempting to spend as much time as possible at her son's side at the hospital and during medical appointments. Further, medical appointments were disrupted with the attendance of the toddler. The sibling was eventually placed in childcare, although the burden of childcare in the intervening period was with the resettlement affiliate and its staff, adding to the workload of resettlement staff. Given the medical complexity of the case and the client's extensive needs, it was difficult for the mother and resettlement staff to devote attention to both the client and his little sister.

At the time of the case's arrival other family members were progressing through the resettlement process and undergoing final medical and security clearances. Assurances were submitted to the Refugee Processing Center at the end of July 2014 for the father, other siblings, and an aunt.

Over the three-month monitoring period, this client had 23 medical appointments, several of which included surgeries and hospitalizations. The Medical Case Manager at the resettlement affiliate accompanied the client and his family to the majority of medical appointments. As is the situation with most severe cases, the resettlement affiliate dedicated a significant amount of resources to the management of this case, including 279 miles of transportation and over 36 hours of dedicated medical case management. It is important to note that these numbers reflect resettlement affiliate investment for this individual case only for the first three months post-arrival, and that engagement of the resettlement affiliate is ongoing beyond the three-month scope of this project.

A significant amount of pre-arrival planning was conducted in the weeks prior to resettlement. Healthcare providers from the community offered their services pro-bono and worked closely with resettlement affiliate case managers to develop the medical plan based on descriptions of the conditions on the SMC, medical and biodata forms. At resettlement the plan was well-established, and the client was able to initiate medical treatment immediately upon arrival, and visited a specialist within one day of arrival in the U.S.

The strength of the partnership between the resettlement affiliate and the healthcare providers contributed significantly to the successful management of the medical needs of this client. Resettlement affiliate staff reports that the efficiency and care given to this case was supported through constant communication between staff at the hospital and affiliate caseworkers and staff.

Care for this client is ongoing, but resettlement staff continues to work towards case self-sufficiency. In addition to continued management of medical issues, the resettlement staff are also working on ensuring the client is enrolled in school, assisting the mother to enroll her daughter in an early childhood education program, and helping her to identify educational opportunities for herself.

Research Questions

This research proposes to answer the following eight research questions in regard to resettling refugees with severe medical conditions:

1. Can refugees access care?

Yes, they are able to access care. All refugees entering the United States are provided with health insurance of varying types depending on locality of resettlement. Resettlement affiliates facilitate the acquisition of health services and educate refugees on local processes for acquisition of services. Medical service providers that accept Medicaid and RMA can be found in all locations. Refugees are able to access primary care and specialists at all research sites included in the study. In Twin Falls, Idaho, and similar rural areas, specialist care may only be found in more densely populated areas such as Boise, Idaho. In these cases, resettlement staff coordinate transportation for refugees.

All income eligible refugees will be able to access health insurance through RMA in the first eight months post-arrival regardless of the locality of resettlement, although thresholds of income eligibility vary based on state Medicaid policy. An insurance coverage gap does exist in states without Medicaid expansion for those refugees who are not able to access health insurance through employers or other means for adults between the ages of 19 and 64 after the initial eight months post-arrival. Refugees resettled nationally are able to access low-cost options and subsidies available through the health marketplaces via the ACA. In cases where refugees are resettled in states without Medicaid expansion and are not able to afford low-cost alternatives, insurance might remain inaccessible, but refugees are still able to access medical services via federally and locally funded health clinics.

Once a client's prescriptions are covered, they are generally able to access the required medications. One exception to this is in Texas, where the state Medicaid program places a limit of three (3) on the number of prescriptions covered each month (similar policies exist in 15 additional states). It is important to note that this is specifically an issue for those refugees who are over 19 and under 65, and enrolled in RMA. For those clients who are resettled in Texas and who have conditions that require four or more medications, this limitation leads the refugee to have to face challenging decisions regarding the importance of their various medications in the treatment of their health conditions. Data gathered from the clients in the database show that 18% of total clients resettled in Houston over the course of this study required four or more medications. Resettlement staff in Houston indicate that it is common practice for clients to prioritize medications and defer acquisition of those medications considered to be less critical. Of the clients requiring more than three medications in Houston, none suffered detrimental effects from this delay; however, this does not negate the fact that this policy can be problematic in the implementation of medical treatment plans.

2. Who pays for it?

RMA (federal government) and Medicaid (state and federal governments) cover insurance costs for refugees immediately post-arrival, although specific pay streams vary based on local policies.

For the majority of the refugees in this study, medical services were paid through the RMA program with the exception of Minnesota, which enrolls qualified refugees directly into the state Medicaid program. In Massachusetts, RMA is administered through the Massachusetts Office of Medicaid in partnership with the Massachusetts Office of Refugees and Immigrants (MORI). There is a similar system in Idaho in which RMA funds are distributed through the Mountain States Group. This programmatic variance in Massachusetts and Idaho is related to the fact that these are Wilson-Fish programs.

3. What are the costs?

Many variables were considered in the evaluation of cost. Survey-based queries on costs of care resulted in limited information on dollar costs for the treatment of individual clients. Clients do not routinely receive information on the costs of the treatments and appointments, and were unable to provide information in the database on these costs. Similarly, resettlement affiliate case managers do not routinely receive this information.

In addition to exploring monetary investment in care, costs were also examined considering various proxies, specifically resettlement affiliate investment in case management hours investment per client and miles driven to ensure that clients were able to access medical services.

Data shows additional average labor and mileage costs associated with the resettlement of medically vulnerable refugees during the 90-day post-arrival period range from \$164.19 per refugee with complex medical conditions, to \$258.95 per refugee with severe medical conditions, based on standard operating costs. Certain situations were found to be the most costly, specifically the management of mental health conditions (\$273.09 per refugee), mobility issues (\$315.85 per refugee), and emergency hospitalizations (\$652.92 per refugee).

4. How do costs and care vary by locality?

USCRI conducted structured interviews with stakeholders operating in each of the focus resettlement communities to develop detailed models on the provision of health services to refugees in the three months post-arrival. Although sites had functionally different models, refugees did receive specialized medical services at all sites, and proxy costs show that regardless of the process through which those services were provided, dedicated hours and miles were elevated above the costs associated with the resettlement of non-medically vulnerable refugees. Further, this study describes the breakdown of each resettlement affiliates' full-time employees (FTEs) devoted to the management of refugees' medical needs. This breakdown shows that each site has a different structure in terms of the number of FTEs, the responsibilities of those FTEs, and the methods through which those positions are funded. These positions are often dependent on the acquisition of federal grants, private donations and local funding streams.

Survey-based data shows great variability in resettlement patterns as pertaining to specific medical conditions. In order to assess how care varies by locality, consistency in conditions across sites is necessary. Upon analysis of the data set, however, findings indicate that conditions were clustered at the various sites, so that severe cases were not uniformly spread throughout the dataset. To illustrate, findings show a larger proportion of TB cases among those resettled in Philadelphia, which requires a far lower rate of engagement (or costs) by resettlement affiliates, as compared with the cases that were resettled in St. Paul, which required a much higher rate of affiliate engagement. An analysis of historical data on arrivals since 2011 shows that the resettlement patterns of medical cases resettled are completely random, and although this study shows a strong pattern in resettlement of severe cases, this is not standard and is only present in this specific data set.

5. What is the responsibility and impact of providing care?

The responsibility of care for the first three months post-arrival is primarily on the resettlement affiliate, the community in which the refugee is resettled, and local medical service providers. Coordination of health screenings, acquisition of accessible housing, travel to medical appointments, acquisition or assurance of medical interpretation, and orientation for the refugee concerning various medical systems are all common services performed by resettlement affiliate for medically vulnerable refugees. Survey data shows that the impact that medical conditions have on resettlement is reduced by the participation of a U.S. tie, the assistance of a MAA or CBO, proactive, culturally and linguistically fluent local health care providers, and other programs unique to the location of resettlement. None of the above avenues of assistance are guaranteed to the resettlement affiliate and cannot be depended on in the provision of case management services in all localities. Medical service providers and state health departments are the primary organizations that may conduct RHAs. While RHAs are not medical care, they do initiate the process of refugees accessing care, especially when RHAs are conducted by primary care providers. Timely access to RHAs and medical services is important beyond addressing refugees' health, as resettlement affiliates have 30-90 days through the R&P program to link refugees to medical services and provide support.

6. How will the ACA affect care?

Once implementation of the ACA is complete, refugees will have access to more health insurance options than before the implementation of the Act. Individual states' decisions on the adoption of Medicaid expansion have the greatest impact on care for medically vulnerable refugees. As a result of the Supreme Court ruling on the ACA (June 2012), states have the option of deciding whether to implement Medicaid expansion within their own states. In 2014, 26 states plus the District of Columbia expanded their Medicaid programs. The ACA also standardized

and streamlined Medicaid eligibility across all states so that a common financial eligibility tool is utilized, Modified Adjusted Gross Income (MAGI).

Of the states considered in this study, Massachusetts and Minnesota have expanded their Medicaid program, and Idaho, Pennsylvania (this has changed since the completion of this study) and Texas have not. In those locations with expanded Medicaid, more refugees will be eligible for Medicaid immediately post-arrival, while refugees in states without expanded Medicaid may still be dependent on RMA for the first eight months post-arrival. In locations without Medicaid expansion, there may be an insurance coverage gap where a refugee is not eligible for state or federal health insurance plans (either via subsidies or employer plans) and cannot afford to purchase private insurance.

While opinions and projections of the impact of the ACA were brought up consistently in interviews with state refugee coordinators and resettlement affiliates, the ability to actually measure the impact of the ACA during the data collection period proved difficult. The majority of clients enrolled in this study had medical services paid for by RMA funds. Because this funding is available for the first eight months post-arrival, at the end of the 90-day period of study, clients' medical services were being paid for with RMA or Medicaid funds.

Minnesota was one of the states in the study directly enrolling refugees into their Medicaid program upon arrival (assuming they met the income eligibility requirements). This too was problematic to measure as Minnesota experienced extensive technical issues related to the enrollment of refugees into their Medicaid program. During the course of this study, MNsure, the new electronic health exchange system designed for health insurance enrollment, was unable to process electronic enrollments for refugees due to a technical limitation. The application being used for enrollment was not programmed to accept refugee identification numbers. The Department of Human Services in Minnesota was working closely with the State Refugee Coordinator to find workarounds to address this problem. While the lag in Medicaid enrollment in Minnesota is expected to be temporary and will be resolved, this issue prevented USCRI from conducting a valid analysis of the impact the ACA has had in the state. Without Minnesota's program as a reference point, it is difficult to compare post-ACA implementation Medicaid systems to pre-ACA systems.

In general, while the advent of the ACA does effect insurance options based on local level engagement in the Act, health care remains accessible to refugees in all locales due to the existence of state and federally funded health centers.

7. Are there strategies and models that are more effective in managing care and associated costs?

In this study USCRI analyzed the strategies and models of five research sites extensively. USCRI conducted interviews with affiliate staff members who focus on refugee health issues. USCRI also conducted interviews with each Refugee Coordinator and Refugee Health Coordinator of the state in which the resettlement affiliate operates.

The five sites described in the body of the report represent five effective models to resettle medically vulnerable refugees. These models were not simply chosen by the resettlement affiliate or state coordinator, but grew through an organic process shaped by a number of variables. These variables include the geographic location of resettlement, the size of the population in the location of resettlement, the existence of ethnic or religious communities, state policy, service provider capacity, and the social, cultural, and economic contexts of the community of resettlement.

Due to this extreme variation in the factors shaping these resettlement models, the models themselves are unique. The benefit of this is that each model is a fit for the community in which it resettles refugees, the drawback is that these models are not perfectly replicable in other locales, and if they could be replicated they may not be as effective as they are in the locale of their creation.

The models described in the body of the report fit into three main categories: Community-Based Collaborative Models, Independent Center Models, and Single Agency Models. This study recommends that in resettlement areas containing multiple resettlement affiliates, a collaborative model should be developed to serve medically vulnerable refugees.

In locations where there are multiple resettlement affiliates and robust state engagement, the model practiced in Minnesota's Twin Cities region is efficient for the provision of services to medically vulnerable refugees. In locations where there is limited state-level engagement, the PRHC is a robust model to ensure that refugees receive needed care in an efficient manner.

Further description of these models can be found in the section titled: "Service Models: A Cost-Benefit Analysis".

8. Based on findings, what are the policy recommendations?

Recommendations based on findings can be read in the "Policy Recommendations" section.

Analysis

Challenges of Providing Care

COST

Findings

Many variables were considered in the evaluation of cost. Survey-based queries on costs of care resulted in limited information on dollar costs for the direct medical treatment of individual refugees. Refugees do not routinely receive information on the costs of the treatments and appointments. Similarly, resettlement affiliate case managers do not routinely receive this information. As a result research sites were unable to enter information in the database on these costs.

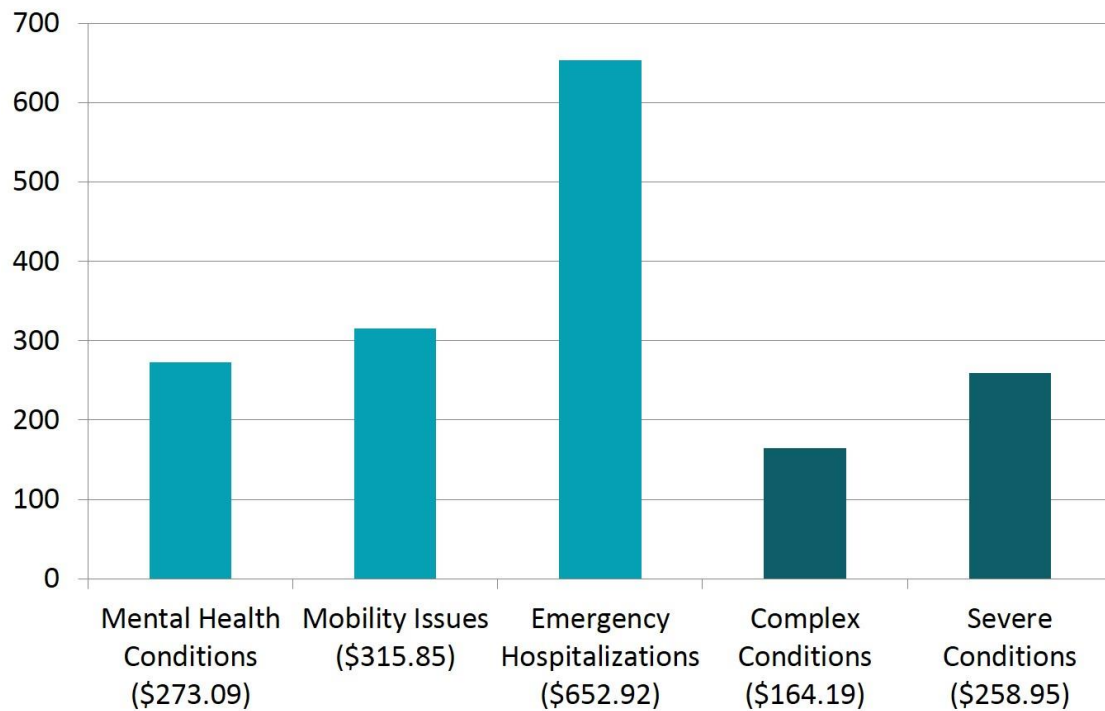
In addition to exploring direct medical service expenses, data was gathered on other cost proxies, specifically resettlement affiliate outlays for case management hours worked and miles driven, per refugee, to ensure that refugees were able to access medical services. Cost information for these proxies was gathered for every medical service conducted for every refugee arriving at the five study sites who met eligibility criteria. Medical services for eligible refugees were monitored during the R&P period, or the first 90 days post-arrival. Staff costs were calculated using standard USCRI rates for case managers and medical case managers, including salary, benefits, taxes and overhead; equaling \$60,372.00 per FTE or \$29.03/hour based on a 2,080 hour work year. Mileage costs were calculated using the Internal Revenue Services' standards for business mileage, or \$.56 per mile.

All information regarding miles and hours gathered in this study focused on those that were required for refugees outside of what was utilized for a typical healthy refugee. Thus, the hours and miles dedicated to the standard RHA were not considered in the analysis of these components. The cost (and specifically the hours worked and mileage dedicated to the provision of services) is dependent on multiple variables including, but not limited to their medical condition, their location of resettlement, their specific familial situation, the existence of a U.S. tie associated with their case, and the refugee's English language skills.

Researchers considered all affiliate actions in the case management of medically vulnerable refugees, above and beyond what is required for the majority of refugees resettled who do not have medical conditions. On average, the total database of refugees enrolled in this study required an additional 5.13 hours of case management and 27.27 miles per refugee. When only considering the most severe cases in the database, an additional 7.69 hours were needed, and 63.76 miles per refugee. The cost of resettling refugees with complex medical conditions was not

distributed evenly among all refugees or all resettlement sites. Over the course of this study 27% of medical case management services were attributed to only 4% of the study's population.

Figure 2: Per Refugee Cost by Type of Medical Condition



Utilizing the costs identified above and data from the database, the average cost per refugee resettled across all five sites translates into an additional \$164.19 investment per refugee by resettlement affiliates for refugees with complex medical conditions and \$258.95 per refugee for refugees with severe medical conditions. Further analysis of the data shows that certain conditions require much heavier investment than others. The two conditions that require the highest level of investment are mental health conditions at \$273.90 per refugee and mobility issues at \$315.85 per refugee. In addition, emergency hospitalizations require a significant amount of investment from resettlement affiliates at \$652.92 per refugee. For a more detailed breakdown on specific costs attributable to hours and mileage for these conditions, see **Figure 3**.

Figure 3: Costs of Management of Mental Health, Mobility Issues and Hospitalizations

	Mental Health	Mobility Issues	Hospitalizations¹
Average Hours of Case Management Per Case	9.19	9.23	19.81
Average Miles Driven Per Case	11.25	85.53	139.25
Total Cost	\$273.09	\$315.84	\$652.92

The Wilson-Fish program does not provide dedicated support for medical case management for medically vulnerable refugees, although it does provide additional case management support which can be utilized to support medical case management at the discretion of the administering affiliate. If the affiliate receiving these per capita funds chooses, funds can be used to prioritize the special needs of medically vulnerable refugees. These funds utilized by Wilson-Fish states serve a roughly equivalent purpose to PC funds available in non-Wilson-Fish states. ORR is currently moving to ensure that no state can accept both PC and Wilson-Fish funding for extended case management.

Conclusions

Data gathered indicates that resettlement affiliates are covering additional costs for the management of complex medical cases across the board, with a particularly high investment required for refugees with severe medical conditions. This investment is in excess of the regular R&P funding provided to resettlement affiliates for resettlement services. Although affiliates receive \$200 of discretionary funding per refugee, this funding is allocated to cover direct refugee expenses and does not cover the additional administrative and medical case management costs of resettling medically vulnerable refugees. Resettlement affiliates must therefore either find private sources of funding or use their reserves to cover these expenses.

USCRI conducted an assessment of arrivals from 2011- 2014 to examine the predictability of flow of medically vulnerable refugees to resettlement sites. For this assessment, refugees with

¹ Within two weeks of arrival

SMC forms were used as a proxy for refugees who would have possibly been included in this study. Data from this assessment portray no regularity on a quarterly basis. Historical data is available in **Appendix C**. Due to the unpredictability in arrivals during any given quarter it is difficult to say what it costs to resettle all medically vulnerable refugees arriving during a “normal” quarter. This results in unpredictable caseloads within affiliates, and case managers and medical case managers are regularly presented with caseloads that are overwhelming or light.

IMPACT OF MEDICAL CONDITIONS


Findings

An important consideration for resettlement planning is the impact of specific medical conditions on the resources of resettlement affiliates. An analysis of the most common medical conditions identified within the study population shows a small number of conditions that create a significant drain on resettlement affiliate resources. These conditions are mental health conditions and mobility issues. Further analysis also shows that hospitalizations occurring within the first two weeks of resettlement result in the single largest draw on affiliate resources.

The management of TB cases does not constitute a high cost for resettlement affiliates. Although 26% of refugees required follow up for TB, a relatively small proportion (6%) of the services provided throughout the course of the survey were dedicated to TB-related appointments. The time dedicated to the management of refugees with TB was similarly small, accounting for 6.2% of the total time dedicated to medical case management.

By isolating these conditions the study found a greater impact on the amount of time resettlement staff spend on a refugee. Those with mental illnesses or mobility issues were significantly more likely to require over 10 additional hours of case management from resettlement staff, while those classified as having severe conditions were 22.7% more likely to receive over 10 hours of case management. Not all conditions appear to lead to increased workloads for resettlement staff as those who had TB and heart conditions experienced lower than average amounts of case management than the data set when taken as a whole. Over the course of this study, research sites did not receive a single refugee with TB or a heart condition that required more than 10 hours of additional case management. The average investment per refugee required to support immediate post-arrival hospitalizations was significantly higher than the average investment in the most work-intensive individual condition.

The experience of refugees with mental illness in this study proved to be a good example of the relative impact of certain medical conditions on the challenges of providing care. Although mental health assessments are often part of the RHA, significant variability exists in the evaluation and treatment processes. By the time refugees arrive in the United States, they have been forced from their homes and communities, witnessed and experienced war and related



atrocities such as torture, and endured long periods of uncertainty about their future and the future of their loved ones. Suicides among refugee populations can occur post-arrival, and the Bhutanese population in particular has been found to have high suicide rates, at more than three times the national average in the United States. (“Suicide and Suicidal Ideation Among Bhutanese Refugees”, “An Investigation into Suicides among Bhutanese Refugees in the US 2009-2012”) In an attempt to mitigate this high suicide rate and related mental health and depression issues, ORR has created linkages with various suicide prevention services, promoted culturally competent mental health screenings, developed partnerships with mental health providers to improve access to care, and promoted mental health education. (“ORR: Emotional Wellness”) Further, ORR has stated that mental health should be part of the RHA, specifically to identify the possibility of refugees experiencing “...acute psychiatric emergencies such as suicidal and homicidal ideation.” However, this has not translated into specific action items on the ORR Domestic Screenings Guideline. (“Medical Screening Protocol for Newly Arriving Refugees”), and the narrowness of scope in defining and identifying mental health issues inadequately addresses the mental health needs of this population.

Identifying mental health issues within refugee populations is difficult for multiple reasons. Culturally, for a variety of groups resettled in the United States, mental health issues are highly stigmatized, are not addressed directly within communities, and are left unidentified and untreated. In addition to cultural barriers, the identification of services and treatment of conditions is further complicated by language barriers.

Despite these hurdles, providers working with refugee populations are developing mental health screening tools appropriate for use with refugee populations. The RHS-15, developed by Pathways to Wellness in 2011, (“Pathways to Wellness: Integrating Refugee Health and Well-Being”) draws heavily from preexisting tools², with a focus on testing efficacy and validity of individual questions while controlling for cultural and linguistic variation. It is important to note that efforts to create an effective and sensitive mental health screening tool are still ongoing, and that while the RHS-15 is being used more widely than other tools, experts in the field are still exploring other screening options. Further, experts are considering the appropriateness of conducting screenings in conjunction with RHAs, since the relatively quick turnaround on RHAs may conflict with the longer time periods associated with the appearance of mental health conditions.

Data indicates that the management of mental illness among incoming populations requires intensive medical case management by resettlement affiliates. Medical case management for

² The New Mexico Refugee Symptoms Checklist-121, The Hopkins Symptom Checklist-25, The Posttraumatic Symptom Scale-Self Report.

refugees arriving with mental illness is higher than affiliate investment for any other condition, and 30% of arriving refugees with mental illness required more than ten hours of case management in the first three months post-arrival. When considering all of the cases of mental illness captured by the survey, 50% of the cases were discovered post-arrival, 40% had received mental health services by the end of the 90-day post-arrival period, and 70% still require assistance to address their mental health needs. The table in **Appendix D** shows data gathered on this group, including type of illness, history of medical service in this area, and how the condition was identified.

This analysis of mental illness among incoming populations indicates a strong need for developing standardized mental health screenings, services and support structures related to the treatment and maintenance of those conditions. The strong need for additional mental health services is underlined by the fact that mental health conditions are often difficult to identify due to limited local mental health services and the strong stigma associated with these types of conditions. Early access to mental health screening can lead to early identification of mental health conditions requiring intensive medical support and can help connect refugees to other community resources and support services in a timely manner. Longer-term studies are needed to fully assess the impact of mental illness among resettled refugee populations and their service needs.

Conclusions

Research findings show that certain medical conditions require greater levels of investment on average from resettlement affiliates. These conditions are not currently identified as requiring higher funding levels to provide the level of support needed for medical case management. Condition-based funding would provide additional targeted support for these conditions and allow condition-specific medical case management.

Mental health assessments should be standardized to promote rigorous and consistent identification of mental illness and mental health issues. Early identification of mental health issues will result in lower costs as the need for emergency hospitalizations decreases, and experts should engage in the development of a standardized test to promote identification of mental health conditions in all arriving ethnic groups.

Immediate post-arrival hospitalizations require a disproportionate amount of investment from resettlement affiliates. The immediate hospitalizations and associated medical services tracked in the database indicate that the resettlement of individuals requiring immediate hospitalization results in an investment that is over 300% more than the cost for a refugee with a complex medical condition.

FLOW OF REFUGEE HEALTH INFORMATION

Findings

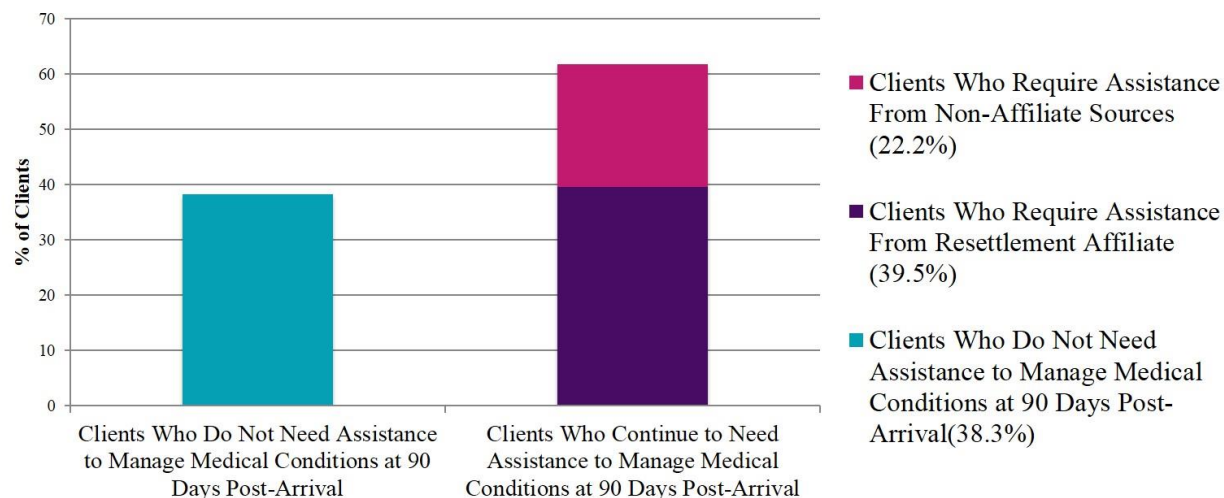
As noted in the previous section, access to accurate and complete pre-arrival information is vital for resettlement affiliates in order to provide effective and timely services. Incorrect or incomplete information can have a detrimental effect on the health of the refugee, the resources of the resettlement affiliate, and the medical service providers in the community. While there is an avenue to report inaccurate information to PRM (the Medical Anomaly Report), this is a seldom-used tool that is only utilized when unreported medical conditions seriously impact initial resettlement. Resettlement affiliates report that feedback is rarely received on reports they have submitted to their national resettlement office and in turn to PRM. Resettlement agency offices report that they do not receive feedback related to medical anomaly reports from PRM.

The underutilization of the current reporting system, and its narrow approach (to be used only when unreported medical conditions seriously impact initial resettlement), results in a limited amount of data that can be used by PRM in its efforts to identify systematic trends in information errors.

Accuracy and thoroughness in pre-arrival information continued to be a theme throughout research. In interviews conducted with all resettlement affiliates in the five research cities, researchers asked each affiliate to provide an example of an especially challenging experience resettling a medically vulnerable refugee. In describing these examples, 75% of affiliates referenced the quality of pre-arrival information as a complicating factor in providing services to the refugee. Identification of a refugee's medical condition pre-arrival is significant in determining whether the resettlement affiliate has the capacity in-house and in the community to provide services during the 90-day R&P period. It is also important in determining if the resettlement affiliate will need to continue to provide assistance to the refugee after the 90-day R&P period ends.

For refugees who did not have additional medical conditions discovered post-arrival, 39% still required assistance from the resettlement affiliate in order to manage their health conditions at the end of their first three months, as seen in **Figure 4**. Additional analysis shows that of refugees who had medical conditions discovered post-arrival, 50% still required assistance from the resettlement affiliate after 90 days post-arrival. So, while pre-arrival knowledge of a medical condition did not affect the overall amount of resources invested into a refugees' case management during the 90-day post-arrival period, it did have an effect on the affiliates' ability to address the refugees' needs within the 90-day R&P period. If medically vulnerable refugees continue to need the support of the resettlement affiliate staff to manage their medical conditions, the overall capacity of those affiliates to service newly arriving medically vulnerable refugees will be diminished.

Figure 4: Client's Needing Assistance at 90 Days Post-Arrival



Pre-arrival information was also vital in supporting positive collaboration in the resettlement community. The ability to create care plans in advance for medically vulnerable refugees, in coordination with care providers, is a process that benefits refugees, resettlement affiliates, and care providers. Conversely, when incomplete or inaccurate medical information is used to create these plans, implementation of these care plans becomes increasingly difficult for all parties involved. It may complicate treatment of a refugee's medical condition. It can also force medical care providers to utilize resources that were not anticipated. States also experience the impact of these types of situations when medically vulnerable refugees must rely on costly emergency room visits (Kliff) and hospitalization ("Expenses per Inpatient Day.") to treat medical conditions that were not planned for. One SRHC explained during an interview that accurate and complete pre-arrival information and the communication of that information, "helps build and improve relationships" and that setting high standards for pre-arrival communication is essential so that, "no one feels dumped on" while resettling medically vulnerable refugees.

One additional theme related to pre-arrival information is the lack of coordination and information sharing regarding specific medical forms, one example being the SMC form. Resettlement affiliates can use the SMC form as a tool to determine baseline needs during pre-arrival planning. However, during the course of interviewing stakeholders, some resettlement affiliates self-reported as not able to access SMC forms until they see the paper copy upon the client's arrival. The reason for this is related to the method in which a client's medical information is transferred to the resettlement affiliate. When a case is assured, all of the client's information is sent to the assuring affiliate. However, medical information is generally restricted to specific personnel at a given affiliate. This results in situations where case managers aren't given access to vital information such as the existence of a SMC form. While the prevalence of

this was not captured in the data collection, this situation was common enough in discussion with resettlement staff to warrant attention in the recommendations section of this report.

Conclusions

Inaccuracy or incompleteness of a refugee's pre-arrival information is an occasional occurrence in the resettlement process. The only tool currently at the disposal of local resettlement affiliates to address these issues is the Medical Anomaly Report. This report is to be used, "For serious unreported medical conditions affecting placement..." Therefore the report does not cover *all* potential inaccuracies or missing data pertaining to a refugee's medical condition that could be discovered by resettlement affiliates during the resettlement process. Additionally, several resettlement affiliates stated that there has been little feedback related to the submitted Medical Anomaly Reports. This results in the perception that there is no feedback loop relating to pre-arrival information. This has had a demotivating factor among resettlement staff tasked with completing these reports. It also affects resettlement affiliates' ability to respond to inquiries from medical service providers who seek additional information following a medical anomaly incident.


Pre-arrival information not only impacts initial resettlement but also the length of engagement of a resettlement affiliate in the management of a refugee's medical condition. Early identification of a refugee's medical condition (ideally pre-arrival) reduces the chances that a resettlement affiliate will need to continue to provide support in managing a refugee's medical conditions after the 90-day post-arrival period.

In addition to the accuracy and completeness of pre-arrival information, the process for sharing pre-arrival information (focusing on, but not limited to, SMC forms) is underdeveloped in certain resettlement models. The ability to inform decisions about a refugee's medical treatment based on SMC forms assumes that the proper stakeholders have access to and regularly use this and other medical forms. Numerous anecdotes support the fact that this is not universally the case.

REFUGEE ACCESS TO MEDICATION

Findings

Evidence from structured interviews with resettlement staff indicates a myriad of issues pertaining to the transport of critical medications during initial travel to the United States, and limited knowledge of the importance of maintaining critical drug regimens. In interviews, stakeholders reported several instances of refugees arriving without critical medications, having given them away prior to travel, operating under the misconception that either replacement pharmaceuticals would be available immediately upon arrival or that traveling with labeled pharmaceuticals was not allowed. This reportedly occurs with frequency, despite the fact that



refugees are often provided with a month's worth of medication prior to travel and overseas orientation on medications management.³

Domestically, resettlement affiliates have adopted a variety of strategies to design and implement orientation for refugees concerning the management of their medication needs and navigating the system through which they will acquire their medication. Some affiliates such as YMCA Houston and NSC Philadelphia have staff resources to assist clients in acquiring medication, and training refugees in their use, on a one-on-one basis. Other affiliates that lack these resources have adapted highly detailed and culturally specific orientation materials that can be accessed by refugees at any time. One example of this strategy would be the International Institute of Buffalo's use of Youtube videos ("The U.S. Pharmacy and How it Works (Nepali)"), recorded in refugees' native languages, which walk the refugee through the process of acquiring prescriptions, how a pharmacy works, and the different methods through which a refugee may pay for the medication. In terms of managing a refugee's medication needs, the International Institute of Buffalo adapts color-coded guides to a refugee's medication regime, allowing a refugee to quickly identify medications, and their instructions for use, visually.

In situations when a refugee arrives without essential medication, the first task required of a resettlement affiliate is to acquire the essential medication for the refugee, often before the refugee has health care coverage. Some resettlement affiliates reported they had developed relationships with local pharmacies that would provide medications despite the uncertainty of a refugee's insurance status. In other situations, resettlement affiliates were forced to purchase medications for refugees out-of-pocket or through the client's portion of the R&P per capita grant.

Once a refugee's prescriptions are covered, they are generally able to access the required medications. One exception to this is in Texas, where the state Medicaid program limits recipients to three prescriptions per month. ("Texas Health and Human Services Program: Your Health Care Guide") It is important to note that this is specifically an issue for those refugees who are over 18 and under 65, and enrolled in RMA or Medicaid. Refugees resettled in Texas with conditions that require four or more medications face challenging decisions regarding the importance of their various medications in the treatment of their health conditions. Data gathered from the refugees in the database show that three refugees resettled in Houston (18% of total refugees resettled in Houston) over the course of this study required four or more medications. Resettlement staff in Houston state that it is common practice for refugees to prioritize medications and defer acquisition of those medications considered to be less critical. Of the three

³ From structured interviews with resettlement affiliate staff

refugees requiring more than three medications in Houston, none suffered detrimental effects from this delay; however, this does not negate the fact that this policy can be problematic in the operationalization of medical treatment plans.

Similar policies, limiting the number of prescription medications an individual can have covered through Medicaid, exist in fifteen additional states. The cap for medications in these states range between three and eight medications. Certain kinds of medications may be exempt from the limit in certain states. Some states have a system in place to allow individuals to exceed the limit if they can prove the medication is a medical necessity. (“Question of the Month ~ January 2013”)

Conclusions

Accessing medication is one of the most complicated components of integrating newly arrived refugees into the local health care system. State policy, the complexity of medical diagnosis and medication regimes are all issues that impact a refugee’s ability to manage their medical conditions.

It is critically important for resettlement affiliates to assess the pharmaceutical needs of medically vulnerable refugees to avoid additional medical complications, and to reiterate to refugees, lessons on medication management. Resettlement affiliates that employ culture and language specific training tools have experienced positive results with additional trainings, and results show that refugees participating in these programs are better able to manage their medications needs and reducing the impact on resettlement staff to provide continual one-on-one support.

Refugees’ access to medications depends on their states’ Medicaid policies. Sixteen different states place limitations on the number of prescription medications an individual can have covered through Medicaid. It is the Resettlement affiliates’ responsibility to assess the benefits and limitations of their states’ medication policies and adapt their resettlement model to take advantage of policies that benefit refugees and mitigate the impact of policies that negatively impact refugees.

Affordable Care Act and Medicaid Expansion

EFFECT OF THE ACA

Findings

Over the course of the data collection period (January 6th, 2014 to July 21st, 2014) each of the eighty-one refugees enrolled in this study depended on state Medicaid or RMA programs to pay for their medical services. This period of study did not lend itself to gauging refugees' ability to purchase insurance through the ACA marketplace. As state policies regarding the ACA move beyond the transitional phase, and more refugees have the opportunity to benefit from programs supported by the ACA, future research will be better positioned to measure the impact of the ACA. There are however, specific initiatives related to the ACA that create opportunities for refugees and resettlement affiliates to reduce the challenges of resettling medically vulnerable refugees.

Medical misdiagnoses linked to the lack of certified medical interpretation services are well-documented. (Hampers et al.) Studies have found that language barriers contribute to medical misdiagnoses and affect overall quality of care, and Limited English Proficiency (LEP) refugees have been found to participate in fewer follow-up appointments, receive fewer recommended preventive services, and had fewer prescriptions provided and managed. (Jacobs) The majority of medical misdiagnoses rendered result in either a costly malpractice suit against providers or a significant ongoing health condition that could have been better addressed with robust and accurate medical interpretation, or both. Federal agencies have long promoted the use of professional medical interpretation as a means of promoting equity in healthcare services for all citizens, regardless of the level of English proficiency. However, the provision of those services has been sporadic, resulting in sub-optimal healthcare services for clients requiring those services. In particular, Title VI of the Civil Rights Act (1964) promotes equity to taxpayers in the receipt of federally funded services. Under this act, healthcare providers receiving federal funds are required to provide medical interpretation services to patients if a given language is spoken by 10% or more of a county's population.

The newly implemented ACA promotes a variety of programs that impact the resettlement of medically vulnerable refugees, such as medical interpretation services for populations with LEP. Addressing the needs of these populations is particularly important in this new healthcare arena, as implementation of the ACA has resulted in a change in the composition of insured populations in the United States. As the numbers of insured have increased, so has the number of insured persons with linguistic and cultural barriers to healthcare. Post-ACA implementation, it is estimated that one in five patients with health insurance will be non-native English speakers, up

from one in eight prior to implementation. (“Medicaid Expansion: New Patients, New Challenges”) According to a 2013 study conducted by the University of California Los Angeles Center for Health Policy Research, the percentage of insured with LEP increased dramatically in the state of California with the ACA, rising from approximately 9% prior to the implementation of the law to 36% afterwards. (Driscoll)

Specifically, the ACA requires healthcare providers utilizing federal funds to provide both written translations and verbal interpretation for patients with limited knowledge of English. However, there is a caveat that requires 10% or more of a county’s population be fluent in the same non-English language to access additional funds for medical interpretation. This 10% threshold is problematic for refugee populations, which may not be resettled in a given region in numbers large enough to fulfill the requirements of this threshold. Further, the ACA requires that certain documents be translated for LEP refugees; these include the Summary of Benefits and Coverage and the Uniform Glossary (a list explaining complicated and confusing terminology associated with health insurance). While these ACA rules indicate an attention to LEP populations in need of insurance coverage, the limitations of the language services mandate will continue to leave refugees lacking linguistically appropriate services, particularly in rural locations without a population large enough to constitute 10% of a county’s population. Based on interviews with stakeholders, this information is not widely known within refugee resettlement affiliates. The ACA language supporting equal access to healthcare services reiterates previous law instituted by Title VI of the Civil Rights Act.

The ACA sponsors Healthcare Navigator programs to promote consumer knowledge of insurance options, address health insurance questions and guide individuals in the acquisition of affordable health insurance plans. As Healthcare Navigators engage with refugee communities, evidence shows refugees become better informed about their health options, gain a higher rate of insurance coverage, and show an improved ability to manage their own health needs. (“Information for Navigator Programs”)

For example, a Community Health Advisor Program was implemented in Boise, Idaho in 2013. Throughout the first 15 months of this ongoing program, program administrators evaluated the efficacy of the program through an analysis of the rate of missed medical appointments by refugees. Results show a dramatic decrease in missed medical appointments after the engagement of the Health Advisors, down to 4.9% from an original rate of 20-25%. In addition to providing information on health management and preventive care, Health Advisors also fill the role of Healthcare Navigator, assisting refugees with the selection of the most appropriate insurance option.

Several affiliates reported refugee participation in Health Navigation/Health Advisor programs. These programs were identified in Massachusetts, Texas, Minnesota, and Idaho. Although these programs are typically funded by states as stipulated by the ACA, private funders have also provided support for programs. This was the case in Texas, where the Health Navigator program was funded by the Chevron Corporation.

Conclusions

Due to the timing of this study, the ability to assess the impact of the ACA on the resettlement of medically vulnerable refugees was limited. Many state policies related to the ACA and Medicaid expansion are still in flux. For example, at the beginning of the data collection phase of this study Pennsylvania had not adopted Medicaid expansion as a policy. During the data collection phase several debates were held in the Pennsylvania state legislature and the Governor's office offered numerous proposals for what an alternative Medicaid expansion policy could look like. In late August, federal regulators approved the Governor's proposal. While this change may impact the refugees who have been resettled in Philadelphia over the course of this study, due to the length of the study this impact will not be measured when the new policy is implemented in early 2015.

There are components of the ACA that could potentially impact medically vulnerable refugees in the short-term, and reduce the stress of care. One of these components is the requirement that healthcare providers utilizing federal funds provide both written translations and verbal interpretation for patients with limited knowledge of English. However, the population in question must meet or exceed 10% of a county's population in order to qualify for additional funding. This will be difficult to reach for most refugee populations, but there are notable exceptions throughout the country. In these areas efforts should be made to identify these populations and advocate for appropriate translation and interpretation services.

In addition to language related services, health navigator programs have proven to be an effective means of improving the orientation process for medically vulnerable refugees. A study conducted through a Boise, Idaho, organization showed that refugees who had been a part of a navigator program missed fewer medical appointments. A reduction in missed medical appointments decreases the challenge of providing care for both medical service providers as well as resettlement staff responsible for booking appointments and coordinating transportation for refugees.

IMPACT OF MEDICAID EXPANSION

Findings

As a result of the Supreme Court ruling on the ACA (June 2012), states have the option of deciding whether to implement Medicaid expansion within their own states. In 2014, 26 states

plus the District of Columbia expanded their Medicaid programs. The ACA also standardized and streamlined Medicaid eligibility across all states so that a common financial eligibility tool is utilized – the MAGI.

Of the states considered in this study, Massachusetts and Minnesota have expanded their Medicaid program, and Idaho, Pennsylvania and Texas have not. States can opt to participate in Medicaid Expansion at any point.

Benefits of Medicaid expansion were explored through interviews conducted with SRCs and SRHCs. These benefits include creating continuity of coverage for refugees, greater flexibility in determining which services will be provided to refugees through state health insurance plans, and a simplification in billing medical costs. Before the most recent Medicaid expansion efforts in Massachusetts, refugees who were not eligible for Medicaid due to exceeding income limitations were enrolled in RMA. At the end of the eight-month RMA period, these refugees would then either transition to Medicaid or have to purchase private insurance plans, resulting in a coverage gap. The most recent Medicaid expansion measures allow almost all refugees to enroll in Medicaid, eliminating this coverage gap. In Minnesota, recent Medicaid expansion efforts have allowed refugees to access a wider array of state-funded programming including transportation and interpretation services. In both states, Medicaid expansion reduces the complexity of billing for medical care. Refugees who are covered by Medicaid immediately post-arrival will bill costs directly to state Medicaid offices. This could avoid potential coverage gaps that occur when transitioning between RMA and another form of coverage.

SRCs and SRHCs in the two Medicaid expansion states report that it is too early in the implementation process to determine the overall cost saving of Medicaid expansion. They do however report that they expect billings to RMA to drop significantly, if they are not eliminated entirely.

Some states, including Minnesota, have encountered Medicaid expansion implementation issues that have impacted medically vulnerable refugees. During the first half of 2014, MNsure, the new electronic health exchange system designed for health insurance enrollment was unable to process electronic enrollments for refugees due to a technical limitation. At that time, the application being used for enrollment was not programmed to accept refugee identification numbers. Once identified, The Department of Human Services in Minnesota worked closely with the SRC to find workarounds to address this problem. This lag in Medicaid enrollment in Minnesota was a temporary issue and has since been resolved.

Figure 5: Comparison of Medicaid Options by State (“Medicaid Eligibility for Adults as of January 1, 2014”)⁴

	IDAHO, PENNSYLVANIA ⁵ , TEXAS	MASSACHUSETTS, MINNESOTA
Medicaid Expansion	Not participating in Medicaid expansion. 21 other states are also not participating.	Participating in Medicaid expansion. 24 other states (plus the District of Columbia) are also participating.
Insurance Coverage Gaps	As a result of non-participation in Medicaid expansion, 4.8 million childless adults (across all states without Medicaid expansion) will not receive coverage nationally.	No insurance coverage gaps for childless adults.
Eligibility Requirements	Median eligibility for parents among the 24 states without Medicaid expansion is 46% of the FPL (federal poverty level), or \$9,000 annually for a family of three.	Individuals receive coverage in states with Medicaid expansion with income levels of 138% FPL or lower. ⁶
Issues for locally resettled refugee populations	Refugees are at-risk of falling into the insurance coverage gap that exists in states not expanding Medicaid in the post-RMA period.	Eligible refugees are able to access health insurance at all times, and are offered subsidies and affordable options as stipulated by the ACA.

⁴ Chart contents may not be descriptive of an individual states policy. It is meant to distinguish between expansion and non-expansion state

⁵ Ongoing debate regarding the possibility of Medicaid expansion during the study period

⁶ Individual states may choose to have higher income limits for Medicaid eligibility

Almost all refugees are able to access health coverage through RMA or Medicaid until the end of the eighth month post-arrival period. For those refugees who are not able to access health insurance through the workplace or purchase private insurance, the state of residency plays a large role in whether health coverage is accessible. If a refugee is resettled in one of the 24 states not expanding Medicaid, they have a much smaller chance of gaining health coverage in the post-eight month period. Conversely, if a refugee is resettled in a state participating in Medicaid expansion, the potential for a coverage gap is smaller.

For refugees who aren't covered by the health insurance vehicles of RMA and Medicaid, either because they are outside of the RMA eligibility period or because of income levels, low-cost options are available nationally through health insurance exchanges. These health insurance exchanges, mandated by the ACA, provide an avenue for refugees to access health insurance at a relatively discounted rate via subsidies.

It is important to note that the inability to access health insurance does not equate to a lack of available medical services. Although Medicaid state plans may be inaccessible to refugees, federally funded local healthcare services are available to low-income adults at FQHCs. These centers are operated through the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), and provide services to low-income adults. In Houston, refugees unable to access insurance through employer-sponsored plans and who don't qualify for Medicaid or subsidies will likely go without insurance, but services are still available through over 50 FQHCs located throughout Houston's Harris County. FQHCs provide primary care services as well as a number of additional services including dental services, mental health and substance abuse services, transportation services, and hospital and specialty care.

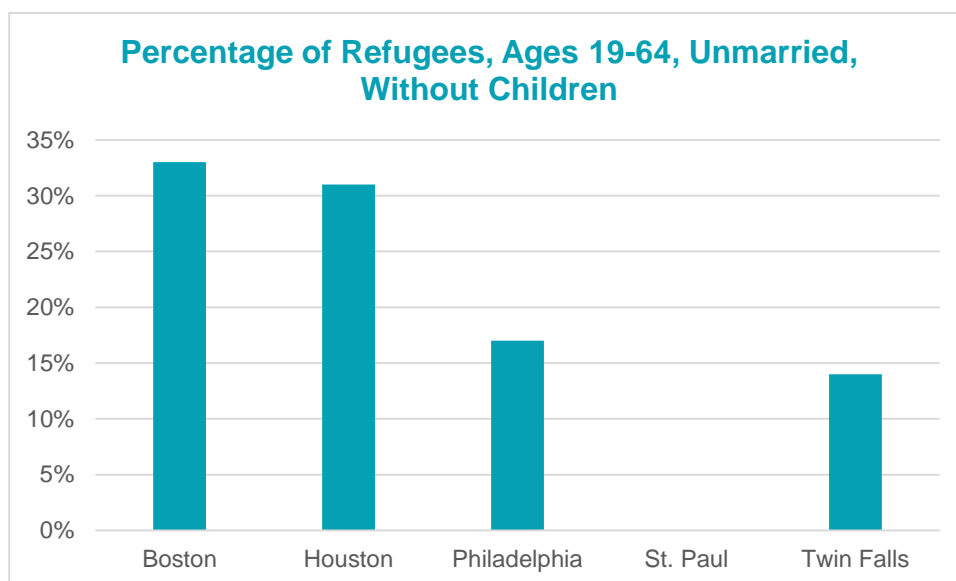
Figure 6: Income Eligibility Limits for States Included in Study (“The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid”)

State	Income limits for a family of three (as a percentage of FPL)	Income limits for childless adults
Idaho	27%	0%
Massachusetts	138%	138%
Minnesota	205%	205% ⁷
Pennsylvania	38%	0%
Texas	19%	0%

⁷ Income limits with payment of small premium through MNSure

As of January 2014, an annual income of \$19,790 for a family of three is considered 100% of the FPL based on Medicaid-issued Federal Poverty Guidelines. (“2014 Poverty Guidelines”) In Texas, a family of three will only be eligible for Medicaid if their income does not exceed \$3,953 per year. While not as restrictive as Texas, income eligibility requirements in Idaho and Pennsylvania remain low, at \$5,741 and \$7,520 respectively. (“Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level as of April 2014”) The restrictive requirements for the Medicaid program in these states point to a high likelihood that low-income refugee families will not meet the eligibility criteria and will remain dependent on emergency room care, with little attention given to preventive healthcare needs when eligibility for RMA times out.

Figure 7: Refugees Aged 19-64, Unmarried, Without Private Insurance



Of the refugees in the data set (n=81), 19.75% fall into the category of being between 19 and 64 and unmarried with no children. 16% of all the refugees in the dataset were resettled in states without Medicaid expansion, leaving them at risk for ongoing health concerns with limited treatment options. For those resettled with the most severe health issues, that can be categorized as a disability, federal benefits may be available through the Supplemental Security Income Benefits program (SSI), which pays benefits to disabled adults and children with limited resources. Eligibility is based on a variety of criteria, including the inability to work due to a medical condition that is expected to last at least 12 months or result in a death. Specific eligibility criteria for SSI can be found at the Office of Social Security website. (“Disability Planner: How We Decide If You Are Disabled”)

The survey asked MCMs to evaluate whether individual refugees were able to attend school or work. Of the 16 refugees who would be ineligible for Medicaid, only eight were considered to be

incapable of either work or study. Seven of the eight were in states without Medicaid expansion (one in Philadelphia, two in Twin Falls, and four in Houston). The other client was resettled in Boston, and coverage for this individual will not be an issue after the initial eight-month post-arrival period, presuming glitches within the new Massachusetts state system are managed.

Conclusions

No matter where refugees are resettled, all income eligible refugees are guaranteed to have eight months of health insurance via RMA, Medicaid, or via a state-based health insurance program. After the eight month post-arrival period, some refugees will be unable to access insurance. All refugees enrolled in this study were enrolled in either RMA or Medicaid from the state in which they were resettled.

Adoption of Medicaid expansion has allowed participating states to enroll most refugees in state Medicaid programs in lieu of RMA. Expanding Medicaid benefits medically vulnerable refugees who experience continuity of coverage from arrival, well beyond the traditional eight-month RMA period. Resettlement affiliates can operate under the assumption that their clients have health insurance and can schedule medical appointments without fear that the clients medical coverage could lapse. Medical service providers experience a simplified billing process that mirrors that of non-refugee patients.

Due to the fact that this study only looked at the first 90 days post-arrival, it was not possible to track the insurance status of refugees at the end of the eight month RMA period. However, by extrapolating information from several questions asked in the survey tool and in the exit form it is possible to project possible insurance status outcomes at the end of this period.

In particular, if a refugee is over 18 and under 65 years of age, single, married with no children, and in a state without expanded Medicaid, that refugee may have difficulty meeting strict income limitations that determine eligibility for coverage. This problem may be exacerbated if a refugee lacks the means to purchase private insurance, and does not qualify for disability insurance. This potential gap is problematic for all refugees, however it is an especially critical issue for medically vulnerable refugees who arrive in the U.S. and do not qualify for SSI.

In 2015, new states will adopt Medicaid expansion measures and may create individual state-based exchanges to enroll their citizens in this new program. Concerns remain that these exchanges may not take into account the unique status of refugees. States that do not account for refugees in their expansion plans may face a similar situation to that of Minnesota in the first half of 2014.

Service Models: A Cost-Benefit Analysis

Findings

The methods and strategies utilized in the provision of medical services by each of the research sites were analyzed over the course of this study. USCRI conducted interviews with affiliate staff members who focus on refugee health issues and the SRC and SRHC for the five study sites. In addition, for models that incorporated unique stakeholders, USCRI interviewed and included their insights into describing these models.

The following findings describe the resettlement models of the five resettlement locations involved in this study. The models seek to describe the way that medically vulnerable refugees move through the resettlement process, detailing the context in which resettlement occurs, as well as the different stakeholders involved in the process. The detailed cost-benefit analysis of the models can be found at the end of this section in **Figure 12**.

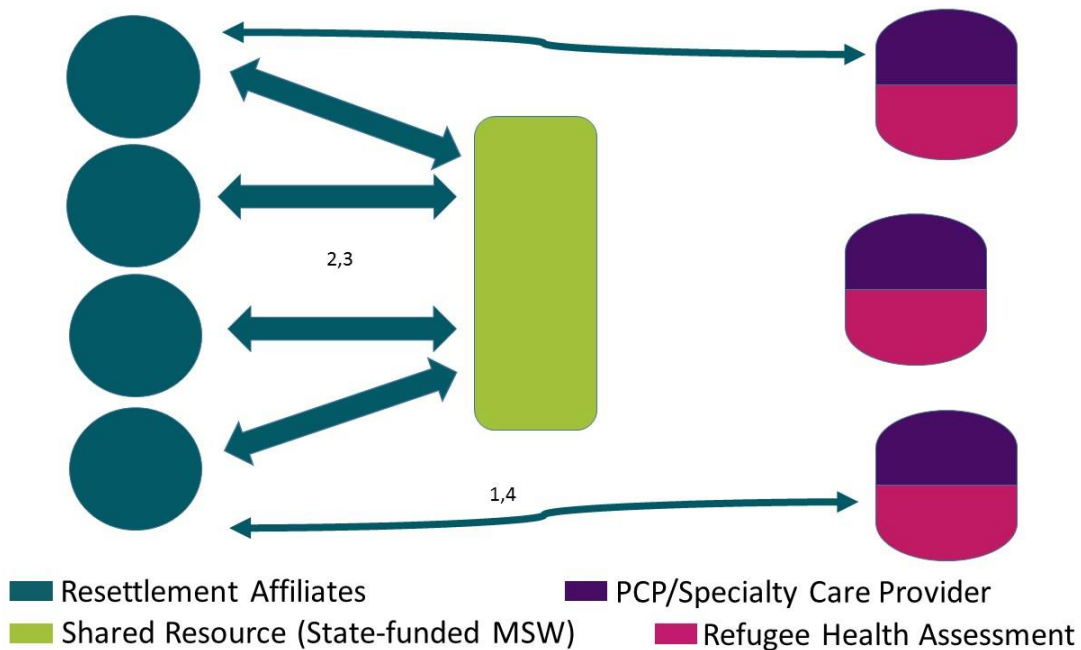
Models analyzed fall into one of three categories:

1. **Community-Based Collaborative Model:** This model serves the entire local resettlement community in which it operates, and functions with a centralized structure dedicated to the support of medically vulnerable refugees across resettlement affiliates. The cost of this model is shared across affiliates or across affiliates in partnership with the state, as are the benefits of sharing a coordination function. Considering that the costs of the programs that serve the communities utilizing this approach are moderate, and that the client base is larger, these models (currently operational in St Paul, Minnesota and Philadelphia, Pennsylvania) are more cost effective than the other models studied. The other models, however, are effective for the provision of medical services and referrals for their refugee populations. The operation of this model is contingent upon broad-based community support and requires integration of stakeholders within local communities. Under this model, medical service providers interact with a single entity regarding flow of refugees into the healthcare system, rather than several, which simplifies coordination on the side of the medical service providers.

Within the category of the Community-Based Collaborative Model, two possible sub-categories were identified. These sub-categories are:

- a. **The State-Based Collaborative Model:** This model is utilized in Minnesota. In this model, the structure for the coordination is supported by the state, with close involvement of the SRCs. This is a top-down approach and can be re-created in resettlement locations with multiple resettlement affiliates and primary care providers.

Figure 8: The State-Based Collaborative Model



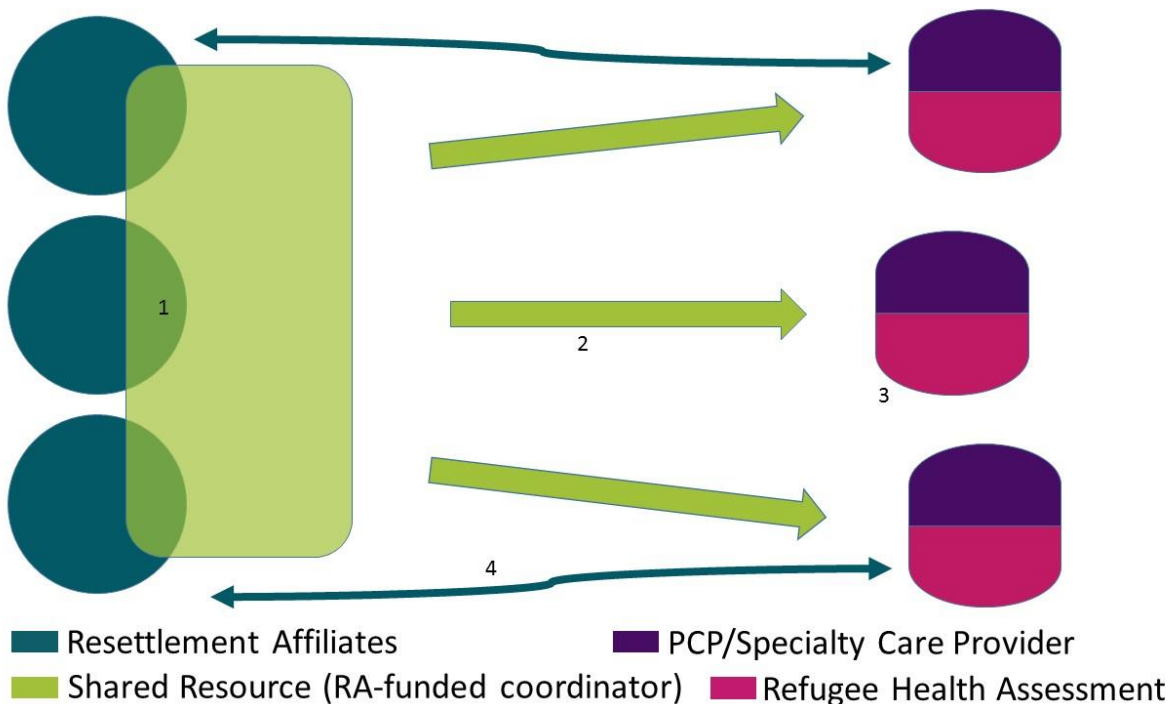
In this collaborative model, resettlement affiliates work with a medical social worker (MSW) in the Minnesota Department of Health Refugee Health Program to establish care plans for medically vulnerable refugees.

1. Resettlement affiliates refer refugees to Primary Care Providers (PCPs) who provide the RHA and continued care, or if a refugee is medically vulnerable, to the state MSW;
2. The MSW assesses whether the refugee is eligible for the program, and if so coordinates with the individual resettlement affiliate on a treatment plan for the refugee;
3. The MSW follows up with the resettlement affiliate over the next several weeks to ensure that the treatment plan is being followed and to manage new issues; and
4. The resettlement affiliate coordinates individually with primary care providers who perform the RHA and provide further care.

- b. **The Affiliate-Based Collaborative Model:** This model is operating in Philadelphia, Pennsylvania. In this model, the structure for coordination is supported by the Refugee Health Collaborative, with limited involvement from the SRC and SRHC. This Collaborative

works closely with other local refugee health officials and depends upon support of a strong and engaged network of local affiliates, both for financial and operational support. This is a bottom-up approach and can be re-created in resettlement locations with multiple resettlement affiliates and primary care providers.

Figure 9: The Affiliate-Based Collaborative Model

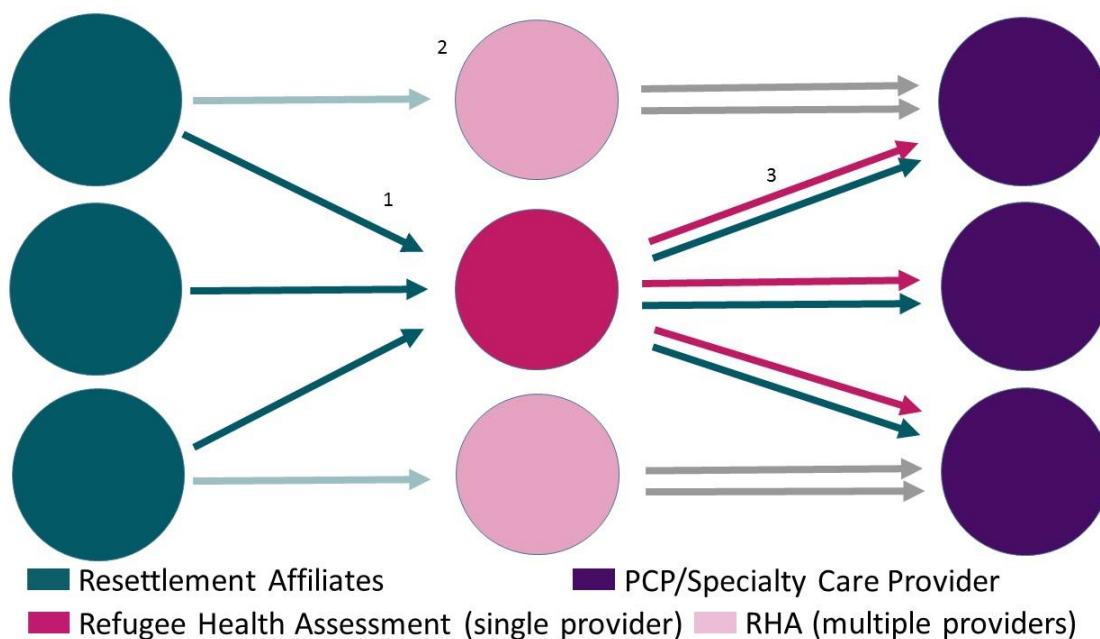


For this collaborative model, founded by NSC in partnership with Philadelphia’s other refugee resettlement affiliates, the various resettlement affiliates invest in a shared coordinator position.

1. Resettlement affiliates refer arrivals to the Coordinator;
2. The Coordinator schedules RHAs with various refugee health clinics;
3. The refugee health clinics perform the RHA and provide primary care; and
4. Resettlement affiliates establish a liaison to work closely with the refugee health clinics to provide on-site assistance and health care access support.

2. **Independent Center Model:** This model is managed by individual agencies in a multi-affiliate resettlement community. Affiliates operating under this model function independently of each other. All medical case management services occur within the confines of the independent affiliates. Costs are not shared between sites in these locations. The two affiliates operating within this model are located in Boston, Massachusetts and Houston, Texas. This model can be used in locations where there is an abundance of medical care providers so each local affiliate has dedicated medical care providers.

Figure 10: The Independent Center Model

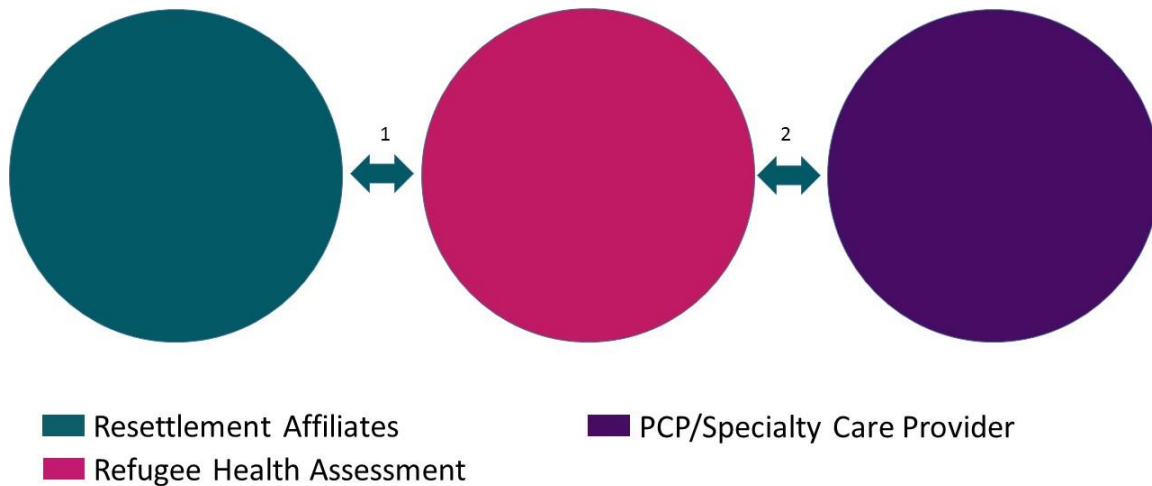


The Independent Center Model is similar to the Single Agency Model in that affiliates independently perform each stage of medical case management. The difference between these models is that in the Independent Center model, there are many affiliates operating within the same city conducting the same processes simultaneously and independently. In the Single Agency Model there is only one affiliate that works with one or many entities to perform RHAs and specialty care. In Houston the RHA is performed by one organization. In Boston the RHA is performed by multiple organizations (represented by the transparent circles and lines).

1. Resettlement affiliate schedules RHAs for refugees;
2. RHAs may be conducted either by a single provider or many providers; and
3. In certain cases the entity administering the RHA will refer a refugee directly to a care provider, in other situations the refugee will contact the resettlement affiliate to coordinate care

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3. **Single Agency Model:** This model is found in settings that contain a relatively small resettlement community consisting of a single affiliate and healthcare provider. In cases like this, such as can be found in Twin Falls, Idaho, the size of the refugee community does not lend to centralized coordination. Instead, the Single Agency affiliate must develop a direct relationship with the local health provider.

Figure 11: The Single Agency Model



At Single Agency sites such as the CSI Refugee Center in Twin Falls, Idaho each stage of medical case management is performed entirely by resettlement staff.

1. Resettlement affiliate schedules RHAs for refugees;
2. Resettlement affiliate manages referrals for PCP and specialists; and
3. Resettlement affiliates follow up with refugees to assure continued care.

The Boston Model

Focus: International Institute of New England (Independent Center Model)

Overview

Massachusetts is a Wilson-Fish state. The administration of refugee programs in Wilson-Fish states is conducted by a non-state entity. In FY2013, a total of 300 refugees were resettled in the Boston area. During the research period, there were three resettlement affiliates in the Boston metro region. Medically vulnerable refugees resettled in the greater Boston area have access to robust medical services for the management of both physical and mental health needs. These services are provided by numerous stakeholders with limited coordination. Though medical resources are numerous and the quality high, there are many barriers to the resettlement of medically vulnerable refugees in the Boston metro region, including the high cost of housing, limited availability of affordable handicap-accessible housing, inconsistency of transportation services and the professionalism of interpreter services.

Based on comparisons with the administrative functions of state programs that manage their own refugee programs, Wilson-Fish states did not vary in programmatic options or outcomes.

The process begins with resettlement staff receiving notification about a refugee's medical needs. They consult directly with local healthcare providers to fully understand the medical needs of the refugee as noted in the biodata and other forms. This step is also the initiation of the planning phase, as these discussions involve setting expectations for individual requirements in terms of medical services and case management from the resettlement affiliate. Often the most difficult step of the pre-arrival process for medically vulnerable refugees is securing affordable and accessible housing. The combination of non-accessible housing stock, high rent, and a generally high cost of living make resettlement in the Boston area more difficult than less expensive urban locations.

To ensure health appointments are scheduled efficiently, case managers notify health centers of upcoming arrivals and whether a case needs urgent attention. The biggest challenge in working with local health centers is getting refugees enrolled in insurance. Changes related to the advent of the ACA complicated the insurance application process for refugees and new refugees must visit health centers to apply. Refugees who need urgent care must wait for their insurance application to process before they can see medical specialists. Although IINE has been in negotiations with certain health enrollment centers to create a weekly time for refugees to be processed, nothing had materialized at the conclusion of the research period and in order to mitigate this issue case managers use the walk-in system.

Once a refugee arrives at IINE, the refugee undergoes a series of unique assessments including a bio-psychosocial exam that attempts to look holistically at a refugee's physical, mental, and social context to assess treatment needs. The results of this assessment help inform the case planning process. Resettlement staff use the intake to determine appropriate community-based service providers to connect with refugees. IINE also engages in a case disposition, or group planning process, for all cases. Using this approach is more time consuming, but assures that all aspects of an individual's circumstances and needs are considered for medically vulnerable refugees. IINE does not have a dedicated MCM and relies on case managers and director-level staff to provide services and to act as guides for medically vulnerable refugees. IINE's staffing model has been developed with a focus on retaining skilled mental health service providers in house. All staff members working on the bio-psychosocial intake have an educational background in providing case management services to traumatized populations. The current intake coordinator is a Licensed Independent Clinical Social Worker (LICSW). Further, all questions on intake are voluntary, and the intake questions have been screened to ensure that questions are not triggers for past trauma.

Additionally, there are bi-monthly program meetings between case managers and the R&P coordinator which incorporate ongoing pre-arrival planning. The meetings serve as a place to collectively share how to best serve refugees. Case managers educate employment specialists on the specific needs of medical cases so that IINE can review employment options or potential alternatives to employment if appropriate. For pre-arrival purposes these meetings serve as a place to discuss housing options and service providers the case managers may need to access.

Once the affiliate conducts initial intake, the refugee goes through a standard refugee health screening process. All area RHA providers are located within medical systems, and generally refer refugees after their initial assessments directly into primary care within the same medical system. While this method does promote continuity of service, it may leave the resettlement affiliate out of the process. This situation can result in communication breakdowns. For example, a refugee may require the resettlement affiliate to coordinate transportation to a medical appointment, however the affiliate may lack key information such as medical appointment time. If the refugee lacks English language skills there may be increased confusion in cases in which the refugee is expected to transmit key information from the service provider back to the resettlement affiliate. IINE is attempting to mitigate this communication issue by piloting a point-person system with one area healthcare provider. A designated intake point person will consult with the refugee before the first appointment to discuss the care plan as well as attend the first medical appointment to try and establish communication with the care provider.

The intake assessment done by IINE identifies refugees presenting bio-psychosocial issues. This takes place well before the RHA and therefore allows time to coordinate more behavioral health

supports. The RHA is a basic wellness check, including blood tests and immunizations, and also has a psychosocial evaluation. The RHA allows for a more direct path to a provider as referrals are often made to behavioral health clinicians after the initial appointment. IINE's assessment is useful in coordinating early interventions, if needed. Until very recently, the information from the RHA was not shared with case managers unless there seemed to be an immediate safety concern. Frequently case managers find out from the refugees about referrals for further medical or behavioral health appointments. In recent months, IINE has engaged in organizing behavioral health forums across providers and lines of communications are improving. As IINE becomes more integrated into the larger provider community, there is planning to increase cross-collaboration and ultimately share communication and resources.

In the intake assessment, IINE uses the "Distress Thermometer" from the RHS-15 as a way to screen for urgent levels of emotional distress.

Case Managers often lack details of refugee health care for a few reasons:

- Case coordination for medically vulnerable refugees is very time intensive and IINE does not have funding to support MCMs. Resettlement case managers address all refugee issues from housing to public benefits to health for a large number of refugees and therefore cannot attend all health appointments and must often rely instead on U.S.-ties or community support workers.
- Personnel at IINE stated that regional medical systems are closed systems and IINE struggles with providers who do not contact case managers with updates and treatment plans. Further, personnel also state that communication between health clinics and IINE is slightly more intensive but the bulk of information is not shared in terms of treatment plans or continued medical support. The majority of medical information IINE receives comes directly from clients and often involves case managers following up with providers to ensure the information is correct or clarified. If a case manager does not attend a client appointment, it falls to the client to report or the case manager to follow up with the provider, complicating delivery of care planning and services.

RMA and/or Medicaid Usage

One unique circumstance in Massachusetts is that it maintained near universal medical coverage for citizens even before the ACA was passed. This state policy simplifies the process of accessing coverage for refugees and reduces the stress on the resettlement affiliate. Before the advent of the ACA, IINE assisted new refugees with the application for health coverage. Previously, limited direction was provided regarding the process of enrollment in the system.

The ACA has clarified this process, and new guidelines require health centers to facilitate the enrollment process for all new refugees.

In the rare case that a refugee does not have health insurance, or if a refugee's health insurance doesn't cover a specific service, the Massachusetts Health Safety Net provides funding to community-based health care centers to provide essential health care services.

Local Community Partners

The quantity and quality of resources available in the Boston area for the support of medically vulnerable refugees is considerable. However, due to a lack of collaboration, there are issues with communication, a potential overlap in the services provided, as well as confusion on behalf of the newly resettled refugee as they interact with numerous, often undifferentiated stakeholders.

Service providers that interact with medically vulnerable refugees in the Boston area include the Department of Public Health (DPH), healthcare navigator programs, healthcare providers and the resettlement sites themselves. Each of these organizations provides its own health-related programming, with little to no coordination between organizations. For instance, the Massachusetts Department of Public Health coordinates through a community health worker outreach program to conduct two home visits within the first three months post arrival. The timing for these visits is not communicated to resettlement staff so refugees are often confused about who is providing outreach at any specific time. Another area in which a lack of communication affects service provision is in the coordination of transportation services. Due to the fact that many service providers do not connect with the resettlement affiliates responsible for the refugees, key information related to appointment times and transportation needs is often not communicated. This results in missed appointments that can greatly impact a refugee's care.

Communication between DPH and IINE consists primarily via case consultation phone calls, faxes of refugee RHA information and quarterly conference calls. For every refugee, IINE faxes a referral and refugee documents to DPH. DPH conducts home visits through a Community Outreach Workers Program, but case managers are not notified of these visits despite requests to coordinate visits and the delivery of health information.

Communication between health clinics and IINE is slightly more intensive but the bulk of information regarding treatment plans or continued medical support is not shared. The majority of medical information IINE receives comes directly from refugees and often involves case managers following up with providers to ensure the information is correct or clarified. If a case manager does not attend a refugee appointment, it falls to the refugee to report or the case manager to follow up with the provider, complicating delivery of care planning and services.

MAAs play a significant role in the resettlement of most of IINE's cases with no U.S. ties. There are several MAA providers who have ethnic-focused and community resources including language, connection to religious organizations, and coordinated support. Many MAAs in Lynn, where resettlement of most of IINE's cases with no U.S. ties takes place, have contracted with an area behavioral health provider to provide additional workers, and IINE refers refugees to these workers who are enrolled according to eligibility requirements (significant medical diagnoses and enrollment in eligible insurance).

The Houston Model

Focus: YMCA International Services (Independent Center Model)

Overview

The refugee program in Texas is managed by the state. In FY2013, a total of 2,347 refugees were resettled in the Houston metro region. During the research period, there were five resettlement affiliates in the Houston metro region including one joint office. The refugee resettlement affiliates in Houston, Texas, have a wealth of resources available to resettle medically vulnerable refugees. Houston is home to some of the most advanced medical facilities in the country (Memorial Hermann, St. Luke's, Texas Medical Center), as well as specialty facilities that focus on individuals with HIV/AIDS (Legacy Clinic, Bering Omega, Thomas Street Health Center), and a variety of strong, supportive ethnic communities. While there exist myriad resources for the resettlement affiliates to draw upon, due to the complexity of the healthcare system in Houston, the decentralized nature of the Texas Department of Public Health and the lack of cooperation between resettlement affiliates, the stress of coordination relies almost entirely on the leadership of the resettlement staff.

YMCA International Services provides services through a large network of community-based partners, but resettlement affiliates in Houston operate within their own individual and discrete universes of providers and partners. YMCA International services identifies medically vulnerable refugees through review of the refugee's pre-arrival information and more recently referrals through the Refugee Health Screening Program conducted by the Harris County Department of Public Health.

Due to the recent addition of a medical case management position at YMCA International Services through the federally-funded PC program, this resettlement affiliate has increased capacity to thoroughly address the ongoing needs of medically vulnerable refugees. Refugees must meet eligibility requirements to be considered for acceptance into medical case management. Some characteristics that result in refugee referral into this program include a SMC form attached to refugee medical history, the existence of HIV/AIDS, being an unaccompanied elderly individual, or having a specific medical history that the staff considers severe enough to need additional medical case management. Refugees who are accepted under this category often have mental health concerns or chronic conditions that require continuous care.

RMA and/or Medicaid Usage

Texas did not expand the Medicaid program in 2014. Following the eight-month RMA period there are many different plans and options available to the refugee depending on various factors including where the refugee is resettled, their family structure, and their income level. The

majority of refugees are enrolled in a traditional Medicaid program with a restrictive pharmaceutical policy that limits the number of medications to three per refugee. This can be a serious matter for a medically vulnerable refugee who has medical conditions that require more than three medications, leaving refugees with the dubious task of choosing which three medications are the most critical for their ongoing care. Refugees resettled in Harris County are eligible for subsidized medical costs at selected providers through the Gold Card program, which is available to low-income individuals. Refugees may also be eligible for the Texas Star program, which is similar to a managed care program. Some of the benefits this type of coverage offers include unlimited prescription coverage, mental health and substance abuse programs, as well as a range of health and wellness benefits. Eligibility for this program has not been clear and is a point of contention between local resettlement affiliates and the State Department of Public Health. Without this managed care plan, medically vulnerable refugees often struggle to afford medications as most plans only cover the first three medications.

As a result of the state's Medicaid policy, it is common for single childless adult refugees in Texas to lack any kind of health coverage at the end of the eight-month RMA period. If a single childless adult refugee over 18 and under the age of 65 in Houston has a medical condition that does not qualify them for disability assistance, yet prevents them in some way from gaining employment, it is very difficult for that individual to find affordable health insurance.

Local Community Partners

One of Houston's most valuable resources for the resettlement of medically vulnerable refugees is the variety of ethnically and culturally specific services available. Houston is home to many Ethnic Community-Based Organizations (ECBOs) that provide assistance to refugees with complex medical conditions in the form of cash assistance, transportation to and from appointments, informal health care orientation, health navigation, and emotional support through acculturation and adjustment activities during the initial resettlement period. Houston also boasts a great wealth of healthcare providers with a strong knowledge of refugee populations, and their linguistic and cultural backgrounds. As a result, healthcare service providers are prepared to engage refugees appropriately, with trained medical interpreters on staff and culturally appropriate services. This often removes the need for an additional interpreter, which removes one of the logistical barriers to care.

In an effort to provide refugees with information on state health insurance options, local partners developed Health Navigation programs. One such partner organization was the Epiphany Community Health Outreach Services, which provided culturally and linguistically sensitive guidance to refugees who were trying to enroll in state insurance programs. In addition to enrolling refugees in appropriate insurance programs, the Health Navigator programs also hired

and trained members of the refugee communities to provide culturally appropriate healthcare navigation to new arrivals. This program was operational from 2009-2011, and used private funding from the Chevron Corporation for its implementation.

While Houston is a large resettlement site with five affiliates working to resettle refugees, there is relatively little coordination between affiliates for the purposes of supporting medically vulnerable refugees. Recently, a Medical Case Management Working Group was established with the goal of encouraging consistent feedback between the resettlement affiliates and local service providers. The group coordinates quarterly meetings with local service providers to address the issues from the perspective of both the service providers and resettlement affiliates. Still in its infancy, the working group has yet to affect change in reducing the impact that communication and coordination issues have on resettlement. Some of these issues include scheduling of RHAs, coordinating medical transport for refugees, and drawing on limited resources specifically tailored to refugee populations.

Houston benefits from a wealth of advanced medical resources, ECBOs, service providers with cultural and linguistic capacity, and established refugee communities that guide the resettlement process. While the Texas Star Medicaid program and the Harris County Gold Card are excellent programs, the number of refugees who are eligible for these programs is limited by the lack of Medicaid expansion in Texas. The coordination of service provision for medically vulnerable refugees is aided by the above two programs, however there are few mechanisms for cooperation and collaboration currently in place in Houston. As a result, the coordination of care for medically vulnerable refugees falls almost entirely on individual affiliates such as YMCA International Services.

The Philadelphia Model

Focus: The Nationalities Service Center (Affiliate-Based Collaborative Model)

Overview

The refugee program in Pennsylvania is managed by the State. In FY2013, a total of 717 refugees were resettled in the Philadelphia metro region. During the research period, there were three resettlement affiliates in the Philadelphia metro region. Philadelphia is unique in that it operates as a resettlement location while not being party to the state of Pennsylvania Participating Provider Agreement (PPA). The agreement sets guidelines for the screening of incoming refugees and the payment structure for the organizations that organize and perform this service. Prior to the agreement, the resettlement organizations in Philadelphia forged a partnership to address the unique circumstances of conducting health assessments and coordinating medical services. This partnership has led to an efficient, self-sustaining system that is more extensive than what is described in the PPA. Therefore Philadelphia-based medical providers have elected not to participate in the PPA. As Philadelphia is not party to the PPA, state officials based in Harrisburg work intensely on refugee health issues in the rest of the state, but have limited interaction with Philadelphia outside of quarterly meetings. The City of Philadelphia funds its own dedicated refugee case manager, the Philadelphia Refugee Case Manager, who plays a significant role in the tracking, management, and reporting of infectious diseases, primarily TB, within the local refugee population.

Philadelphia has a large number of health providers who are well-versed in the management of refugee health conditions. The PRHC, founded by NSC in partnership with Philadelphia's other refugee resettlement affiliates, attempts to ensure that all refugees who are arriving in Philadelphia receive a high standard of care. The PRHC operates as a true "public-private partnership" with partial funding provided by the R&P program to fund the critical core service of timely access to an initial health screening. This is then supplemented by private funding, developed out of the need to support refugee's long-term access to care and the need to ensure that refugees are fully aware of how to access the medical system. This multi-faceted funding allows for timely access as well as long-term supports. The system that has been developed is considered to be a success, as is indicated in various interviews with state and local personnel. **Figure 9** (The Affiliate-Based Collaborative Model) above shows how newly arrived refugees move through the system developed by the PRHC in order to receive medical services at the appropriate community clinic, healthcare center, or hospital.

In addition to the PRHC, Philadelphia is also home to the Refugee Mental Health Collaborative. Operating in a manner similar to the PRHC, the Mental Health Collaborative consists of local resettlement affiliates working closely with mental health providers and medical personnel, as

well as community based intervention programs, to ensure that refugees are able to access linguistically and culturally appropriate mental health services.

The rest of the state operates on a fundamentally different model from Philadelphia. The state is divided into regions, and state officials are responsible for ensuring that health screening services are provided. State officials are also responsible for the coordination of health sites throughout the state. Conversely, in Philadelphia, the PRHC takes on the function of the state officials in the coordination of providers.

Funding issues also vary between the rest of Pennsylvania and Philadelphia. For example, the State Refugee Health Office provides funds to local providers (with the exception of Philadelphia) to provide medical interpretation services. Due to their lack of participation in the PPA, the PRHC does not have access to these funds. While it is true that additional funding can help ease the difficulties caused by either the lack of interpretation or inappropriate interpretation (that is, interpretation not provided by trained medical interpreters), the PRHC leadership believes that funds could be better utilized in supporting access to care while also ensuring that medical interpretation is provided under the Title VI mandate of the Civil Rights Act.

From the perspective of the State Refugee Officers, the inclusion of Philadelphia into the rest of the State's refugee processes would be preferred. The inclusion of Philadelphia with the rest of Pennsylvania would streamline administrative, monitoring, and evaluation processes for State Refugee Officers.

RMA and/or Medicaid Usage

New arrivals in Pennsylvania are either enrolled in the State Medical Assistance Program (MA) or RMA. To gain eligibility for RMA, a refugee must be deemed ineligible for MA. Those ineligible for MA (typically either single or childless adults) are provided with coverage via the RMA vehicle. The income limit for initial eligibility is 100% of the Federal Poverty Guidelines. ("Refugee Medical Assistance Policy")

In 2013, the NSC conducted several outreach efforts to existing refugee communities for the purpose of raising awareness about the impending changes to healthcare due to the implementation of the ACA. Through these efforts NSC was able to gather data related to refugees over the last year to learn more about health insurance options for refugees who timed out of eligibility for RMA. Of the 180 households who completed screening with the NSC over the last year, 112 households, or 62%, were able to access health insurance outside of RMA, either through Medicaid (28%) or through the ACA marketplace (34%). The remaining 38% of households were left without insurance. ("Nationalities Services Center")

While the State of Pennsylvania is not currently providing expanded Medicaid to its residents, the discussion surrounding Medicaid expansion in Pennsylvania is active. Recently, the Pennsylvania State legislature failed to secure a waiver from the Federal Government to add work and job-search requirements to enrollment criteria. Soon after, the Governor's office proposed an alternative to allow private insurers to provide Pennsylvania's Medicaid subsidized coverage to its citizens.

During the period of this study, Pennsylvania had not decided to adopt Medicaid expansion measures. Since then, Medicaid expansion measures have been approved by the state. Implementation will begin January 1st, 2015.

Local Community Partners

The development of the PRHC resulted in the creation of strong local community linkages between various local stakeholders in the refugee health and resettlement field. The PRHC Coordinator works with all local resettlement affiliates to standardize and streamline services for refugees with medical issues, troubleshoot issues related to the provision of medical services, and coordinate among resettlement affiliates. Refugee-based information flows throughout the intake process, and case managers at the various local resettlement affiliates are able to access refugee information and to continue to play a critical role in the management of medical cases. This high level of coordination and information exchange provides a strong system for the quick provision of services while ensuring that plans are developed and followed to provide appropriate care. Further, Philadelphia is home to a wide network of hospitals (Children's Hospital of Philadelphia), primary care physicians (Jefferson Family Medicine Associates, Penn Center for Primary Care, Fairmont Primary Care Center), clinics (Einstein Refugee Wellness Center), and specialized care facilities (Drexel Women's Care Center) that are integrated into the referral process, and possess a collective wealth of knowledge on the particular burden of health issues affecting refugee populations.

The St. Paul Model


Focus: International Institute of Minnesota (State-Based Collaborative Model)

Overview

The refugee program in Minnesota is managed by the state. In FY2013, a total of 1,845 refugees were resettled in the St. Paul and Minneapolis Twin Cities area. During the research period, there were six resettlement affiliates in the Twin Cities, including one joint office. IIMN at St. Paul promotes refugee health through a robust pre-arrival planning period for medically vulnerable refugees. To assist with this goal, the Refugee Health Program (RHP) at the MDH developed a system in 2012 to identify and coordinate a care plan for newly arrived refugees with chronic or acute health conditions residing in the seven metropolitan counties of Minnesota (Dicker). The current system for providing care in St. Paul relies heavily upon the detection of medically vulnerable refugees early in the resettlement process (ideally pre-arrival) using a triaging algorithm created by the state. The implementation of the algorithm-dependent system required a greater level of collaboration between stakeholders in the local resettlement community, particularly between local resettlement affiliates, the MDH, local public health, and local social service providers.

Health information is assessed by resettlement affiliate case managers as soon as it is received from the national office. If the refugee appears to have a serious medical condition based on preliminary medical forms received by the resettlement affiliates that information will be forwarded along to the dedicated Refugee Consultant and MSW at the RHP. This position provides broad oversight of the project, reviews and triages referred cases per established ranking algorithm; and this MSW, supported through the Minnesota State Refugee Plan as a shared resource for five resettlement affiliates, works exclusively on the coordination of care plans for medically vulnerable refugees and the identification of systems and resources to facilitate timely access to care. This process involves consulting with resettlement affiliates on health-related issues, regularly coordinating care plans with local affiliates, and referring refugees with medical issues to care providers for urgent health assessments and specialty care. Through this process, all of the resettlement affiliates in the area have regular engagement with the State Refugee Health Program staff and the local health departments.

As a result of this pre-arrival planning, medically vulnerable refugees have a medical care plan at arrival, including appointments with appropriate health care providers and specialists facilitated by the MSW. The case managers and medical case managers at the resettlement affiliates implement the medical care plan. The MSW continues to monitor the implementation through close coordination with the case managers and provides consultative support to them as needed.



The great majority of Minnesota’s refugees are resettled in the Twin Cities metro area, although refugees are resettled throughout the state. Each county within the state has a designated public health nurse who provides oversight for refugee health issues within that county. Communication is facilitated through regular meetings held with the county representatives, state officials, and local resettlement affiliates.

Scope or eligibility for this program is limited to refugees who need immediate access to care upon arrival for their health needs, before the standard/routine health assessment. Although some refugees need assistance navigating the health care system after their health assessment, sufficient capacity is lacking to link them to follow-up care.

RMA and/or Medicaid Usage

The state of Minnesota has been an active partner in providing health insurance to its eligible residents for many years. Prior to the passing of the ACA, Minnesota expanded their Medicaid program to include low-income adults without children, resulting in insurance coverage for an additional 84,000 people. In January 2014, Minnesota’s Medicaid program expanded further to include individuals younger than 65 who earn up to 133% of the FPL. It is expected that this latest change to the plan will result in coverage for an additional 57,000 individuals. (“Medicaid Expansion: Coverage for more Minnesotans starting in 2011”)

Health insurance accessibility is typically not an issue for refugees resettled in Minnesota as a result of these policies. The SRC in Minnesota, who works directly on refugee health insurance accessibility issues, noted that Medicaid in Minnesota covered the great majority of refugees resettled in the state, and only a small number have had to draw on RMA over the past several years. With the ACA and expanded access to state health programs, it is his expectation that RMA is poised to become “obsolete.” He added “...the eight month time period should be out of our lexicon now. The only reason a refugee would leave Medicaid is if they meet the income level of 133% above poverty.”⁸

Local Community Partners

The relationship between the MSW and the resettlement affiliate creates the added benefit of close collaboration with local service providers. Through the creation of care plans for medically vulnerable refugees, the MSW, local resettlement staff, and health care providers are able to identify gaps and find resources to address health needs and barriers to care. This process eliminates the need for other formal mechanisms for collaboration such as a working group. Another byproduct of this effective relationship is that it increases collaboration between the five

⁸ In-person interview conducted Wednesday, March 5, 2014

resettlement affiliates in the Minneapolis/St. Paul area through a shared resource and transferable practices.

There are two refugee-focused care providers resettlement affiliates rely on to provide services to their refugees, each with their own specialty. UCare clinics offer medical services including medical transportation funded through Medicaid. Another partner, HealthPartners Center for International Health, specializes in identifying and treating mental health conditions impacting refugees. Their experience, combined with their cultural and linguistic capacity, makes them a preferred provider for a variety of services. Resettlement affiliates receive support from local refugee communities (specifically the Karen and Hmong) to provide informal cultural and healthcare orientation, as well as transportation and interpretation.

The Twin Falls Model

Focus: College of Southern Idaho (Single Agency Model)

Overview

Idaho is a Wilson-Fish state, and the refugee program and the cash component of the program is operated by a non-profit organization, Mountain States Group. In FY2013, a total of 300 refugees were resettled in the Twin Falls area. During the research period, there was one resettlement affiliate operating in the city. The resettlement program in Twin Falls, Idaho, is located at the College of Southern Idaho. This site is unique among the sites under consideration for this study in that it is smaller in size and located in a more rural location. All medical services are coordinated through a single individual at CSI, who guides newly resettled refugees through the process of healthcare orientation and accessing the medical system. The simplicity of this model is a benefit for new arrivals, as it negates the need for them to learn to navigate the internal workings of a more complex system.

There are many benefits to resettling in a rural location. A common difficulty with resettling medically vulnerable refugees is the lack of accessible housing. This is not an issue in Twin Falls. Housing is affordable and available, and locating low-income housing that is handicap accessible is manageable. Further, the limited number of care providers in the area created a situation where there are enough medical services providers to fill the need while providing a simpler system of healthcare services to navigate. In cases where local services are not able to manage a medical need, refugees are able to access specialty services in Boise.

The MCM is central to all activities of the new refugees, including the scheduling of the health screenings, making appointments with specialists as needed, and generally managing healthcare services for refugees. Additionally, the case manager coordinates transportation services and interpretation services as needed.

Coordination between the resettlement affiliate in Twin Falls and the SRC and SRHC is limited. The SRC and SRHC are based in Boise, where the great majority of refugees in Idaho are resettled (67%).⁹

⁹ From interview with State Refugee Coordinator. January 29th, 2014

RMA and/or Medicaid Usage

The state of Idaho has opted out of Medicaid expansion, and as a result is still heavily dependent on RMA for the provision of health coverage for incoming populations for the first eight months post-arrival. There are currently no plans to expand Medicaid in Idaho.

The lack of Medicaid expansion in the state does not translate into a lack of accessibility of refugees to healthcare services during the first eight months post-arrival. The income eligibility requirement for the RMA program in Idaho is 150% of the FPL. (“Idaho Refugee Medical Assistance Policy”) In cases where a refugee earns an income upwards of the 150% FPL level, that refugee is able to “spend down” until income matches the required amount for eligibility.

In the eight months post-arrival, accessibility to healthcare becomes more difficult. Under the current state Medicaid plan, coverage does not extend to adults without children under the age of 19. (“Idaho Medicaid Program: Health Coverage for Idaho Families”) For those adults, employment becomes increasingly important as a vehicle to secure health insurance and all the associated critical medical services. Adult, childless refugees with medical conditions that are barriers to sustainable employment may not have other healthcare options. This is the case for all states that have not implemented Medicaid expansion.

Local Community Partners

CSI is the only refugee resettlement affiliate based in Twin Falls, Idaho. Because this is a small community, the choices of healthcare providers are relatively limited. As a result, the process of coordinating with care providers within this community is more streamlined than in other, larger resettlement locations. All of CSI’s health screenings are conducted by the South Central Health District, and CSI has strong relationships with St. Luke’s Hospital and Family Health Services for the treatment of medical conditions and health maintenance. For more serious or rare conditions, refugees travel to Boise, approximately two hours by car.

Certain ethnic communities have stronger support networks in Twin Falls. The Nepali community is helpful in providing basic services to newly arrived refugees with medical conditions. These services can include transportation, interpretation or informal healthcare orientation.

Conclusions

The five models described in the previous section represent five effective ways of resettling medically vulnerable refugees. The models were not simply chosen by the resettlement affiliate or state coordinator, but grew through an organic process shaped by a number of variables. These variables include the geographic location of resettlement, the size of the population in the

location of resettlement, the existence of ethnic or religious communities and organizations, state policy, service provider capacity, and the social, cultural, and economic contexts of the community of resettlement. Due to this extreme variation in the factors shaping these resettlement models, the models themselves are unique. The benefit of this is that each model is a fit for the community in which it resettles refugees, the drawback is that these models are not perfectly replicable in other locales, and if they could be replicated they may not be as effective as they are in the locale of their creation.

However, the development of a community-based collaborative model in locations where there is a relatively large resettlement community and multiple affiliates working on resettling refugees with health conditions proves to be cost-effective and efficient in the resettlement of medically vulnerable refugees. The research sites examined in Philadelphia and St Paul both utilized this type of model, which requires collaboration between numerous resettlement affiliates and local officials. The overarching challenge in the development of these types of models is that funding is not readily available within affiliates for supporting positions required for the functioning of these models. Funding sources for models are fluid and vary from year to year. It should also be noted there are many ways to create community-based collaborative models, and while the Philadelphia and St Paul models are placed in the same category here, the operation and implementation of these models vary significantly from each other. Philadelphia uses an affiliate-based collaborative model and St Paul uses a state-based collaborative model.

Further, the community-based collaborative models studied proved to be the most cost-effective, when considering the services these models afford, as well the decreased impact on the resettlement affiliate, service providers, and refugees themselves. The total approximate cost of staffing these models is \$102,588 in Philadelphia and \$90,558 in St Paul. For comparative purposes, the cost of the other models studied were \$120,744.00 for Houston, \$105,651 for Boston, and \$60,372.00 for Twin Falls. The costs of these models were moderate when considered in comparison with the costs of all the other models. Of all the five models considered, the costs of the two collaborative models were only more expensive than the smallest site considered, and less expensive than the other two sites of similar size. This is also the case when considering costs per refugee. Although this study did not follow all of the medically vulnerable resettled in the focus cities, the benefits of the collaborative models are spread throughout those cities and all refugees resettled in those cities rather than just at the resettlement sites as is the case with the models in Boston and Houston. All calculations of costs are approximations based on standardized rates for case managers and mileage.

The community-based collaborative model is recommended for resettlement sites with multiple resettlement affiliates and a relatively large community of refugees being resettled. For smaller communities, such as Twin Falls, the addition of a coordinator operating across affiliates in an

individual city would not be an appropriate approach to managing the flow of refugees across medical care providers. The community-based collaborative model requires several resettlement affiliates operating within a single community.

The following table provides a breakdown of each model's approximate cost, source of funding support, and strengths of the model as related to resources and programming.

Figure 12: Model Costs and Benefits

Site Model	Resources Utilized Annually (FTEs dedicated to MCM, funding sources and related personnel costs) ¹⁰	Benefits of Model
Boston (IINE), <i>Independent Center Model</i>	<ul style="list-style-type: none"> • 1.75 dedicated FTEs • Annual personnel costs: \$105,651.00 • Positions funded by private foundations, R&P, MG, RCA, and the City of Boston Community Block Grants 	<ul style="list-style-type: none"> • In-house Licensed Independent Clinical Social Worker (LICSW) conducts bio-psychosocial intake examination <ul style="list-style-type: none"> ○ This often takes place well before the RHA and therefore allows time to coordinate more behavioral health supports • Allows for early intervention when needed
Houston (YMCA), <i>Independent Center Model</i>	<ul style="list-style-type: none"> • 2.0 dedicated FTEs • Annual personnel costs: \$120,744.00 • Positions funded by R&P, MG and PC grants 	<ul style="list-style-type: none"> • Approximately 100-120 refugees enrolled per year in extended medical case management program • Refugees referred into PC program according to need <ul style="list-style-type: none"> ○ Refugees can be enrolled for up to a year • MCMs perform one on one case management specific to a medically vulnerable refugee’s needs • MCMs have medical expertise allowing them to participate in creating treatment plan

¹⁰ Personnel costs were calculated using the standard USCRI rate of \$60,372.00; this rate includes salary costs and benefits and assumes standardization of positions across pay grades and titles.

Site Model	Resources Utilized Annually (FTEs dedicated to MCM, funding sources and related personnel costs) ¹¹	Benefits of Model
Philadelphia (NSC), <i>Affiliate- Based Collaborative Model</i>	<ul style="list-style-type: none"> • 2.5 dedicated affiliate-based FTEs (includes 1.0 HealthCorps FTE¹²) • Annual personnel costs: \$102,558.00 • Positions are funded through PC grant, Survivors of Torture grant, R&P, Victims of trafficking grant, and on-site fundraising. 	<ul style="list-style-type: none"> • The PRHC reduces stress on care providers by coordinating between resettlement affiliates for health screening appointments and ongoing care • Utilizes full-time Philadelphia HealthCorps member to act as a liaison between the resettlement affiliate, the refugees, and the care providers • Medical Support Services provides medical care coordination for refugees with high-risk chronic disease. Also assists with outreach efforts regarding the Affordable Care Act by helping refugees enroll in insurance as a Certified Application Counselor, and by assisting with community education/outreach events

¹¹ Personnel costs were calculated using the standard USCRI rate of \$60,372.00; this rate includes salary costs and benefits and assumes standardization of positions across pay grades and titles.

¹² Via the HealthCorps program, additional staff was obtained at a rate of \$12,000 per year.

Site Model	Resources Utilized Annually (FTEs dedicated to MCM, funding sources and related personnel costs) ¹³	Benefits of Model
Saint Paul (IIMN), <i>State-Based Collaborative Model</i>	<ul style="list-style-type: none"> • 1.5 dedicated FTEs • Annual personnel costs: \$90,558.00 • Positions funded through R&P and MN Department of Health 	<ul style="list-style-type: none"> • Full-time MSW employed by the DPH engages in pre-arrival coordination with the resettlement affiliate to create care plan and to prepare service providers and the community for the refugees arrival • Post-arrival notifications and enrollment in the MSW program enables arrivals with information missing on initial paperwork to receive appropriate health services for their medical needs in a timely manner • Part-time medical case manager follows up on care plans to ensure refugees medical needs are being met
Twin Falls (CSI), <i>Single Agency Model</i>	<ul style="list-style-type: none"> • 1.0 dedicated FTEs • Annual personnel costs: \$60,372.00 • Position funded through R&P and MG 	<ul style="list-style-type: none"> • Line-case management model allows MCM to focus on RHS and follow up • Because there is one case manager responsible for healthcare, there are minimal communication issues between staff members • Due to the fact that CSI is the only resettlement office it can ensure quick access to RHS and service providers

¹³ Personnel costs were calculated using the standard USCRI rate of \$60,372.00; this rate includes salary costs and benefits and assumes standardization of positions across pay grades and titles.

Policy Recommendations

Challenges of Providing Care

COST

1. PRM should increase the administrative component of the per capita funding for a subset of medically vulnerable cases identified pre-arrival. The conditions to be considered for additional per capita assistance should include mental health, cases with mobility issues and those requiring hospitalization within two weeks of arrival, as these require a level of investment far exceeding that of an average medically vulnerable case. In addition, ORR should strengthen and continue to support extended case management for medical cases (including those with conditions identified above) through the PC and Wilson-Fish programs.

Data shows that a subset of severe cases account for the majority of additional support required by resettlement affiliates in the first three months post-arrival. The three conditions that were found to require the most support were mental illness, mobility issues, and refugees requiring immediate hospitalization upon arrival. For conditions identified pre-arrival additional funding for these specific conditions on a per-capita basis would promote the successful resettlement of refugees with these conditions. Specific per-capita costs are \$273.09 for refugees with mental health conditions and \$315.85 for refugees with mobility issues.

Data shows that the resettlement of refugees who are hospitalized in the first two weeks in the U.S. require significant support, more than for any individual condition. These refugees on average required an additional 19.81 hours and 139.25 miles in support of their hospitalization, which translates into an average additional \$652.92 investment.

IMPACT OF MEDICAL CONDITIONS

2. The Centers for Disease Control and Prevention (CDC) should convene a working group and review multiple mental health assessment tools (such as the RHS-15), selecting the most appropriate tool for post-arrival mental health screening. The CDC mental health guidelines currently used should be assessed by this working group. The goal of this assessment would be to determine whether greater guidance could be provided to states and clinicians regarding the provision of mental health services to refugees.

CDC provides guidelines for components of RHAs during the post-arrival period. (“General Refugee Health Guidelines”) These recommendations do not require mental health testing, although it is commonly accepted that refugees arrive with a significant mental health burden

related to the trauma of the refugee experience. Since resettlement is a stressful process, an increase in mental health issues related to stress and anxiety is to be expected post-arrival, and additional assessment methods could be useful during this period. By convening experts on both mental health assessment and screening policy, a working group could effectively evaluate the various assessment tools currently available, and select the one most appropriate for post-arrival mental health assessment for multiple ethnic groups.

FLOW OF REFUGEE HEALTH INFORMATION

3. Develop and improve information-sharing and coordination related to SMC and other medical forms, especially during the pre-arrival planning phase of resettlement.

The receipt of timely and accurate pre-arrival information is critical to an affiliate's ability to coordinate tailored medical services, particularly for those who arrive with critical conditions requiring immediate support. Resettlement affiliates should continue to develop and improve information-sharing and coordination related to SMC and other medical forms, especially during the pre-arrival planning phase of resettlement of medically vulnerable refugees. Resettlement affiliates should develop internal policies on information-sharing to encompass all relevant staff that have a role in medical case management. Sharing SMC forms and other medical information with staff will promote pre-arrival planning for cases and ensure that staff are prepared to manage the most severe cases. Information on biodata on timing of recommended follow up, as well as other medical forms should be utilized to determine when medical information should be shared with medical service providers, state refugee officials and local health providers. Information should be shared, where applicable through secure, electronic channels.

REFUGEE ACCESS TO MEDICATION

4. Where possible, PRM, IOM, CDC, UNHCR and other pertinent agencies should coordinate to provide two months' worth of critical medications in a sealed package to refugees immediately prior to departure for the U.S.

Action should be taken to consistently provide refugees with two months' worth of critical medications upon departure. Currently, some refugees arrive with one month's of critical medications. Data shows there are time lags in medication acquisition post-arrival relating to insurance processing, which effects a refugee's ability to access medications in a timely manner. To manage this time lag, it is important that refugees arrive with a supply of critical medications that will last until the enrollment process is complete.

5. PRM should strengthen and reinforce trainings on medication and prescription management with RSCs overseas. National resettlement agencies should promote adoption of best

practices for prescriptions management post-arrival and reinforce it through Community Orientation delivery across affiliate sites.

Although refugees are provided with medications upon departure, data shows that additional reinforcement of medications management is needed to promote appropriate usage and maintenance of pharmaceuticals. Domestically, national resettlement affiliates should provide additional support via orientation to refugees immediately upon arrival to promote understanding of medications management and to reinforce previous trainings. Overseas orientation and education provided to outgoing populations should focus on the importance of not sharing or selling medications, ensuring that medications are kept with them at all times, continuing the physician-prescribed treatment throughout the travel period and upon resettlement. Domestic orientation should include information on the management of critical medications, review of dosing instructions, information on refilling prescriptions, and the importance of maintaining drug regimens. Orientation methodology should be reviewed to ensure that current best practices are utilized across affiliates. Some training tools currently in use have been provided in **Appendix K**.

Affordable Care Act (ACA) and Medicaid Expansion

EFFECT OF THE ACA

6. Resettlement affiliates should participate in Health Navigator and Health Advisor programs by engaging in partnerships with organizations that provide these services, by accessing existing programs, or by seeking grant opportunities.

Data shows that these programs are successful in providing additional and needed support to refugees. As refugee communities become engaged with Navigator programming, evidence indicates refugees become better informed about their health options, gain a higher rate of insurance coverage, and show an improved ability to manage their own health needs.

The federal government, through the Centers for Medicaid/Medicare Services at the Department of Health and Human Services, funds many Health Navigator programs throughout the country, and the last funding cycle (FY2014) awarded \$60 million in grants to programs proposing to provide navigator services within their communities. The implementation of Navigator programs is part of the ACA legislation and a requirement of Health Marketplace Exchanges. Further, the federal government has developed guidance on Navigator programs and certification requirements for those providing these services. Resettlement affiliates should locate locally funded programs, inform Navigators on local refugee communities and provide access to those communities. A resource to be used in the

implementation of this program has been developed by ORR (“Information for Navigator Programs - Refugee and Other Special Populations”).

7. SRCs and resettlement affiliates should identify local communities who meet eligibility requirements and ensure established ethnic communities receive mandated language support.

The ACA requires robust and professional medical interpretation services when a county has a particular language group represented at levels higher than 10%. Affiliates should ensure that counties with large refugee populations that meet the criteria outlined by the ACA receive medical interpretation funding. This could be accomplished through the implementation of advocacy and outreach programs in resettlement affiliates to ensure that refugees are included in the programs that have been developed.

The ACA fully supports the requirements previously set forth by Title VI of the Civil Rights Act and reiterates the importance of ensuring that accessibility to healthcare services is open and protected from discrimination, particularly when the organizations providing services receive federal funding.

IMPACT OF MEDICAID EXPANSION

8. Resettlement affiliates, SRCs and SRHCs should strengthen partnerships to address any possible gap in coverage by focusing on federal and local health options in locations without Medicaid expansion.

For refugees resettled in states without Medicaid expansion, resettlement affiliates should provide detailed information about local federal health options that are available in the locality. Information should include the location of FQHCs, the types of services provided by different FQHCs, and any cultural or linguistic capacity available at different FQHCs. This will ensure that refugees continue to receive services in locations without Medicaid Expansion.

9. In states pursuing Medicaid expansion, SRCs and SRHCs should endeavor to incorporate refugees’ unique circumstances into the planning and implementation of new policy.

In states that are undergoing Medicaid expansion, SRCs and SRHCs should involve themselves in the process at an early stage to ensure that refugees are taken into account. Some expansion states have struggled with longer enrollment periods as well as technical glitches that may prevent refugees from enrolling in Medicaid entirely. SRCs and SRHCs involved in Medicaid expansion efforts should endeavor to adopt best practices to ensure that refugees are able to enroll into Medicaid without delay.

Service Models: A Cost Benefit Analysis

- 10.** Use external organizations to support resettlement services. SRCs and resettlement affiliates should identify local MAAs and CBOs and build partnerships with them to promote successful resettlement of the medically vulnerable.

Develop processes for CBOs and MAAs to be better incorporated into the provision of medical case management services. When integrated into the provision of services, MAAs and CBOs can be partners in the provision of services to medically vulnerable refugees. Training on basic medical case management and confidentiality issues is needed to ensure CBOs and MAAs are well-versed in the needs of these clients. Since knowledge of the services of local healthcare providers is an integral part of being able to operate within home communities, trainings should be locally-based. Thus, when considering training options, local sources should be explored as they would be best suited to provide the type of targeted orientation required by these groups.

Consider using local and national volunteer services to support resettlement staff – federal programs such as AmeriCorps and other national programs such as HealthCorps provide cost-effective staffing options.

- 11.** Build a collaborative model. Three categories of service model were identified during this study. Resettlement affiliates should consider the models presented and determine which have characteristics or functions that would be appropriate for their site. In cases where characteristics of a collaborative community-based model is appropriate, local resettlement stakeholders should build partnerships to manage the implementation of a centralized coordination structure.

This report outlines a variety of service models that can be adapted to other resettlement communities. To build a collaborative, community-based model, resettlement affiliates need to conduct an assessment of the capacity of their internal services as well as their local community's, to determine where collaboration can be successfully implemented across a number of partner organizations. For the internal assessment, services requiring enhancement need to be identified. Other local resettlement affiliates and local stakeholders (including CBOs and MAAs) need to conduct similar assessments. Once the assessments are complete, either a top-down model of coordination or a bottom-up model needs to be created based on the level of engagement of SRHCs, SRCs, or other state officials. For locales with a high level of engagement by SRHCs and SRCs, a top-down model should be developed. Regardless of the model chosen, state refugee officials should be included in all discussions on model development and implementation. The creation of a model of this type will result in

a solid flow of refugees through local health care systems. This report recommends a consideration of the models utilized by the state of Minnesota and the City of Philadelphia as robust collaborative models, with Minnesota illustrating a top-down model, and Philadelphia a bottom-up one.

Future Studies

Findings from this study provide data on the challenges of resettling medically vulnerable refugees and an understanding of the costs of services provided by resettlement affiliates. To fully understand the impact of medical conditions on the refugees and the communities in which they are resettled, future studies should focus on the specific conditions that were found to require a high level of additional investment. These conditions are mental illness, mobility issues, and medical issues requiring immediate hospitalization upon arrival. Clients with these conditions require a high degree of support from resettlement affiliates, and many need ongoing support after the end of the R&P period. Mental health and related illness are particularly difficult to evaluate given the high level of stigma attached with this type of condition, and a longer-term study of the status of clients with this type of condition is needed to better understand the availability of services and care.

Although this current study provides an overview of five models and the processes used by each of them, a true analysis of these sites would be longer-term. Given the random nature of the flow of cases, a larger database studied over a longer period of time would allow for a deeper understanding of the relative efficiency of sites while minimizing the effects of quarterly fluctuations. Further, this study was conducted in a period of flux, in the midst of changes to health systems as a result of the ACA. To better understand the effects of these changes, a study should be conducted after all the ACA changes have been implemented and all the effects of the transition have been managed.

This study was limited in its ability to assess efficiencies at sites and compare them with the relative efficiencies of other sites due to the quantity of variables affecting each of the sites, the variations in the models themselves, multiple funding streams, and the short-term nature of this study. Future studies should focus on individual sites and consider efficiencies within the context of a site's individual state processes, funding streams, and site structure.

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Appendices

Appendix A – USCRI and Refugee Health

In FY 2013, USCRI resettled 11.8% of the refugee population arriving in the United States through PRM’s R&P program. These refugees were resettled in 21 states and 31 cities across the country. Of the cases resettled during that timeframe USCRI resettled numerous medical cases of varying conditions, including chronic diseases, mental health issues, and a variety of disabilities. Some of these cases required urgent or immediate post-arrival follow-up including stage four cancers, need for open-heart surgeries and immediate hospitalizations and hospice care.

USCRI has participated in formulating and distributing refugee-specific health materials, initiating and implementing collaborative networks for improving refugee health, providing technical assistance to affiliates and individuals, health and cultural competence training and education, clinical case management of refugees with special health conditions and needs, and pioneering work to bring together refugees with disabilities and those who can help them achieve greater independence and self-sufficiency. The project directly aligns with USCRI’s mission to protect the rights and address the needs of persons in forced or voluntary migration worldwide by advancing fair and humane public policy, facilitating and providing direct professional services, and promoting the full participation of migrants in community life.

Appendix B – RMA Data for Participant States

State	FY 2013 ORR Eligible Populations ¹					FY 2013 RMA New Enrollees ²				% of FY 2013 population enrolled in RMA ⁴
	Asylee	Cuban - Haitian Entrant	Refugee	SIV	Total ORR Populations	Trimester 1 New Enrollees	Trimester 2 New Enrollees	Trimester 3 New Enrollees	Total New Enrollees ³	
IDAHO	4	2	920	20	946	127	117	137	381	40%
MASSACHUSETTS	229	55	1,829	60	2,173	317	249	221	787	36%
MINNESOTA	93	4	2,214	15	2,326	18	16	16	50	2%
PENNSYLVANIA	331	152	2,507	43	3,033	659	507	537	1,703	56%
TEXAS	793	1,670	7,475	502	10,440	2,471	2,408	1,932	6,811	65%

Footnotes:

¹ FY 2013 ORR Eligible Populations data does not account for secondary migration.


² New Enrollee numbers are reported to ORR from State Refugee Programs through the ORR-6. States may have different systems and processes for collecting and reporting data and face different challenges in providing standard data. A "new enrollee" may be a new arriving refugee or a refugee who migrated to a different state and applies for RMA in the new state.

³ The new enrollee data is a subset of the total RMA caseload. The total RMA caseload will vary by month as new RMA recipients enroll, current recipients time out of RMA, and active RMA recipients roll over from month to month. Recipients of medical screenings paid for by funding from the RMA program may not be included in the chart.

⁴ The % of FY 2013 ORR population enrolled in RMA does not account for secondary migration and is only an estimate.

The Office of Refugee Resettlement covers health insurance costs for refugees resettled in the United States for the first eight months post arrival via RMA if they are ineligible for Medicaid or Medicare. State insurance policy directly affects the number of refugees enrolled in state-managed RMA programs, and is linked to the federal costs for care. In cases where the state has more restrictive eligibility requirements for Medicaid, RMA enrollment is higher and federal costs increase. Alternatively, in states participating in Medicaid expansion with a more “universal” model for health care provision, RMA drawdowns are lower, transferring costs to states after the initial federal coverage period.

As discussed earlier, of the five states considered for this study, two opted to expand Medicaid as part of the implementation of the ACA. In Minnesota and Massachusetts, levels of RMA enrollment are lower than in states not participating in Medicaid expansion. In the case of Minnesota, the change in RMA usage is particularly striking, with only 2% of refugees enrolled. Although Minnesota and Massachusetts both have lower rates of RMA utilization than states not participating in Medicaid expansion, the difference in usage between these two states is large. The difference can be attributed to variations in processing policies between the two states. In 2013, Massachusetts enrolled eligible refugees in RMA, and then transferred all those without other viable health insurance options to the state Medicaid plan. Conversely, Minnesota enrolled eligible refugees directly into the state Medicaid Plan and only utilized RMA for individuals deemed ineligible for other plans. With the advent of the ACA in January 2014, this prioritization changed for Massachusetts and a much higher percentage of incoming refugees



will be placed in state Medicaid programs as a first option. Predictions for RMA utilization for Massachusetts for 2014 are significantly lower than the 36% utilized for 2013.¹⁴

Although an attempt was made to gather individual medical cost information for refugees enrolled in this study, cost information was not identified. In cases where the refugee was enrolled in an insurance program, billing information was not provided to the refugee. Cost information in the database was only made available in cases where insurance was pending and a bill was produced in response, and in cases where pro-bono services were quantified. As a result, the cost data obtained from the survey was reported in limited circumstances, and do not lend to the reporting of findings.

All of the refugees enrolled in this study were covered by either RMA or a state Medicaid program. None of the new refugees had access to private insurance or ACA subsidies. All information gathered over the course of this study considered confidentiality issues required by HIPAA.

¹⁴ From communication with State Refugee Officer, August 14, 2014

Appendix C – Historical Arrival Data for Participating Resettlement Affiliates

FY 2011		Total cases	Total persons	Number of persons with		% of persons with SMC forms	% of persons with Relevant Medical Conditions
				SMC forms	Relevant Medical Conditions		
Bos	Q1	13	43	2	3	5%	7%
	Q2	12	31	6	7	19%	23%
	Q3	15	19	2	3	11%	16%
	Q4	42	79	2	7	3%	9%
	AVG	20.5	43	3	5	7%	12%
Hou	Q1	57	130	6	14	5%	11%
	Q2	52	122	13	25	11%	20%
	Q3	21	63	1	10	2%	16%
	Q4	46	112	6	28	5%	25%
	AVG	44	106.75	6.5	19.25	6%	18%
Phil	Q1	30	61	4	5	7%	8%
	Q2	38	86	8	15	9%	17%
	Q3	35	78	6	9	8%	12%
	Q4	47	120	14	28	12%	23%
	AVG	37.5	86.25	8	14.25	9%	17%
ST.P	Q1	31	76	4	15	5%	20%
	Q2	35	100	5	16	5%	16%
	Q3	23	66	2	3	3%	5%
	Q4	36	106	7	23	7%	22%
	AVG	31.25	87	4.5	14.25	5%	16%
TF	Q1	23	77	12	12	16%	16%
	Q2	28	64	10	17	16%	27%
	Q3	23	37	3	7	8%	19%
	Q4	62	118	17	30	14%	25%
	AVG	34	74	10.5	16.5	14%	22%

FY 2012		Total cases	Total persons	Number of persons with		% of persons with SMC forms	% of persons with Relevant Medical Conditions
				SMC forms	Relevant Medical Conditions		
Bos	Q1	4	11	0	0	0%	0%
	Q2	12	23	0	0	0%	0%
	Q3	28	57	11	10	19%	18%
	Q4	32	79	1	3	1%	4%
	AVG	19	42.5	3	3.25	7%	8%
Hou	Q1	40	87	8	19	9%	22%
	Q2	41	78	11	15	14%	19%
	Q3	76	171	20	27	12%	16%
	Q4	75	161	20	32	12%	20%
	AVG	58	124.25	14.75	23.25	12%	19%
Phil	Q1	13	31	3	5	10%	16%
	Q2	34	56	3	9	5%	16%
	Q3	34	60	7	10	12%	17%
	Q4	92	199	31	37	16%	19%
	AVG	43.25	86.5	11	15.25	13%	18%
ST.P	Q1	25	45	0	7	0%	16%
	Q2	44	94	10	20	11%	21%
	Q3	32	63	15	19	24%	30%
	Q4	48	106	6	17	6%	16%
	AVG	37.25	77	7.75	15.75	10%	20%
TF	Q1	27	48	5	6	10%	13%
	Q2	29	37	3	9	8%	24%
	Q3	48	88	6	14	7%	16%
	Q4	53	91	9	16	10%	18%
	AVG	39.25	66	5.75	11.25	9%	17%

FY 2013		Total cases	Total persons	Number of persons with		% of persons with SMC forms	% of persons with Relevant Medical Conditions
				SMC forms	Relevant Medical Conditions		
Bos	Q1	24	46	2	11	4%	24%
	Q2	20	44	2	4	1%	4%
	Q3	25	68	2	9	19%	18%
	Q4	38	81	2	16	0%	0%
	AVG	24	51.25	3.5	8	7%	16%
Hou	Q1	68	146	15	27	10%	18%
	Q2	73	137	6	32	4%	23%
	Q3	60	145	20	52	14%	36%
	Q4	78	184	30	78	16%	42%
	AVG	69.75	153	17.75	47.25	12%	31%
Phil	Q1	31	72	15	16	21%	22%
	Q2	49	120	5	26	4%	22%
	Q3	29	59	10	26	17%	44%
	Q4	55	122	14	37	11%	30%
	AVG	41	93.25	11	26.25	12%	28%
ST.P	Q1	57	119	8	26	7%	22%
	Q2	40	98	5	29	5%	30%
	Q3	35	86	7	38	8%	44%
	Q4	34	108	11	51	10%	47%
	AVG	41.5	102.75	7.75	36	8%	35%
TF	Q1	44	79	6	14	8%	18%
	Q2	34	88	10	32	11%	36%
	Q3	30	65	8	21	12%	32%
	Q4	35	68	5	13	7%	19%
	AVG	35.75	75	7.25	20	10%	27%

FY 2014		Total cases	Total persons	Number of persons with		% of persons with SMC forms	% of persons with Relevant Medical Conditions
				SMC forms	Relevant Medical Conditions		
Bos	Q1	34	55	3	9	5%	16%
	Q2	29	60	8	15	13%	25%
	Q3	39	90	8	7	9%	8%
	Q4						
	AVG	25.5	51.25	4.75	7.75	9%	15%
Hou	Q1	73	171	9	35	5%	20%
	Q2	72	180	9	21	5%	12%
	Q3	50	110	9	12	8%	11%
	Q4						
	AVG	48.75	115.25	6.75	17	6%	15%
Phil	Q1	41	98	18	45	18%	46%
	Q2	38	89	19	28	21%	31%
	Q3	26	59	2	10	3%	17%
	Q4						
	AVG	26.25	61.5	9.75	20.75	16%	34%
ST.P	Q1	32	81	5	37	6%	46%
	Q2	44	118	7	19	6%	16%
	Q3	51	136	6	34	4%	25%
	Q4						
	AVG	31.75	83.75	4.5	22.5	5%	27%
TF	Q1	21	38	5	15	13%	39%
	Q2	67	139	9	15	6%	11%
	Q3	35	81	14	16	17%	20%
	Q4						
	AVG	41	86	9.33	15.33	12%	23%

Appendix D – Clients with Mental Health Conditions

Client	Arrival Date	Mental Illness	when was the condition discovered?	Days until first medical services related to mental illness	How was the condition discovered	Did the client receive any mental health services during the first 90 days	At the end of the 90 day period are they continuing to access mental health services	At the end of the data-gathering period (3 months post-arrival), does the client still require assistance from your office to address their health conditions?	Type of Service provided by staff
BOS06	3/12	PTSD- and body aches and pain (Somatization Disorders) Depression	Pre arrival	28	Biodata	Yes	Yes	Yes	Referral to CBO mental health services. Attended appointment with client. Helped acquire medication
BOS07	3/26	Depression/Anxiety	62 days post-arrival	still pending	Through medical service;Observation	Yes	Yes	Yes	Obtained referral for behavioral health clinician to address anxiety and depression
HOU11	3/26	Psychiatrist follow up for anxiety disorder.	Pre arrival	Has not yet received MHS	SMC Form;Biodata	No	No	Yes	Client has not requested any services
PHIL11	2/4	Past history of Major Depressive Disorder	Pre arrival	Has not yet received MHS	Significant Medical Condition Form (SMC);Bio Data;Pre-Departure Medical Screening Form (PDMS)	No	No	No	Client has not requested any services
Phil22	1/29	No full diagnosis because it was after the 90 day period	75 days post-arrival	25	Client requested MHS	No	Yes	Yes	Called community behavioral health for a referral. Enrolled in the PPR (Philadelphia Partnership for Resilience – Survivors of Torture)
PHIL23	2/13	No full diagnosis because it was after the 90 day period	105 days post arrival (discovered through extended case management)	Has not yet received MHS	Client requested MHS	No	Yes	Yes	The client requires mental health needs and is on waitlist for Philadelphia Partnership for Resilience as a survivor of torture.
PHIL24	2/11	Major depressive disorder and generalized anxiety disorder	Pre Arrival	Has not yet received MHS	Bio Data;Pre-Departure Medical Screening Form (PDMS)	No	No	Yes	Referred to Philadelphia Partnership for Resilience as a survivor of torture.
PHIL34	1/22	No diagnosis	Day of Arrival	Has not yet received MHS	Client expressed feelings of depression	No	No	Yes	case manager did safety training and planning as an informal way to address client's needs. Client does not want MHS.
STP06	3/28	Major depression	Pre Arrival	Has not yet received MHS	Medical Assessment Form	Waiting for Feedback	Waiting for Feedback	No	
TF03	1/16	PTSD	20 Days post arrival	57	Health Screening	Yes	Yes	No	Linked with MHS

Appendix E – List of Forms Related to Medical Conditions

Form	Generated By	Intended Audience	Stage of Resettlement	Intended use	Comments/ Notes
Resettlement Registration Form (RRF)	UNHCR (internal)	Resettlement Country	RRF is used at submission and adjudication.	The resettlement submission document UNHCR uses on individual resettlement cases.	The RRF is a document containing detailed information regarding each member of the resettlement submission including bio data, refugee claim, need for resettlement and any special needs.
Medical Assessment Form (MAF)	UNHCR	IOM and medical providers in country of resettlement.	MAF is generated prior to UNHCR submission and attached to RRF. MAF is transmitted to Resettlement Agencies for use after arrival.	The medical form accompanying a resettlement submission being referred under the Medical Needs Criterion. Normally valid for six months.	Qualified physicians fill out MAFs. MAF is geared toward a medical professional and has information about the condition, diagnosis, prognosis and medication of patient.
Significant Medical Conditions Form (SMC)	IOM	Resettlement agencies which should share this information with local/state officials during placement discussions; CDC also receives the SMC through EDN.	At the time of case allocation that is post USCIS interview and medical exam.	The SMC form is designed to provide a tool for transmitting advance information on refugees' post- arrival follow-up or additional assistance needs to receiving agencies in the country of destination. The form is required to be filled for any refugee diagnosed with medical conditions requiring additional assistance from the resettlement agency and/or local health care providers.	Instructions for the use of the SMC are on the last page the SMC form.
Bio Form	Resettlement Support Center (RSC)	Resettlement Agency	Case Allocation		Medical information isn't routinely included in Bio Form. The Resettlement Agencies should review all sources of medical information. The bio includes information entered into WRAPS only. The agencies are expected to review the DS medical forms and any other scanned reports.
DS Forms	Panel Physicians	Resettlement Agency; CDC; State and local health officials	Forwarded to Resettlement Agency at case allocation; and shared with State and local health officials via EDN (on average within 3 months of departure, but may be longer)		Documents overseas medical exam which is used by CDC to identify conditions of public health significance; and state and local health officials to identify conditions needing follow-up
Pre-Departure Medical Screening Form (PDMS)	IOM	Resettlement Agency; Medical screening provider	Immediately prior to departure	Documents medical tests, and treatment given immediately prior to departure.	

Source: Adapted from the ARHC-RCUSA-SCORR Health Committee

Appendix F – Companion Guide for PRM Domestic Refugee Health Capacity Study

USCRI Health Capacity Study

Study of Domestic Capacity to Provide Medical Care for Vulnerable Refugees

The goal of the Study of Domestic Capacity to Provide Medical Care for Vulnerable Refugees is to assess the domestic capacity to care for refugees with significant medical conditions and apply research findings to policy recommendations. To accomplish this goal, USCRI has developed a survey tool to measure and analyze the costs and services provided to refugees with severe medical conditions and those with chronic or ongoing medical needs. The application of this tool and subsequent data analysis will provide information on the burden of providing appropriate medical and case management services to arrivals with significant medical conditions.

The survey form is electronic and operates on a google platform. A new form is required for each individual eligible refugee. Forms can be revisited throughout the initial three months of resettlement to allow for the incorporation of additional information. In cases where refugees exhibit multiple medical conditions, information for each individual condition needs to be included in the survey. The survey is chronological in nature. It begins with pre-arrival planning and progresses to post-arrival planning, medical services conducted, and treatment provided until the end of the initial three months. An exit survey will be sent to you for each client at the end of the three-month period.

Survey Companion Guide

The purpose of this guide is to provide additional information and guidance for each of the questions on the survey. The guide is organized by question, so that each numbered question on the guide corresponds to an equivalently numbered question on the survey tool. In the event that this guide does not provide clarity on a specific question, please contact Dina Dajani or John Meagher. Contact information is provided at the top of this document.

The survey should not include any self-identifying information; however agencies should have an internal method of tracking participants to eliminate duplication.

Note: This survey is designed to capture both physical and mental health conditions. Please be sure to capture data regarding ALL conditions.

Client Eligibility for Data Collection

Each data-gathering site is responsible for the identification of eligible clients for the Study. Eligible clients are those who arrive in the period between January 6, 2014 and April 6, 2014.

Each client should be monitored for three months. The data gathering period will be completed by July 6, 2014.

This study utilizes an assistance-based approach for the identification of clients so as to capture data on refugees with severe medical conditions and those with chronic or ongoing medical needs. These services must fall outside the standard care provided during initial refugee medical screening and routine follow-up. This approach will ensure that a statistically relevant sample size is achieved as well as guaranteeing that all clients with severe medical conditions are included in the Study.

Client identification may occur either pre-arrival or post-arrival. Affiliates can identify clients pre-arrival based on notification from the national headquarters. Affiliates can identify clients post-arrival based on identification of significant medical needs.

Medical attention or medical-related agency services are any health-related support activities conducted either by medical personnel or agency staff. They include:

1. Appointments with medical care providers for chronic or ongoing medical needs and related coordination (not including initial refugee medical screening and routine follow-up);
2. Acquisition of needed medical supplies such as wheelchairs and home-based care items for significant, chronic or ongoing medical needs;
3. Management of housing needs, such as the need to identify accessible housing related to medical issues;
4. Interpretation needs, including medical interpretation;
5. Planning for the management of cases with significant medical conditions.

For the purposes of this Study and inclusion in the category, a severe medical condition is identified as an individual that has a condition that meets one or more of the criteria below:

1. Clients requiring urgent/lifesaving medical interventions;
2. Clients requiring hospitalization upon arrival and continued care;
3. Clients requiring assistance for daily living activities such as clients with physical disability (amputees, paralyzed, cerebral palsies, etc...);
4. Mental health disorders such as schizophrenia, bi-polar and/or history of attempted suicide;
5. High-risk pregnancy;
6. Congenital heart defect requiring surgery; and/or
7. Complex chronic conditions such as cancer, renal failure, and blood disorders.

Guidance on Official Transfers and Secondary Migrants

Data should be collected on all official transfers with significant medical conditions who are still within their first three months of arrival and meet the official eligibility criteria outlined in this

guide. Official transfers should be treated the same way as cases allocated to your site. You will identify these clients through question 4 of the “case information” section. Secondary migrants who are not official transfers are not eligible for this study, as service provision for secondary migrants is not covered by the Cooperative Agreement between voluntary agencies and the Department of State. However, given that affiliates organizations provide support to secondary migrants outside of the official Cooperative Agreement, and that this support directly affects an agency’s capacity, we request that some basic information surrounding secondary migrants be provided outside of the survey. Please note that all eligibility requirements surrounding secondary migrants must be in line with the guidance provided in previous sections.

We request agencies track basic information about secondary migrants with significant medical conditions who arrive in their communities within the first three months of resettlement. Specifically, we ask that sites track the date the secondary migrant arrived at their initial resettlement site, the date the secondary migrant was first seen by agency personnel, a general assessment of the level of assistance given, and some basic information about the complexity of the medical condition of the case. A spreadsheet has been included at the end of this guide for the purposes of tracking this information.

Remember to select the “Send me a copy of my response” option at the end of the form before you submit. This will allow you to access and update these forms later.

Guidance on Survey Questions

Please note that individual surveys can be re-visited at any time over the course of the three-month period for the purpose of inputting additional information as it becomes available.

Case Information

1. If you respond “yes” to this question it will skip directly to the “medical services” section, so you can immediately report on new medical services the client has received.
2. The date that you received Advanced Booking Notification (ABN) for the case.
3. The date the refugee arrived at the airport in your city. Not the date of arrival at port-of-entry.
4. If the client did not arrive, give an explanation of why, as noted in the flight deletion notice. Notify the project team at USCRI if this occurs. In the event that this is an official transfer, please indicate this was the case in this section. The official date of transfer should also be recorded under this question.
5. The country in which processing for the client took place.
6. How many individuals are part of the case? This does not include members of a hard-cross or soft-cross referenced cases.
7. List the case by their relationship code and include their age. Please do not use names or other identifying information of the clients.
8. If there is a U.S. tie, what is their relationship to the client, as noted on the bio data?

9. Is there a case hard-cross referenced to the client's case? If so, what is the relationship to the client, as noted on the bio data?

Demographic Information

1. List the client's age.
2. Check the client's gender.
3. List the client's nationality, as noted in the bio data. Use the country codes. (Refer to attached spreadsheet for questions 3, 4, 5)
4. List the client's ethnicity, as noted on the bio data. Use the ethnicity codes.
5. List the languages spoken by client, using commas to separate them. Use language codes.
6. Check the level of English reading proficiency based on bio data assessment. If there is a significant disparity between what is in the bio data and the client's actual proficiency, please make note of this.
7. Check the level of English writing proficiency based on bio data assessment. If there is a significant disparity between what is in the bio data and the client's actual proficiency, please make note of this.
8. Check the level of English speaking proficiency based on bio data assessment. If there is a significant disparity between what is in the bio data and the client's actual proficiency, please make note of this.

Health Information

Medical Condition

1. Be as detailed as possible in explaining the primary medical condition.
2. For the purposes of this Study and inclusion in the category, a severe medical condition is identified as an individual that has a condition that meets one or more of the criteria below. If the client meets one of the following criteria, select "yes".
 - a. Clients requiring urgent/lifesaving medical interventions;
 - b. Clients requiring hospitalization upon arrival and continued care;
 - c. Clients requiring assistance for daily living activities such as clients with physical disability (amputees, paralyzed, cerebral palsies, etc...);
 - d. Mental health disorders such as schizophrenia, bi-polar and/or history of attempted suicide;
 - e. High-risk pregnancy;
 - f. Congenital heart defect requiring surgery; and/or
 - g. Complex chronic conditions such as cancer, renal failure, and blood disorders.

3. Does the medical condition affect the client's physical mobility in any way and does the client necessitate the use of special medical equipment?
4. Check the box to indicate whether you were made aware of this condition pre-arrival.
5. How did you learn about this condition, either through pre-arrival forms or other non-standardized means? The forms listed below may be received as part of the pre-arrival medical information packet or in the International Organization for Migration (IOM) bag. This may be shared by the national resettlement agency during allocation or as part of a medical update follow-up. Select all that may apply:
 - a. Significant Medical Condition (SMC) form
 - b. United Nations High Commissioner for Refugees (UNHCR) Medical Assessment Form
 - c. Bio data
 - d. Department of State (DS) Medical Examination Form, which may include
 - DS-3024 (Chest X-Ray and Classification Worksheet)
 - DS-3025 (Vaccination Documentation Worksheet)
 - DS-3026 (Medical History and Physical Examination Worksheet)
 - e. Pre-Departure Medical Screening Form (PDMS) – an IOM form
 - f. Doctor's notes – which may be included as part of the pre-arrival medical information packet or in the IOM bag
 - g. Upon arrival – through information garnered from the medical escort or in the IOM bag
 - h. U.S. Tie – information shared by the U.S. Tie
 - i. Through a diagnosis by a local health provider
 - j. Other – list any other source of information
6. If you answer "yes" to this question, you will be asked to answer questions regarding the additional health condition. If you select no, you will move onto the Medical Treatment Plan section.

Medical Treatment Plan

1. Does the client require regularly scheduled medical attention to manage the medical condition(s) noted in the health information section?
2. When are the appointments or treatments scheduled?
3. Estimate the time and resources used by staff in preparing for the case pre-arrival. Time spent on coordination of appointments, additional time spent acquiring accessible housing (beyond Reception and Placement (R&P) requirements), acquisition of required medical supplies, are examples of information that should be considered in the response to this question.
4. Choose the options applicable to the client.
 - a. Transportation – assisting the client to go to medical appointments (mileage of staff time, bus tokens, taxi fare, etc.)

- b. Interpretation - costs associated to provide linguistically appropriate medical services
 - c. Staff consultation with local health centers – time spent in coordinating follow-up appointments and sharing medical information
 - d. Creation of a treatment plan – time associated in creating a specialized treatment plan and tracking of appointments associated with the plan
 - e. Staff time in specialized housing needs - additional time spent acquiring accessible housing (beyond Reception and Placement (R&P) requirements),
 - f. Coordination of volunteers – time spent coordinating volunteers who might assist with transportation, interpretation, picking up prescriptions, etc.
 - g. Other – list any other resources
5. Choose the programs or funding mechanisms that you anticipate will cover the costs of the client’s medical services.
 6. If the client pays for private insurance, what are the monthly payments and deductibles for the plan?
 7. Does the client receive Affordable Care Act (ACA) subsidies for their private insurance? How much are they (How much do they reduce the monthly deductible)?
 8. Select from the provided list who assists in the provision of health care services for the client.
 9. Describe the services provided by the organization(s) checked in the previous question.

Medical Services and Case Management

The goal of this section is to gain a greater understanding of the specific type of service received by the client. This section is divided into three sub-sections. They are Medical Services, Pre-Arrival Planning or Case Management, and Services provided by Auxiliary Individuals or Organizations. Please fill out the appropriate sub-section(s) based on your answer(s) to question 1 in this section.

1. Select the types of service providers who participated in providing assistance to address the primary medical condition of the client. It could be one, two, or all. You will have an opportunity to answer questions based on the participation of each of these types of providers.
 - a. Medical Services
 - b. Pre-arrival planning or case management by staff
 - c. Services provided by auxiliary individuals or organizations

If you checked Medical Services, answer the following questions. Please note that information in this section was created to capture planned appointments in addition to

emergency medical visits and services. If the service provided was an emergency service, please enter the data for questions 2 and 5-13.

2. On what date was the appointment scheduled to occur?
3. Did the client attend the appointment?
4. If the client did not attend the appointment, list why not?
5. What type of medical service was it? Check one.
6. What was the reason for the visit?
7. Be as descriptive as possible about the diagnosis to the best of your knowledge.
8. Was there a follow-up appointment scheduled? List when the next appointment will take place.
9. If a treatment plan did not exist before this medical service, did the service prompt the creation of a treatment plan? Or was the treatment plan amended to address new information?
10. List plan for future medical services as well as estimated staff resources that will be attributed to servicing this case.
11. Based on billing information that may be available to you, what were the costs of the medical service?
12. Were there any medication(s) prescribed? If so, what were they?
13. What were the costs associated with the medication(s) prescribed? Look for the cost on the prescription receipt from the pharmacy.

If you checked Pre-arrival Planning or Case Management by Staff, answer the following questions:

14. List the date service was performed. If coordination for a medical service occurred before the appointment, this date will be different from the one listed under "Medical Service". If the service performed took several days to complete, please provide the date the service was completed.
15. Which staff members (listed by position) assisted in providing the service?
16. Describe the service provided in as much detail as possible.
17. List the mileage traveled by each staff involved in the provision of this service.
18. Check the amount of time spent by each staff involved in the provision of this service.
19. Use this area to encapsulate staff resources used or noted under "other" in question number 4 in the Medical Treatment Plan section.

If you checked Services Provided by Auxiliary Individuals or Organizations, answer the following questions:

20. List the date the service was provided.
21. Select the group or individual that provided the service.
22. Briefly describe the group or individual. For those that assist frequently more information will be gathered through other means.
23. Describe the service provided.
24. Provide or estimate the mileage traveled by each auxiliary individual/organization involved in the provision of this service.
25. List the amount of time spent by each auxiliary individual/organization involved in the provision of this service.
26. Use this area to encapsulate resources that are not captured above. For instance, specific equipment used to provide a service for a client.
27. If answered “No”, you will have the opportunity to provide information on an additional service.

Remember to select the “Send me a copy of my response” option at the end of the form before you submit. This will allow you to access and update these forms later.

Guidance on Exit Survey Questions

Process for Closing a Client Form:

1. You will receive notification from USCRI that the exit survey has been delivered to your google inbox.
2. You will have **five business days** following notification to fully update the client form and fill out the exit survey for that client.
3. Briefly review all previously entered data for accuracy.
4. Update the Medical Services/Case Management section of the form to reflect the most up to date information.
5. Complete the exit survey.
6. Notify USCRI project staff that the case has been closed.

Exit Survey Guide:

1. If the clients medical needs have not been resolved, and they need further treatment, select yes.
2. If the client still requires the assistance of your organization to meet their medical needs, select yes.
3. Is the client employed (or searching for employment) or enrolled in school?
4. If there is a limitation, either physical or mental, to their ability to work or attend school, please note that here.
5. Does this client have a US-tie?
6. If “yes” to question #5, rate the helpfulness of the US tie to the management of the clients health conditions using a scale of 1-10, “1” being “no support given”, 10 being “a significant amount of support”.

-
7. Use this question to describe any unique circumstances that complicated the delivery of treatment to the patient.
 8. Did the client receive health-focus education, orientation or training?
 9. If “yes” to question #8, please briefly describe those programs.

Describe any other issues you had with the case that were not captured elsewhere.

Appendix G – Participating Resettlement Affiliate Structured Interview

Name:

Affiliate:

Contact information:

Which best describes your affiliate's locality? Metropolitan, suburban, rural, other?

1. Describe the process of resettlement when a refugee arrives with a significant medical condition (SMC), starting from the point at which you are first made aware of the client's health concerns.

- a. How does your affiliate manage refugees with significant medical conditions? What are the specifics of the model?
- b. Do you have on-site resources for the management of health issues? Do you have a dedicated medical case manager?
- c. What special programming and resources, if any, do you have for this client population?
- d. Is there a dedicated medical interpreter?
- e. Is there health care education?
- f. Is there an orientation processes specifically tailored for the needs of these clients?
- g. Is there any other programming (such as vocational training, language classes, health or cultural orientation classes) that is dedicated to this group?

2. Do you typically conduct a health assessment for all arrivals? How does this assessment vary for refugees with significant medical conditions?

3. How does your affiliate manage costs associated with the resettlement of refugees with significant medical conditions, both medical and auxiliary costs?

- a. Do you expect your system of pay to vary with the advent of the Affordable Care Act (ACA)?

4. How do you work with partners in your local community on the provision of healthcare services?

- a. Who provides healthcare services within your community? Hospitals, clinics, others?
- b. How do you interact with this group?

-
- c. Are partners well-versed in the specific health needs of the various refugee groups? Do healthcare providers in your network regularly encounter health conditions with which they are unfamiliar?
 - d. Are there any free/low cost healthcare options (free clinics, doc in a box?) commonly used by your clients? Are there any local non-profits that provide health care services for low-income families?
5. What role does your State Refugee Health Coordinator play in the provision of healthcare services to refugees with SMCs? What is their level of engagement? What about the State Refugee Coordinator? Do you have any other officials in your area (city, county) working on refugee health issues? What are their roles?
 6. Are there any regular volunteers working with your affiliate to provide support for this population? If so, how are volunteers managed? What kind of affiliate-based support (such as training and oversight) do they receive?
 7. What barriers to care exist within your community for this population?
 - a. Proximity/accessibility of hospitals and clinics from affiliate?
 - b. Proximity/accessibility of housing from affiliate and healthcare centers?
 - c. Cultural barriers to care?
 - d. Limited medical interpretation?
 8. Generally speaking, do refugees with significant medical conditions arriving with U.S. ties fare better than those who do not have those ties?
 9. How does state policy affect health care outcomes?
 10. What changes could your state make to enhance outcomes?
 11. Does you have access to Refugee Medical Assistance (RMA)?
 12. What are the thresholds for Medicaid?
 13. Is there state or locality-based programming unique to your area we have not identified yet?
 14. What do you believe are your three biggest obstacles/assets in resettling refugees with medical conditions?
 15. Where do you think your capacity is in relation to the amount of medical cases you currently receive?

-
- a. Would you want to resettle more medical cases?
 - b. What resources would you need to accomplish this?

Appendix H – Other Local Resettlement Affiliates Structured Interview

Name:

Position:

Affiliate:

City:

Contact information:

Which best describes your affiliate's locality? Metropolitan, suburban, rural, other?

1. Tell me about a recent case that arrived at your site with a significant medical condition. What did your affiliate do pre-arrival? Post-arrival? 3 months post-arrival?

- a. Do you gather any data surrounding the refugees who arrive with significant medical conditions? If yes, what specifically do you gather?
- b. What percentage of clients arrive with significant medical conditions at your site?

2. Do you typically conduct a health assessment for all arrivals? How does this assessment vary for refugees with significant medical conditions?

3. How do you work with partners in your local community on the provision of healthcare services?

- a. Who provides healthcare services within your community? Hospitals, clinics, others?
- b. How do you interact with this group?
- c. Are partners well-versed in the specific health needs of the various refugee groups? Do healthcare providers in your network regularly encounter health conditions with which they are unfamiliar?
- d. Are there any free/low cost healthcare options (free clinics, doc in a box?) commonly used by your clients? Are there any local non-profits that provide health care services for low-income families?
- e. What role does your State Refugee Health Coordinator play in the provision of healthcare services to refugees with SMCs? What is their level of engagement? What about the State

-
- Refugee Coordinator? Do you have any other officials in your area (city, county) working on refugee health issues? What are their roles?
- f. Are there any regular volunteers working with your affiliate to provide support for this population? If so, how are volunteers managed? What kind of affiliate-based support (such as training and oversight) do they receive?
4. How does your affiliate manage costs associated with the resettlement of refugees with significant medical conditions, both medical and auxiliary costs?
- a. Do you expect your system of pay to vary with the advent of the Affordable Care Act (ACA)?
5. How does state policy affect health care outcomes?
- a. What changes could your state make to enhance outcomes?
 - b. Does you have access to Refugee Medical Assistance (RMA)?
 - c. How do you utilize Medicaid with refugee populations?
 - d. Is there state or locality-based programming unique to your area we have not identified yet?
6. Generally speaking, do refugees with significant medical conditions arriving with U.S. ties fare better than those who do not have those ties?
7. What barriers to care exist within your community for this population?
- a. Proximity/accessibility of hospitals and clinics from affiliate?
 - b. Proximity/accessibility of housing from affiliate and healthcare centers?
 - c. Cultural barriers to care?
 - d. Limited medical interpretation?
8. What do you believe are your three biggest obstacles/assets in resettling refugees with medical conditions?
9. Where do you think your capacity is in relation to the amount of medical cases you currently receive?

-
- a. Would you want to resettle more medical cases?
 - b. What resources would you need to accomplish this?

10. In an ideal world, how would you adjust your affiliate's current model to improve the delivery of services to recently resettled refugees?

Appendix I – State Refugee and Refugee Health Coordinator Structured Interview

Note: Although the various state-based refugee officials are responsible for activities in the entirety of the state in which they operate, we are specifically interested in how they engage with the refugee health communities in the particular cities we are considering. As much as possible, conversations should focus on the city in question, and not the whole state.

Also, please inform subjects that all questions pertain to both physical and mental health issues.

Name:

Title:

State:

1. What types of activities surrounding the resettlement of refugees with significant health conditions does your office conduct?
 - a. Do you ever engage with treatment-level coordination for individual refugees? If so, describe a recent case in which you have been involved. Does this extend to mental health cases as well?
 - b. Do you engage with refugee health issues on a policy level? Please provide an example of recent health policy issues in your state that concerned the management of refugees with severe health conditions.
2. Is there a system in place for resettlement affiliates to share refugee medical information with your office and/or state and local public health officials pre-arrival for the purposes of planning for appropriate post-arrival care?
3. Describe coordination and collaboration with local affiliates.
 - a. Which affiliates do you regularly work with?*
 - b. Do you have regular meetings? If so, what are the specifics? How often, what types of issues are discussed, who else attends those meetings?
 - c. What activities do you normally engage in with them?
4. Describe coordination and collaboration with local health agencies.
 - a. Which agencies do you regularly work with?*
 - b. Do you have regular meetings? If so, what are the specifics? How often, what types of issues are discussed, who else attends those meetings?
 - c. What activities do you normally engage in with them?

-
5. Describe coordination and collaboration with other state officials (If you are interviewing the State Refugee Coordinator, you are specifically asking about the State Refugee Health Coordinator. In some places, such as Philadelphia, this is complicated by the fact that the city of Philadelphia also has a refugee coordinator for the city. In cases like this, we need to be sure to capture the dynamic surrounding having a third party)
 - a. Please list all the officials in your state that are engaged in the resettlement of refugees with severe medical conditions.*
 - b. Do you have regular meetings? If so, what are the specifics? How often, what types of issues are discussed, who else attends those meetings?
 - c. What activities do you typically engage with this group on?
 6. Please describe the model for the resettlement of refugees with significant medical conditions currently utilized by your state.
 - a. How do you think this could be improved?
 - b. To what extent does the complexity of the case affect the level of time/resources spent on the case?
 - c. Have you created any policies specifically related to medical refugee cases that are unique to your state?
 - d. Describe the impact of medically vulnerable refugees' cases on the resettlement system?
 - e. What policy changes or resources would make the resettlement of medically vulnerable refugees more effective?
 - f. Do you monitor the numbers of medically vulnerable refugees that enter your state? Would you be willing to share the data you gather? (looking for basic demographic information if they can provide it)
 - g. Do you use RMA to cover costs associated with the resettlement of these refugees? If so, would you be able to provide data on RMA usage and costs for the city we are considering? What about for the state overall? Do you report RMA expenditures back to the Office of Refugee Resettlement? What specifics do you report?
 7. How does state policy (particularly pertaining to local adaption of the Affordable Care Act and Medicaid expansion) affect your state's ability to provide medical services to new arrivals? Do you envision health care accessibility will be affected? If so, how?
 8. In your opinion, what are the barriers to accessing health services for refugees in your state? Do you have recommendations on how the process could be improved?

*For questions on who else they work with: We want as complete a list as possible to confirm community map information we have developed from our original affiliate interviews

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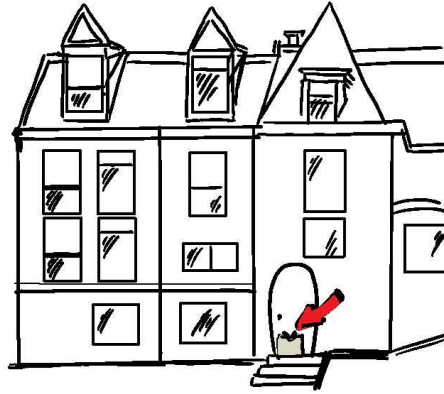
Appendix K – Prescription Medication Management Resources

Picking Up Prescriptions

1. Your physician will call in your prescription to the pharmacy, or provide you with a paper copy.



2. Sometimes, your prescription can be delivered to your home.



3. Sometimes, you may have to pick up your prescription at the pharmacy. These are the names of some common pharmacies.



4. When you pick up your prescription at the pharmacy, your pharmacist will explain how to take your medicine.



5. When picking up your prescription, bring your insurance card and photo ID.



6. Call your pharmacy for a refill when you only have a few pills left.

