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A Collaborative Community Approach to Refugee Health:

The Exemplary Model of Lancaster County, Pennsylvania

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ABSTRACT

Historically, Lancaster County has been a safe haven for groups like the Amish, Quakers, and Huguenots who fled religious and political persecution in the 17th Century. Since the late 20th Century, Lancaster County has become the home of a new influx of more than 4,589 refugees who have come as the result of protracted crises in countries as widespread as Bhutan, Burma, Sudan, Somalia and Iraq.

Into a community that comes predominantly from European and Hispanic roots, these refugees bring not only cultural diversity, but also unique public health and socio-economic challenges. This article traces the process by which the Lancaster community, with the guidance of Lancaster General Hospital, proactively collaborated with other local stakeholders to address public health issues in the refugee community.

INTRODUCTION

Since 1987 Church World Service (CWS), and since 2005 Lutheran Refugee Services (LRS), have resettled over 4,589 refugees to Lancaster County. Refugees in the past have arrived from disparate countries such as Russia, Turkey, Sudan, Somalia, Bhutan, Burma and Cuba. In fiscal year 2011 alone, the two voluntary agencies (Volags) resettled 648 refugees mainly from Bhutan, Burma, Iraq and Cuba. Most of these refugees are resettled in Lancaster City because of the availability of affordable housing, access to public transportation, and employment opportunities. Although resettlement is necessary to fulfill our international legal and moral obligations, the large influx of resettled refugees into a small community can put a significant strain on local social services, including health care.

This article traces the process by which the Lancaster public health community came together with other local stakeholders to address pressing public health issues among refugees proactively and collaboratively.

WHO ARE THE REFUGEES?

In 2011, the world celebrated the sixtieth anniversary of the United Nations Convention Relating to the Status of Refugees (hereafter called the Refugee Convention). Yet, at the end of 2011, there were still some 15.2 million refugees worldwide, with 26.4 million people displaced within their own country.[1] Resettlement is only an option for less than one percent of the world's refugees—a last resort for those in an otherwise protracted, intractable situation. The United States, along with twenty-five other countries, resettles refugees through the process enshrined in the Refugee Act of 1980. In consultation with Congress, the President of the United States sets the annual refugee ceiling number, which has for the past several years hovered around 80,000. In 2011, almost three-quarters of arriving refugees came from Burma, Bhutan, or Iraq.[2]

Refugees are individuals who qualify for protection under the Refugee Convention because they have been persecuted (or have a well-founded fear of persecution) owing to their race, religion, nationality, political opinion or membership in a

particular social group.[3] Many have faced horrific torture or rape, witnessed the murder of family members, or watched their homes being destroyed by government agents. Many have languished for years in dangerous refugee camps waiting and wanting to return to their homes, to no avail. Unfortunately, many also suffer from some form of Post-Traumatic Stress Disorder (PTSD).

Refugees are legal immigrants who have been resettled in the United States through a unique international, national, and non-governmental collaboration. On the international end, the United Nations High Commission for Refugees (UNHCR) works with the United States Department of State, (Bureau for Population, Refugees and Migration) and the United States Department of Homeland Security overseas to identify and process bona fide refugees. Within the United States, the Department of Health and Human Services (Office of Refugee Resettlement) works with nine national-level voluntary agencies (Volags) that in turn work with their local branch offices to resettle refugees into local communities.

Volags receive $1,850 per refugee to provide housing, food, clothing, and other necessities to help facilitate refugee integration into the community within a thirty to ninety day period.[4] Refugees are also eligible to receive temporary resettlement assistance in the form of cash, medical assistance, and social services from the Office of Refugee Resettlement (ORR) located within the Department of Health and Human Services.[4] This can include eight months of cash assistance, medical assistance, employment assistance and citizenship services, supplemental income, and temporary assistance for needy families.[4] Refugees also receive Refugee Medical Assistance (RMA) for eight months, which is the same as regular Medicaid.

This public-private partnership between the federal and state government agencies and local Volags for resettlement is not without its problems. Local communities and governments are often unaware of the number of resettled refugees coming into their community until after the refugees arrive, and must scramble to accommodate the needs of new arrivals. This can be especially challenging in light of the public health needs and other issues that refugees face.

THE GRASSROOTS COMMUNITY RESPONSE

Before coming here, many refugees lived in squalid conditions in refugee camps in bordering countries, often without basic necessities such as electricity or running water. Although refugees are screened for public health-related issues that would disqualify them from resettlement *before* their arrival in the United States, the Center for Disease Control (CDC) also recommends a post-arrival medical screening of refugees within thirty days of their arrival. These medical screenings are especially important to ensure follow-up for any medical issues identified overseas, to identify persons with communicable diseases of potential importance for public health, and to refer refugees to primary care providers for on-going health care.[5]

In 2009, Lancaster General Hospital (LGH) was contacted by the Pennsylvania Department of Health with a request to assist them in developing a solution to ensure that all refugees settled in Lancaster County received a physical examination within thirty days of their arrival. Since a core of LGH's mission is "to advance the health and well-being of the communities we serve," LGH was committed to finding a solution to this access-to-care issue. At the center of LGH's principles of community health improvement is partnership and collaboration. LGH recognized that there are many community organizations that have similar missions and capabilities that meet community needs, and they began by convening a coalition of community partners who have been dedicated to caring for refugees in Lancaster for many years. These organizations included two Federally Qualified Health Centers (South East Lancaster Health Services [SELHS] and Welsh Mountain Health Services), two free clinics (Water Street health Services and Hope Within Community Health Center), and Lancaster General Hospital).

LGH worked with the Pennsylvania Department of Health to refine needed tools for refugee clinics across the State such as a Refugee Health Assessment, the Preferred Provider Agreement, and the Mental Health Assessment tool. At the onset of LGH's coalition meeting of the Refugee Health Network, they conducted an assessment of needs that highlighted a gap in services available to accommodate the volume of refugees entering the county each month. The gap is the result of the fact that 95% of refugees are resettled within Lancaster City. In assessing the availability of Primary Care services in the city, it emerged that although SELHS (a Federally Qualified Health Clinic) was able and willing to become the ultimate medical home for these refugees, it was unable to

meet the need for the large number of initial physical examinations of refugees that was needed within one month of their arrival.

The solution that was developed allowed the network to experience firsthand the magic of a coalition. At first it appeared that LGH's Downtown Family Medicine did not have clinic space or time available, but nevertheless there were members of the Family Practice Residency's Faculty who were willing to precept residents to conduct the initial physical examinations. At that point all that was needed was office space to see the patients and a nurse to coordinate the visit. Water Street Health Services, a free clinic, had office space available one afternoon a week, and offered the space to the Lancaster General Health Family Practice Residency Program.

OUTCOMES

As a result of this collaborative approach, LGH implemented a Refugee Clinic that operates once a week to ensure that refugees are seen for an initial physical within one month of arrival into the county, and SELHS sees refugees in their offices every day throughout the day. Welsh Mountain Health Services, Lancaster County's federally qualified rural health center, and Hope Within (a free clinic), agreed to provide back-up when volumes were high, to ensure that physical exams are conducted in a timely fashion.

Another issue that required resolution arose from the regulation that refugees who wish to adjust their status to become permanent residents (or green-card holders), must - like other "aliens" in the United States - have a medical examination by a Civil Surgeon designated by the United States Citizenship and Immigration Services (USCIS). During the course of the coalition meetings, it became apparent that Lancaster County did not have a suitably designated Civil Surgeon to conduct these examinations.

As a result, refugees, many without cars, had to travel outside of Lancaster County in order to be certified by a Civil Surgeon as being medically admissible. To remedy this situation, the Coalition identified medical providers within our county who were able and willing to become certified as Civil Surgeons. As a result, Lancaster County now has three Civil Surgeons.

CHALLENGES FOR PROVIDERS IN MEETING REFUGEES' HEALTH NEEDS

The key challenges in dealing with refugees are largely related to language and culture. Most refugees do not speak English, and many providers are afraid to use the Cyraphone (a telephone interpretation service). Without adequate translation services, considerable information is lost on both sides. The provider often fails to collect accurate information and can thus fail to give accurate instructions to the client.

The cultural issues involving refugees are more complex. Many Cuban refugees have been exposed to a medical system similar to our own and can therefore be given a diagnosis and handed a prescription without much more explanation. With other refugee groups (Bhutanese, Burmese and Iraqi), much more direction and support is needed due to the cultural differences and barriers.

Some refugees come from areas without any exposure to Western medicine so they will describe a specific set of symptoms that would be very clear to their own traditional healers but seem very muddled to a local provider. Then, if a diagnosis can be made, they must be helped to understand our pharmacy system and follow up procedures. Most refugees have very little understanding of chronic disease and don't comprehend the importance of medical follow-up beyond taking medication for thirty-days. Refugees are often unfamiliar with the concept of specialists and because they are familiar and comfortable with their primary-care physician, they are reticent to go elsewhere. Similarly, refugees do not understand the complexities of health insurance, which becomes an issue after their eight-month Refugee Medical Assistance expires.

Though a few diseases, such as *Leishmaniasis*, are unique to refugees, for the most part they have common diseases found in any city. Since refugees are rigorously screened for active TB prior to admittance to the U.S., there are few cases of active TB in refugee arrivals. Still, providers sometimes have to deal with complications associated with latent TB and post TB treatment. Bhutanese refugees often have Vitamin B12 deficiency and Tuberculosis (TB), and the CDC has found that they also tend to suffer from anemia, malnutrition, and other micronutrient deficiencies.[6]

As a consequence of the unique challenges of culture and language associated with resettled refugees, local health providers have hired staff members who speak their languages. Translators who speak Nepali (Bhutanese refugees), Burmese, Chin (Burmese refugees), and Spanish (Cuban refugees) are utilized for interpretation within a visit but also to call patients

with test results or instructions. These staff members are very helpful not just with language but in navigating cultural sensitivity. For example, in one visit, a patient described symptoms that were not understood by the provider, which caused confusion and an inability to treat. The interpreter, who was of the same ethnic background as the patient, explained that these were symptoms of perceived witchcraft and that the patient thought that a witch was doing something to her. The presence of a staff interpreter during this consultation enabled explanation and treatment. These staff members also ensure efficiency and understanding by explaining drug refills and specialist referrals to refugee patients. Often, these staff members are themselves resettled refugees who have gone through this process. They help to normalize refugee health care and they provide cultural diversity in provider's offices.

LESSONS LEARNED, MODEL FOR COLLABORATION

The desirability of Lancaster County as a destination for refugee resettlement is un-likely to change, given the availability of affordable housing, access to public transportation, and employment opportunities. The recent influx and growing number of resettled refugees has challenged the local healthcare system, and will continue to do so as the ethnic composition of the refugee population changes.

However, the Lancaster health community, with LGH at its helm, is now more prepared to deal with the challenges of meeting public health requirements for refugee resettlement mandated by the federal government. LGH has ensured a pro-active approach to this issue by bringing other local stakeholders to the proverbial table to optimize best practices in the delivery of health care to refugees.

One of the key recommendations from a 2012 report of the Government Accountability Office was to use more consultation between local refugee resettlement agencies and local stakeholders prior to making refugee placement decisions. The health issues of refugee and the Lancaster community's lack of preparedness helped precipitate a pro-active, collaborative approach to dealing with the health needs of refugees.

Fig. 1.

THE LANCASTER COUNTY REFUGEE COALITION

Although the certification of Civil Surgeons and the availability of medical examinations for refugees within the first 30 days of their arrival have achieved the program's immediate goals, the Lancaster County Refugee Health Network has gone further and become part of a larger Lancaster County Refugee Coalition (LCRC) aimed at holistically addressing the needs of local refugee. The LCRC developed as an outcome of a conference held in March 2012 entitled "It Takes a Community: Optimizing Refugee Resettlement in Lancaster County." The conference was a partnership between Franklin & Marshall College's Ware Institute for Civic Engagement and Church World Service, with funding from a Lancaster County Community Foundation grant. Almost two hundred service-providers and interested community members met to discuss how to optimize refugee resettlement in Lancaster County, with the goal of making Lancaster County a best-practices national example. Lancaster is on its way to becoming a model for grassroots collaboration between several local stakeholders and lead organizations that can result in a more streamlined and efficient process of refugee health management.

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