REFUGEE HEALTH SUMMIT 2014

APRIL 24, 2014
EDUCATIONAL OPPORTUNITY CENTER
BUFFALO, NY

Organized by:

The University at Buffalo's Office of Global Health Initiatives

INTRODUCTION

The Refugee Health Summit was facilitated and organized by the UB Office of Global Health Initiatives in collaboration with 11 community organizations and 11 UB Schools and Offices over a 6 month period.

Summit Goal:
Examine barriers and explore solutions to culturally engaged health care provision for refugees in Buffalo

Summit Objectives:

- Describe existing barriers of culturally engaged health care provision for stakeholder groups in WNY
- Learn about successful models to providing engaged health care for refugees in Buffalo and beyond
- Identify potential linkages and spark collaborations to adapt and implement solutions to expand culturally engaged health care for refugees in Buffalo

UB PhD candidates Anne Weaver and Christina Crabtree-Ide assist with check-in at the Summit

Panel

Denise Phillips Beehag, Director of Refugee and Employment Services, International Institute of Buffalo
Chan Myae Thu, Client Services Coordinator, Burmese Community Support Center
Bishnu Adhikari, Employment Specialist, Journey's End Refugee Services, Inc.
Oma Chapagain, Bhutanese/Nepali Community member
Dianne M. Loomis, Associate Clinical Professor, School of Nursing, UB
Cheryl Brown, Public Health Representative II, NY State Dept. of Health, Western Region

Panelists answer participant questions at the 2014 Summit

WHAT ARE EXISTING BARRIERS TO CULTURALLY ENGAGED HEALTH CARE PROVISION?

Mental Health Care

- Mental health manifestations are hard to describe therefore providers need to know *how* to ask questions.
- Providers have access to training through International Institute and other agencies but they don't feel equipped with that training. A list of resources to access and link refugees is needed.
- We need to stress the importance of trauma informed care when treating patients.

Cultural differences

- Not ever having had access to care, many refugees are unable to explain what is happening and they lack understanding of complex medical terms and issues.
- The Burmese community and other communities are not familiar with preventive medical care (for example teaching grocery literacy/nutrition).

Interpretation/Translation: a vital first step toward community capacity building

- There is no interpretation available at pharmacies. Pharmacies should provide written instructions in every language.
- Insurance companies need to provide policies written in every language and provide interpretation for non-English speakers.

Coordination of care

- A lack of coordination of care (no central registry) leads to problems in maintaining records and duplication of services.
- Providers are not reimbursed for the amount of time they spend with refugees as appointments take much longer due to interpretation.
- Resettlement agencies are funded to provide assistance the first 90 days the refugee is in country. It becomes difficult for resettlement agencies to provide assistance to physicians after 90 days.
- Refugees rarely attend follow up appointments and most primary care practices don't call clients to remind them about their visit.

Education

- We need cultural education for refugees, health care providers, and community members. Is there a model for the development of an educational resource to assist with this in the Center for International Rehabilitation Research and Information Exchange (CIRRIE - UB Public Health)? Can we put together some sort of preventive care groups in the community?
- What role can the university play in supporting those gaps?

Human Capacity

- Refugee communities want to support themselves beyond resettlement but we lack a formal structure.
- We must enhance community capacity to reduce issues of trust and aid in interpretation.

TAKE AWAY: WHAT DOES BUFFALO HAVE

- Jewish Family Services received a grant for survivors of torture and the core of their project is care coordination. They need collective support and advisement.
- Lakeshore Behavioral Health has professionally trained mental health workers fluent in Spanish and Arabic.
- Buffalo has resources in the community to provide training for providers and refugees.
- School of Pharmacy should offer continuing education programs for colleagues in the field.
- School of Social Work should think of creative ways to use students to build capacity and build linkage between primary care and mental health/trauma care.
- Colleges and universities should recruit talent from the refugee community. Refugees need training to enhance capacity building.
- The Greater Buffalo United Accountable Healthcare Network (GBUAHN) is a resource that could be used as a model to organize care coordination for refugees.

TAKE AWAY: WHAT DOES BUFFALO NEED

- We need good people, funding, and an organizational structure (reference Beacon model of care) that starts simply and moves to more complex issues.
- We need to come up with an inventory list of what resources are available and prioritize them according to the needs of the community.
- We need a resource center or platform that collects information for providers and refugees and is a host to all programs working with refugee resettlement and post resettlement.
- We need to be in touch with Buffalo Immigrant Refugee Empowerment Coalition (BIREC) which has developed a prioritized list of all concerns.
- We need to advocate for an electronic database that houses all refugee health forms. This will decrease duplication of services and provide better coordination of care.
- We need to advocate for policy changes that reimburse provider work and sustainable billing of services.
- Refugees and agencies need support to provide assistance further down the line than 90 days.
- Refugees need providers to call their patients for follow-up exam reminders.
- The community needs to mobilize local talent or human capital to address leadership, education, and empowerment.
- The community needs more robust relationships between health centers and resettlement agencies.

SPEAKERS: MODELS THAT OFFER POTENTIAL SOLUTIONS TO BARRIERS?

DR. MYRON GLICK, JERICHO ROAD COMMUNITY HEALTH CENTER (JRCHC)

How do you provide excellent quality holistic care to an incredibly diverse refugee population?

How does JRCHC overcome language barriers?

- Hire a diverse staff
- Hire a interpreting team
- Build a system for walk-in appointments into the schedule
- Make an organizational decision to invest in people over time

How does JRCHC provide culturally competent care to a diverse population?

- Encourage diversity in organization and invest in community relationships

How does JRCHC provide attempt to address non-medical barriers to care?

- Hope drop-in center provides support for post-resettlement issues and advocacy

How does JRCHC provide obstetric care to diverse population?

- Priscilla project provides prenatal care, birth plans, mentors, and doulas for women and families

How does JRCHC incorporate new refugees into the health center?

- Building capacity
- Initial assessment is an opportunity to build relationships and incorporate into the life of the practice

Dr. Myron Glick, CMO JRCHC

Questions

Is there potential to organize a continuing education seminar series for providers in the community?

Anyone at JRCHC will come and equip physicians to work with refugee populations.

Have you experimented with a medical line for non-English speakers?

JRCHC does not have one. Keep hours open as long as possible and accept walk-ins.

DR. KIM GRISWOLD, UNIVERSITY AT BUFFALO FAMILY MEDICINE

Kim Griswold speaking at the 2014 Refugee Health Summit

A Mental Health Survey was conducted in 2010 with the goal to identify needs and challenges the community is facing in terms of mental health conditions.

Survey Questions

1. How are resettled refugees with mental health problems identified?
2. What challenges do providers face in identifying issues, finding care, or providing treatment?
3. What are any solutions providers might propose for prevention, identification, or management of mental health illness?

Findings:

- Face to face interpretation was wanted and needed but expensive.
- Resettlement agencies identified mental health problems. How does that get translated to providers and what about HIPPA laws?
- There is a difference between adjustment, acculturation, and a diagnosable mental illness: wherever refugees are on their timeline, their culture, their experience has an effect on their mental health status.
- It takes a long time to establish trust, if refugees don't trust their providers they won't share everything. Practitioners have to work hard at gaining trust so they can focus on trauma.
- There is little to no concept of mental health treatment or counseling for refugees. Refugees don't see the utility in it. There is an idea that you have to be very sick or have evil spirits to be mentally ill.
- Providers become anxious because they don't understand the cultural differences.

2010 Survey Suggestions	**Suggestions Met by 2014**
• Education	• An increased number of primary care providers serving refugees
• Symposium	• Summit in Buffalo, Conference in Rochester
• Information and orientation packets with definition added onto screening	• Behavioral health resources are available in primary care
• Involve refugees	• Refugee support centers are involving refugee leaders • Patients are participating in their health
• Trauma center	• Center for survivors of torture developed to identify survivors of extreme torture in the community
• Collaboration	
• Funding	

- **What are the current needs?**
  Training of bi-lingual/bi-cultural mental health providers
- Scholarship and funding
- Informational packets that list community resources for refugees and providers
- Client-centered interpretation and legal services
- Use of community health workers to navigate the system: It is important the client sees value in it
- Best practice research (UB)
- Hospitals should be more greatly involved. When refugees end up in the hospital there is a breakdown of information sharing with primary care providers or counselors
    - Increase training of medical students and health trainees
    - Increase discussions in the community and include physicians
    - Take information to the hospitals
    - Conduct more research projects and bring providers on board
- Make adjustments to the screening process:
    - Refugees may be over-diagnosed when they are adjusting. Screening does not pick up the right diagnoses and can give false positives
- Refugees may not be ready to talk about things for a number of years

Background: Rochester is unique in that there is only one resettlement agency. In 2008 Rochester General took a leadership role and became the one sole provider for newly arriving refugee care.

Barriers: The various barriers are common across all cities. Agencies are all connected but the problem is *how* to connect them. That happens through leadership.

What do you need: You need bandwidth. The NY State Health Foundation pays a percentage of salaries to get Rochester General Facilitators into the community to put the pieces together. Buffalo needs to figure out how to get bandwidth. Identify barriers and put together a plan, but someone has to carry it forward.

Challenge: Buffalo needs to think about *who* is going to be at the table. We need to shift mentality from the current state of things to future state and to do that you need different people at the table looking at the issues from different angles.

Example: Rochester is currently experimenting with Remote Simultaneous Medical Interpretation (RSMI), a voice over system such as what is used by the UN that takes the interpreter out of the room and offers face to face doctor-patient communication through headset technology. Down the road Rochester envisions installing sets of headphones in pharmacies and perhaps in a call center that has access to various resources and information.

Jim Sutton speaking with Refugee Health Summit participants

FINAL THOUGHTS FOR IMPROVED HEALTH CARE

Mental Health: The Priscilla Project has been transformative and could be used as a model for mental health care but we need hospital assistance and bandwidth to make this bigger to serve all refugees
Coordination: We are not utilizing our powerbase as well as we might. We need to develop a formal mechanism, a steering committee that can advise on how to better involve hospitals and improve coordination between agencies and across the community.
Prevention: Refugees need skills training on stress management and prevention; with support they can better navigate the system.
Electronic Records: We need to involve technology in our discussions. For example, CDC is experimenting with an online registry called Electronic Disease Notification System (EDN) which starts by loading health information abroad and follows refugees downstream. Washington State has recently developed a statewide registry.
Insurance: We need to work with insurance companies to understand changes in policies due to the Affordable Health Care Act. The hospitals are adjusting but refugees are falling through cracks because they are not linked; we need to infiltrate this system *as* conversations are taking place.
Interpretation: How we can offer interpreting services at a lower cost? Let's develop innovative, creative ways to provide these services and use our community resources. We should begin sharing resources that already exist.
Human Capital: We need to cultivate leadership in refugee communities and provide continuing education for current providers.
Portal of information: We need to develop a portal that houses information and resources that are useful to the community and improve coordination of care for refugees.

BREAKOUT SESSIONS

Based on information shared by panelists, speakers, and participants summit facilitators emphasized five topics to discuss in breakout sessions. Within each breakout session, participants were asked to develop concrete action steps needing to be taken in the next 1-5 years to improve quality of care.

Office of Global Health Initiatives Director, Pavani Ram, introducing breakout session topics

Coordination of stakeholders

- Identify the stakeholders.
- Populate a resource portal for Buffalo.
- Once a resource portal is available online, build relationships and make connections.
- Guide the development of an annual conference to look back over the year: where were we, where have we come over the year, what new partnerships were developed, how is the portal functioning, and where are we going in the coming year?

There is a need for a very focused small committee who can move the group goals forward. UB could be a central more neutral organization that could provide logistic support for the committee.
A strategic committee should provide some sort of assessment to measure health service and make it available online to encourage good practice.

Mentorship of providers

- Develop a web-based resource.
- We need to break up 15 min visits and give providers more time to meet with patients.
- Referrals are where the ball often drops – we need to look at ways to improve consultation visits. For example utilize telemedicine or interpreters, have consultants or specialists located at the health center where refugees or immigrants are given care.
- We have to educate the providers in the field but also the students coming up in the ranks. We need to begin to use grand rounds to provide a refugee/cultural competency educational session. Invite or hire refugees to present their experiences.
- UB Interprofessional Education can incorporate cultural competency into interprofessional courses in higher education.
- We need to make web-based YouTube videos available on the portal as resources for providers.
- We need to see what resources are currently available in CIRRIE.

Mobilization of human capital

- Identify human capital in the community and have them commit to a leadership position. We need to make leaders of community members who have been educated in their country of origin and can transfer their skills.
- We must create an infrastructure to provide an educational forum for refugees to teach each other about available programs available.

Interpretation

- A resource portal must include interpretation resources
- We should look into the development of an app to find interpreters, resettlement agencies, etc. UB IT/Computer Science could assist with this.
- We need to educate community members to be interpreters, train healthcare providers in other languages, offer Interprofessional courses that address interpretation, provide linguistic department trainings and offer students to be interpreters.
- We need research possible interpreting grants.
- We must also address non-verbal communication
- We need standard reference images/pictures to be distributed for those who don't have interpreters and in hospitals and waiting rooms.
- We need to look into remote interpretation.
- We must promote the hiring of bi-lingual employees within the healthcare setting. We need to encourage this within hospitals and healthcare settings. To do this we should begin by promoting refugee involvement in various programs in higher education.
- We need to encourage multi-lingual providers from other states to come to Buffalo.
- When a mistake is made and there is loss of life, how do we hold medical establishments accountable? – NY State Department of Health has the Hospital unit and the Medical Misconduct unit. Once told about an event, they will investigate.

Improving linkages in care, addressing gaps in care

- There is a breakdown in care from conducting health assessments to primary care to specialty care.
    - Volunteers/student interns can be knocking on doors to help get people to where they need to go.
    - Health education needs to incorporate preventive care. We must think of creative ways to use people in the community from multiple sources.
- Gaps in care lead to duplication of services
    - We must get the health assessment online. We need to investigate the use of electronic records and Helathelink.
- How can we build mental health capacity?
    - Can we begin to place mental health providers in community centers? What does it look like with most mental health care delivered in primary care? What do we need to know about this in order to creatively expand mental health care delivery?
- We need ongoing educational events around health education/promotion.
    - We need to provide transportation to specialty care or utilize health navigators and community health care workers.
    - We need to investigate the use of a mapping system (ArcGIS) to plot providers and look at the regions where refugees are living. A transportation network can evolve from those plottings.
    - We should collaborate with existing transportation services if possible.
- We must provide culturally competent care in hospitals.
    - Can we advocate for culturally competent care through social work departments at hospitals?

VITAL NEXT STEPS

Task	Who	Jul	Aug	Sept	Oct	Nov	Dec
Convene a Steering Committee	Community advocates and UB Faculty	X					
Regular meetings with Steering Committee and task forces	Community advocates and UB faculty		X	X	X	X	X
Collect information for online portal	UB School of Public Health and Health Professions and Department of Family Medicine	X					
Develop Online Portal	UB Communications or outside source		X	X	X	X	X
Convene UB Faculty to discuss UB involvement	UB Office of Global Health Initiatives, UB School of Nursing, UB Department of Family Medicine			X			

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Neighborhood Health Center
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University at Buffalo
- Global Health Initiative GSA
- Office of Global Health Initiatives
- Office of Interprofessional Education
- Office of Public Health Practice
- School of Dental Medicine
- School of Management
- School of Medicine and Biomedical Sciences
- School of Nursing
- School of Pharmacy and Pharmaceutical Sciences
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UB Office of Interprofessional Education

PANELISTS AND SPEAKERS

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Chan Myae Thu, Client Services Coordinator, Burmese Community Support Center

Dr. Myron Glick, Founder and Chief Medical Officer, Jericho Road Community Health Center
Dr. Kim Griswold, Associate Professor, Family Medicine and Psychiatry, UB
Jim Sutton, RPA-C, Director, Office of Community Medicine, Rochester General

SUMMIT COORDINATION AND PLANNING

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UB School of Social Work
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