Assessment of the Health Needs of Refugees in the Tri-County Region

Tri-County Health Department

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Executive Summary

Between July and December, 2015, Tri-County Health Department (TCHD) conducted an assessment of the health needs of refugees living in Adams, Arapahoe, and Douglas Counties. Data to inform the assessment were gathered from the Colorado Department of Public Health and Environment (CDPHE), the Colorado Department of Human Services (CDHS), the United States Census 2009-2013 American Community survey, and primarily from key individuals and organizations that work with refugees in the community. Ten key health issues/challenges were identified: language and culture, coordination of health services, access to health services, Medicaid enrollment and re-enrollment, access to dental and specialty medical care, awareness of health services, health education and health literacy, health system navigation, mental health and substance abuse, and health data. A TCHD work group chose the following priorities for initial action: coordination and colocation of TCHD services, communication with the community, Medicaid enrollment and re-enrollment, and data collection through WIC. In addition, a TCHD strategic communications team will work with the Aurora Office of International and Immigrant Affairs to co-develop a health education campaign targeting immigrants. As a parallel development, the Centers for Disease Control and Prevention recently awarded a grant to CDPHE and CDHS to collect longer-term refugee health data in order to fill existing data gaps, a project that may inform TCHD efforts over time.

Background

Approximately 2,000 refugees have entered Colorado annually between 2010 and 2014. Over half resettle in Adams and Arapahoe Counties. While the United States President has increased the target number of refugee arrivals to the U.S. in 2016 from 70,000 to 85,000 in order to help with the Syrian refugee crisis, the number of refugees resettling in Colorado is unlikely to change in the near future given limited capacity to increase support (Colorado Department of Human Services (CDHS)).

The top refugee countries of origin represented in the Tri-County region in 2014 were Iraq, Myanmar, Somalia, Bhutan, Democratic Republic of Congo, Eritrea, and Afghanistan (Colorado Department of Public Health and Environment (CDPHE), Appendix Table). At the time of resettlement, most were adults under 65 years old. Thirty to forty percent were children. While resettlement locations were spread across the Denver metropolitan area, the most densely populated resettlement locations were in Aurora along the Colfax – I-225 corridor (CDHS, Appendix Figure). Refugees tend to settle in disparate communities characterized by culture and language. By report, refugee locations of residence often change after resettlement.

There are few available data that address refugee health needs. CDPHE collects medical screening data at resettlement (CDPHE, Appendix Table). In 2014, many refugees had physical or mental abnormalities that were not inadmissible to the U.S. (Class B conditions). Parasitic infections were commonly diagnosed at medical screening. A small percentage, 0-3%, had chronic infections such as hepatitis B or C. By far the most common conditions detected in screening were those related to mental health, with the prevalence of any mental health disorder

at the time of screening likely around 20-30%. Notably, there are no data that address long-term refugee health.

In order better understand and address the health needs of refugees living in the Tri-County region, Tri-County Health Department (TCHD) conducted an assessment of the health needs of refugees in Adams, Arapahoe, and Douglas Counties, with focus in Aurora, Colorado. There were several stimuli for this assessment. First, TCHD recognized the need to reach out to refugees during the creation of its 2014-2019 Strategic Plan (1). Second, TCHD was enlisted by Aurora City Councilwoman Molly Markert to participate in the City of Aurora's comprehensive strategic plan for immigrant integration (2). Third, in October 2014, the CDPHE decentralized the process of medical screening of refugees at resettlement, creating some confusion amongst TCHD nurses who work with refugees. Finally, during the time period of the assessment, refugee resettlement was highlighted by the media in the setting of a Syrian refugee crisis. In general, the healthcare climate was favorable to addressing the needs of refugees, making it in an opportune time to organize TCHD refugee services and partner with other like-minded organizations.

Objectives

1. To identify the most important health needs of refugees.
2. To identify potential partners for collaboration.
3. To identify potential responses by TCHD.

Methods

From July to December, 2015, data were collected through key informant interviews (Box). Data were used to create a list of key health issues/challenges for refugees. A TCHD work group was then assembled to prioritize 3-5 key health issues/challenges for intervention. Few quantitative data addressing refugee health existed and are summarized in the background section above.

Box. Key informants interviewed to assess refugee health needs.

Ardas Family Medicine

Asian Pacific Development Center

Aurora Health Access

Aurora Office of Immigrant and International Affairs

Aurora Strong Resilience Center

Aurora Welcome Center

Colorado Department of Human Services, Colorado Refugee Services Program

Colorado Department of Public Health and Environment

Colorado Refugee Wellness Center

Denver Refugee Clinic

Littleton Immigrant Integration Initiative

Lutheran Family Services

Metro Community Provider Network Refugee Clinic

Spring Institute

Findings

Key Health Issues/Challenges

There were 10 key health issues/challenges identified through key informant interviews. These are listed in **Table 1** and grouped into categories that describe their common public health implication. Key health issues/challenges and their implications are discussed in detail below.

Table 1. Key health issues/challenges for refugees in the Tri-County region.

Health Issue/Challenge	Category
1. Language and Culture	Fundamental to any health intervention
2. Coordination of health services	Access to care
3. Access to health services	
4. Medicaid enrollment and re-enrollment	
5. Access to dental and specialty medical care	
6. Awareness of health services	Health education
7. Health education and health literacy	
8. Navigation of the health system	
9. Mental health/substance abuse	Specific health conditions
10. Health data	Public health epidemiology

1. *Language and culture.* Refugees in Colorado are not a single population, but are multiple distinct nationalities from different areas of the world. Groups differ in language and culture,

prior life experiences, the level of priority placed on health and their approach to health care, familiarity with U.S. culture, and in the degree of social and economic support available upon resettlement. Language and culture affect the individual's awareness and access to health services and ability to benefit from health interventions.

In order to be effective, any public health intervention for refugees must be accompanied by communication in the appropriate language and in a culturally appropriate manner. This implies use of translation services, with in-person translators perhaps more effective than telephone translation services, distribution of multiply translated and culturally appropriate materials, and use of communication routes likely to be accessed by the intended population. Healthcare providers require education about the importance of addressing language and culture in care and an understanding of the associated challenges.

2. *Coordination of health services.* There is room for improvement in the coordination of refugee health services within TCHD and in the community. Within TCHD, there are staff members in most divisions that work with refugees. THCD has a refugee clinic at 15400 East 14th Place in Aurora where nurses provide immunizations and assistance with immigration paperwork. Nutrition staff members at the Women, Infants, and Children (WIC) offices see many refugees. The WIC office at 9000 East Colfax Avenue is located in a top resettlement area. Epidemiology staff members track elevated blood lead levels in refugees. Emergency preparedness staff members supervise the Medical Reserve Corps, one of whose current interests is in improving communication lines with refugee groups. TCHD staff members also served on the Aurora Immigrant/Refugee Task Force, established by the City Aurora to

build relationships with Aurora residents, and task forces of the Aurora Health Access healthcare coalition. However, staff members have limited knowledge of the full range of services that TCHD offers to refugees, and there is no central refugee services coordinator or program.

Likewise, in the community there are many organizations that provide services to refugees. The Colorado Refugee Services Program (CRSP) within CDHS oversees refugee resettlement in Colorado. CRSP contracts with the local offices of two voluntary agencies (Volags), Lutheran Family Services and African Community Center, the chief coordinators of refugee resettlement in Colorado communities. Volags aid refugees in obtaining public benefits, housing, food, clothing, pocket money, transportation, employment, school enrollment, medical screening and medical enrollment within the first months of arrival. However, there is no central coordination of the other organizations supporting refugees. CDPHE created a Refugee Health Resource Guide in the past, which was an extensive catalogue of organizations providing refugee services. TCHD developed a "passport" to refugee services that was never put into use. CRSP does host community meetings to bring together providers and community members. Overall, though, the system of refugee care is disjointed.

Organizing refugee services at TCHD is feasible. Organizing refugee services in the community is a more difficult prospect. However, TCHD may not be the most appropriate entity to serve as lead organizer for the community sector.

As a related issue, the directors of the refugee clinics in Denver and Aurora are requesting central oversight of the medical screening process. Prior to October 2014, CDPHE screened all refugee arrivals to Colorado. Since that time, the screening process has been

decentralized to four federally qualified health centers, including the Denver Refugee Clinic, Metro Community Provider Network in Aurora, Sunrise Community Health Center in Greeley, and Peak Vista Community Health Center in Colorado Springs. The rationale for decentralization was to directly link refugees to a primary medical home. The concern of the refugee clinic directors is that lack of oversight results in non-standard treatment and screening protocols.

3. *Access to health services.* Refugee access to health services is hindered by language and cultural barriers, location, hours, and Medicaid enrollment (discussed separately below). Language is a barrier to making healthcare appointments and understanding information about when and where to go to appointments. Refugees may have limited transportation options making it difficult for them to travel to distant locations. Health services may be offered at inconvenient hours to refugees who are just entering the workforce, often at a level where they may have limited control over their work hours.

   The implications of this issue are that health services would be more effective if made convenient. Co-located services within walking distance of refugee communities or in areas easily reachable by public transportation would address transportation challenges. Walk-in appointments and expanded hours would address challenges posed by language and work.

4. *Medicaid enrollment and re-enrollment.* Volags help refugees to enroll in Medicaid within seven days of arrival, with the expectation that they will achieve coverage within 45 days. However, medical screening often takes place before coverage is achieved, and clinic providers are uncertain whether their patients are able to obtain prescribed medical

treatments. Refugees are also dropping out of Medicaid at the time of re-enrollment, perhaps due to lack of awareness of the need to re-enroll, poor communication in the form of reminders sent to the wrong address or in the wrong language, or to insufficient skills needed to complete the process. In addition, Denver Health Medicaid may overly restrict a patient's care options by limiting choice of providers to the Denver Health Network. Issues around initial enrollment can be explored further with Denver Health and MCPN. Communication around re-enrollment can be improved.

5. *Access to dental and specialty medical care*. Community healthcare providers suggest that it is difficult to obtain referrals to dental and specialty medical care for refugees. This may be an issue inherent to Medicaid recipients in general. Language and culture also play a role in the patient's ability to make and keep appointments. Potential solutions might involve identifying appropriate community partners to provide the needed services.

6. *Awareness of health services*. Refugees and healthcare providers alike are not completely aware of the full range of services that TCHD offers, with nursing and nutrition services being the most relevant. This issue might be addressed through advertising in formats appropriate to language and culture and listing available services in convenient locations in understandable languages. Disseminating information might be best done through organizations central to refugee health (e.g. Volags or clinics) or that provide information to immigrants and refugees (e.g. Aurora Welcome Center).

7. *Health education and health literacy.* Health education level and health literacy are generally low among refugees. Refugees may be unaware of the need to establish a primary medical home. They may not understand or trust the benefits of clinical preventive services. Many refugees will return to the Volags for help when ill, without having previously established medical care. Inadequate access to care contributes to this challenge.

   The implication is that refugees may benefit from health education. The best method of providing education may differ by group. Standard messaging could be delivered through organizations that are central points of contact such as Volags, clinics, community organizations, informational organizations, schools, or English as a Second Language (ESL), or through targeted media. Aurora Health Access is interested in providing health education to refugees through ESL.

8. *Navigation of the health system.* Navigating the U.S. healthcare system is particularly difficult for newly resettled refugees. The Spring Institute contracts with CRSP to provide a limited orientation to the healthcare system upon refugee arrival. TCHD and many key informants provide navigation services, including Ardas Family Medicine, Asian Pacific Development Center, Aurora Health Access, the Colorado Refugee Wellness Center, Spring Institute, and the Volags. Navigation might be more effective if coordinated. Also, navigators may be more likely to reach those in need if located in the community rather than in the healthcare setting.

9. *Mental health and substance abuse.* Mental health and substance abuse were the only specific health concerns that were consistently raised by key informants. Twenty to thirty percent of refugees report some form of mental health problem upon arrival. This is likely an underestimate as mental health problems are underreported due to an associated stigma and during the "honeymoon period" after initial arrival to the U.S. Some key informants expressed concern that access to mental health care was difficult for refugees.

   The Aurora Mental Health Center (AuMH) collaborates with MCPN within the Colorado Refugee Wellness Center to provide primary mental health care to refugees. AuMH staff feels that they have the capacity to meet current demand for mental health care in their area. If appointments within the refugee clinic are not immediately available, refugee patients are able to see AuMH providers outside the Colorado Refugee Wellness Center. However, the system of linking refugees with these other AuMH providers may need to be streamlined. In addition, AuMH is building capacity at other sites. Asian Pacific Development Center is a subsidiary of AuMH and provides mental health services as part of comprehensive refugee services. It is unclear what role TCHD should play in assuring mental health care for refugees at this time, given limited objective data to quantify the access problem. AuMH is planning to collect mental health data from refugees at 3, 6, and 9 months after resettlement. Further discussion with AuMH with regard to data collection may be warranted to clarify issue of access to mental health care. This topic will also be relevant to the Denver Metropolitan-wide Local Public Health Agency collaboration addressing mental health stigma and coordination of mental health screening, referral, and treatment services recently funded by the State Innovation Model grant.

10. *Health data.* There were no long-term health data available to inform this assessment. WIC databases included an indicator of refugee status, but this was underutilized. Fortunately, on October 1, 2015, CDPHE announced that it received a joint CDC-funded grant with CRSP to study the long-term health outcomes of refugees (Lori Kennedy MSPH, CDPHE). The award was for $667,000 annually for five years. Also, the Colorado Refugee Wellness Center plans to collect mental health data from refugees at several time-points after resettlement (Jan Jenkins PhD, Colorado Refugee Wellness Center). These efforts will begin to address the existing gap in refugee health data.

Potential Partners for Collaboration

Each of the key informants who contributed to this assessment is a potential partner for collaboration. However, the following potential partners should be highlighted:

1. *The Aurora Office of International and Immigrant Affairs.* This Office listed "integration through mental and physical health and wellness" as one of its goals and activities in its comprehensive strategic plan. TCHD was listed as a potential partner (2). Aurora's effort to coordinate and provide services to immigrants and refugees has political support and poses and opportunity for TCHD to collaborate in achieving aligned health goals. On November 6, 2015, TCHD representatives met with Aurora City Councilwoman, Molly Markert, Assistant City Manager, Roberto Venegas, and the Director of the Office of International and Immigrant Affairs, Ricardo Gambetta, to review the TCHD refugee health needs assessment and explore how TCHD and Aurora might work together. Aurora officials were interested in

developing a health education campaign targeting the larger population of immigrants. Their top priority issue was drinking and driving, a concern of the Aurora Police. However, mental health, substance abuse, and obesity were also perceived as important issues. As a result of this meeting, strategic communications personnel from Aurora and TCHD will meet to consider potential topics and methods for a campaign.

2. *Aurora Health Access.* The Aurora Health Access Task Force on Pediatric Refugee Health decided to provide health education through ESL and community health navigation with the Aurora Welcome Center Natural Helpers Program. The latter project, Natural Helpers, is a program whereby new immigrants will be linked to public services through trained, neighborhood volunteers. Recently, the Task Force dissolved, but Aurora Health Access plans to go forward with the proposed activities. In general, Aurora Health Access has decided to support existing services rather than create new services.

3. *CDPHE/CRSP*. Data collected by CDPHE and CRSP on long-term refugee health outcomes will be useful to TCHD for public health planning. In addition, it may be possible for TCHD to participate in a quarterly meeting of the refugee clinic directors, CDPHE, and CRSP in order to have input into the mechanism of oversight of resettlement screening.

Finally, faith communities that support refugees may be potential partners. The following organizations were indicated by a representative of Aurora Health Access to be faith communities that reach out to and support refugees in various ways: Jewish Family Services

(Denver), Restoration Outreach Programs (Aurora), Mosaic Church of Aurora, Aurora Interfaith Community Services, Catholic Charities Little Flower Assistance Center (Aurora), St. Lawrence Korean Catholic Community Church (Aurora), and Queen of Vietnamese Martyrs Catholic Church (Wheat Ridge) (Rich McLean, personal communication). Meg Allen of the Colorado Providers for Integration Network was a suggested contact for further information about faith based refugee services. The exact activities of the above organizations were not evaluated as part of this assessment but should be evaluated further if partnership is to be considered.

Potential Responses

TCHD convened an internal Refugee Health Work Group to review the above assessment and plan potential responses. The Work Group will be led by Wendy Nading, and Alix Hopkins of the Nursing Division. The first two meetings occurred on October 29 and December 11, 2015. Representatives from administration, nursing, nutrition, and emergency preparedness attended and included: Alicia Cone, Christopher Czaja, Lisa DeVries, John Douglas, Penny Grande, Alix Hopkins, Melanie Morrison, Wendy Nading, Michael Perret-Gentil, Joanne Holden, and Sue Howk. The Work Group set the following initial priorities for action:

1. *Coordination and colocation of TCHD services.* TCHD will designate one or more persons to coordinate refugee services. Nursing and Nutrition services potentially may be collocated at the 9000 East Colfax Avenue office, including WIC, immunizations, green card paperwork, and Medicaid enrollment. Refugee clinic hours of operation will be reevaluated. This effort will address key health issues 2, 3, 6, and 8 above.

2. *Communication with the community.* TCHD will query the Medical Reserve Corp. with regard to their findings on best lines of communication to refugees in the community. The TCHD Strategic Communications Director was recruited to begin formulating messages around mental health, substance abuse, and/or obesity. Effective health communication may involve partnering with the Aurora Office of International and Immigrant Affairs (see potential partners above). These efforts will address key health issues 1, 6, 7, and 9 above.

3. *Medicaid enrollment and re-enrollment.* Work group members will evaluate options for facilitating earlier Medicaid coverage and improved re-enrollment for refugees. This effort will address key health issue 4 above.

4. *Data collection through WIC*. Work group members will put a procedure in place to collect more robust data from refugees accessing WIC by increasing use of the refugee indicator in the WIC database. This effort will address key health issue 10 above.

Conclusions

TCHD identified 10 key health issues/challenges for refugees living in the Tri-County Area. The findings of this assessment were subjective, but represent a consensus gathered from persons and organizations that work most closely with refugees in the community. There may be

opportunities in the future to gather more information about health needs directly from refugee community leaders through surveys and/or focus groups.

The first action steps will be to coordinate and co-locate TCHD refugee services, improve communication with the refugee community, address problems with Medicaid enrollment and re-enrollment, and collect better health data from refugees. The most prominent initial partnership will be with the Aurora Office of Immigration and International Affairs to develop a health campaign specifically for immigrants and refugees. The TCHD Work Group will continue to develop and coordinate refugee activities across TCHD programs and with external partners.

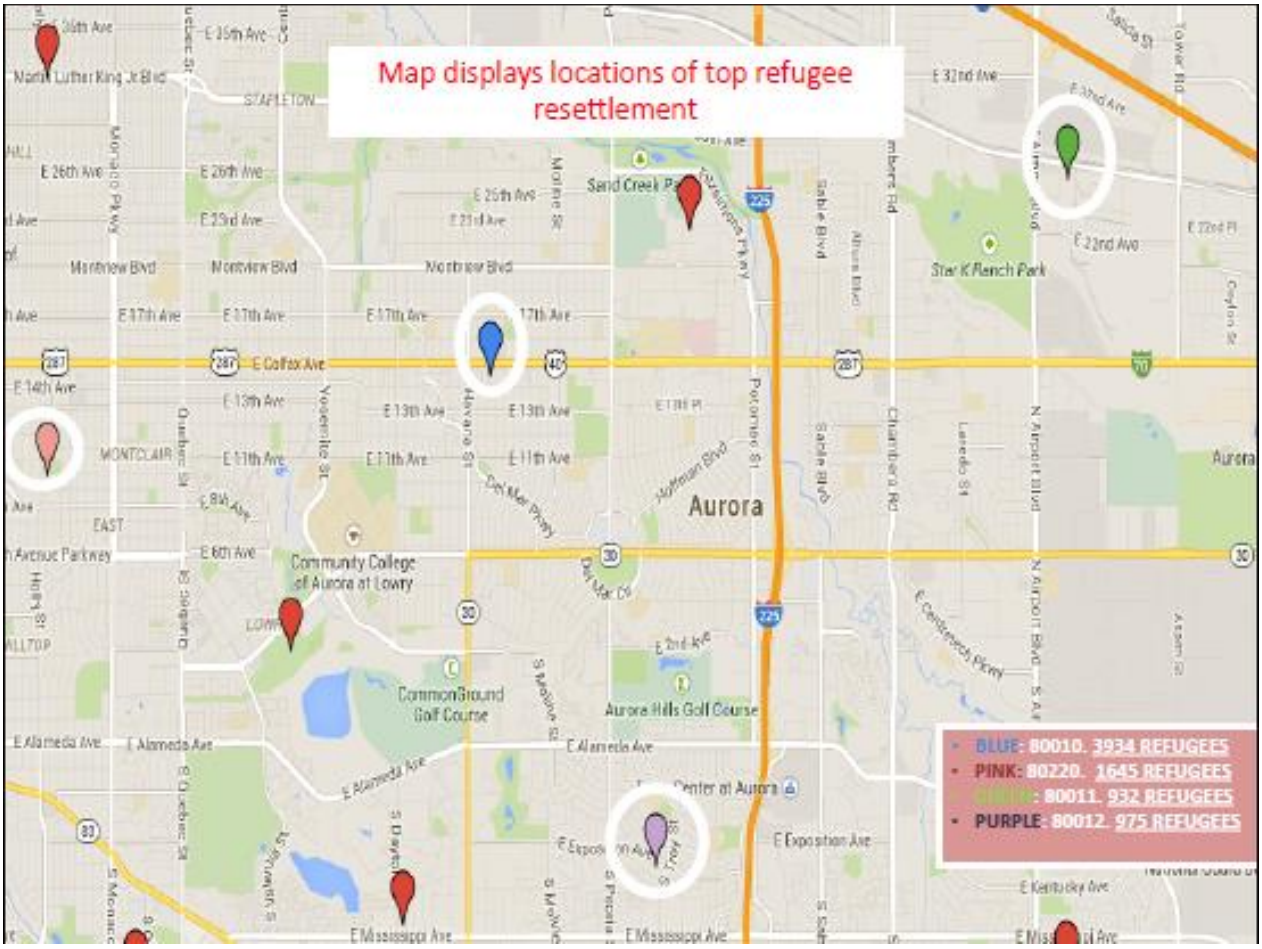
References

1. Tri-County Health Department. Strategic Plan, 2014-2019. http://www.tchd.org/DocumentCenter/View/2024, last accessed December 2, 2015.
2. City of Aurora, Office of International and Immigrant Affairs. Comprehensive strategic plan 2015-2018. https://www.auroragov.org/cs/groups/public/documents/document/024722.pdf, last accessed December 2, 2015.

Appendix

Table. Select characteristics of refugees in the Tri-County region, 2014 (CDPHE).			
	Adams (%) N=453	**Arapahoe (%) N=746**	**Douglas (%) N=1**
Age			
≤18 years	40	28	100
19-64 years	58	70	
≥65 years	2	2	
Female	49	46	100
Nationality (>5% prevalence)			
Iraq		26	
Myanmar	30	18	
Somalia	19	13	
Bhutan	19	10	
DR Congo	7	9	
Eritrea		5	
Afghanistan		5	
Class B or B/TB	31	24	0
Screening Positive			
Parasite	10	12	
HIV	0	0	
Lead	3	8	
Hepatitis B (sAg)	3	3	
Hepatitis C	1	0	
Mental Health			
Adjustment Disorder	0	4	
Anxiety	1	4	
Depression	4	12	
PTSD	4	9	
Substance Abuse	1	1	
Other (broad)	12	12	1

Figure. Top refugee resettlement locations in Colorado (CDHS, February 2015).



- Figure provided by CDHS. The significance of the red markers is unclear, and the figure was prepared by an intern no longer with CDHS.

Tri-County Health Department Refugee Health Work Group: Alicia Cone, Christopher Czaja, Lisa DeVries, John Douglas, Penny Grande, Alix Hopkins, Melanie Morrison, Wendy Nading, Michael Perret-Gentil, Joanne Holden, and Sue Howk.