

Health Access and Perceptions of Newly Arrived Refugees in Philadelphia

Philadelphia Refugee Health Collaborative*

Funded by the Pennsylvania Department of Health, Refugee Health Program
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This Pennsylvania Department of Health funded project, undertaken by the Philadelphia Refugee Health Collaborative (PRHC), gives an opportunity to refugees to share their experiences with the health care system through qualitative interviews. Information from these interviews provides insights into what works well and what can be improved in the PRHC system in meeting clients' needs. The objectives of this project are to: 1) gather feedback from recently arrived refugees in Philadelphia on their experience in accessing health care and services to inform resettlement agency practices in supporting access to care; 2) gather feedback from recently arrived refugees on their experience in utilizing health care to inform clinic practices in providing accessible and culturally competent care; 3) collect information from PRHC clinics and resettlement agencies to understand health services provided for newly arrived refugees. The major themes that emerged during this project include: access to care, resettlement agency support and the refugee health orientation, and health clinic support.

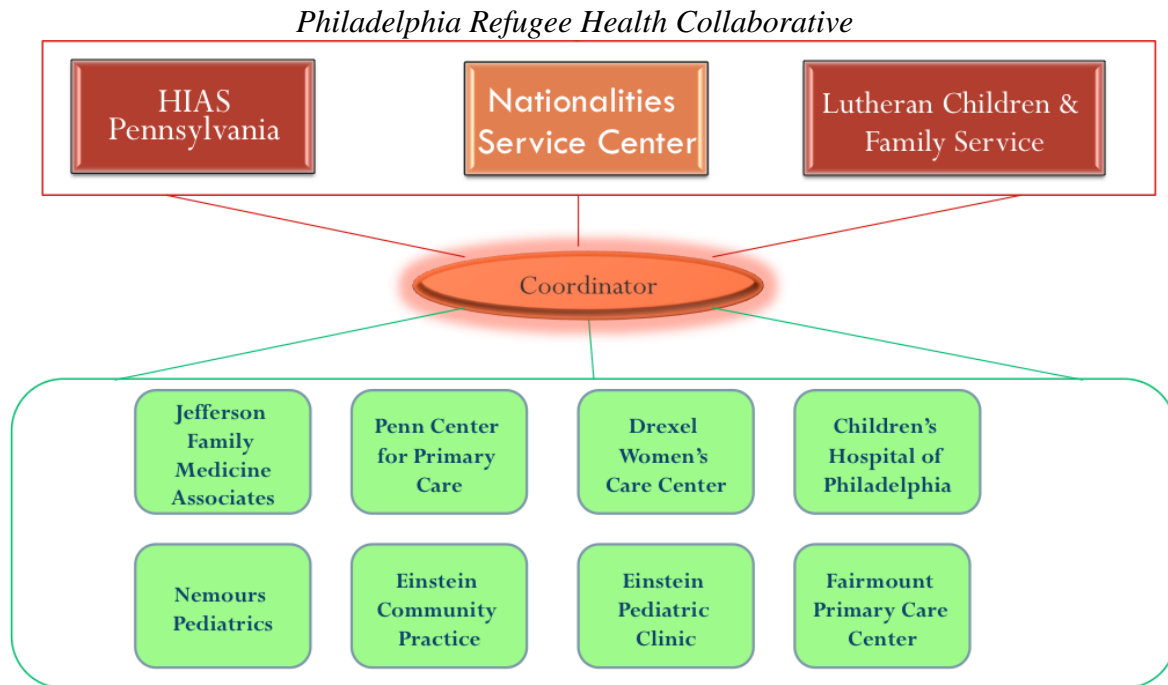
The researchers conducted interviews with 83 refugees who arrived in Philadelphia within the last year and were resettled and screened by a PRHC partner. In addition, information was gathered from PRHC resettlement agencies and clinics. Open-ended surveys were administered to the health coordinator of each PRHC resettlement agency. Telephone calls were placed to each PRHC clinic in order to determine the availability of language interpretation for callers through their appointment scheduling system. The data from these interviews and surveys are synthesized in this report, which provides recommendations for future directions of the Philadelphia Refugee Health Collaborative.

BACKGROUND

The Philadelphia Refugee Health Collaborative, established in 2010, is a regional coalition consisting of Philadelphia's 3 refugee resettlement agencies and 8 refugee health clinics. PRHC's mission is "to create an equitable system of refugee health care in the Philadelphia region that ensures a consistently high standard of care for all newly arrived refugees" (PRHC, 2013). Through its network, PRHC provides initial and ongoing health care to all newly arrived refugees in the region. The PRHC includes the resettlement agencies: Hebrew Immigrant Aid Society (HIAS), Lutheran Children and Family Services (LCFS), and Nationalities Service Center (NSC). The clinic partners of the Collaborative include: Children's Hospital of Philadelphia (CHOP), Drexel Women's Care Center, Einstein Community Practice,

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Einstein Pediatric Clinic, Fairmount Primary Care Center, Jefferson Family Medicine (JFMA), Nemours Pediatrics, and Penn Center for Primary Care (PCPC).

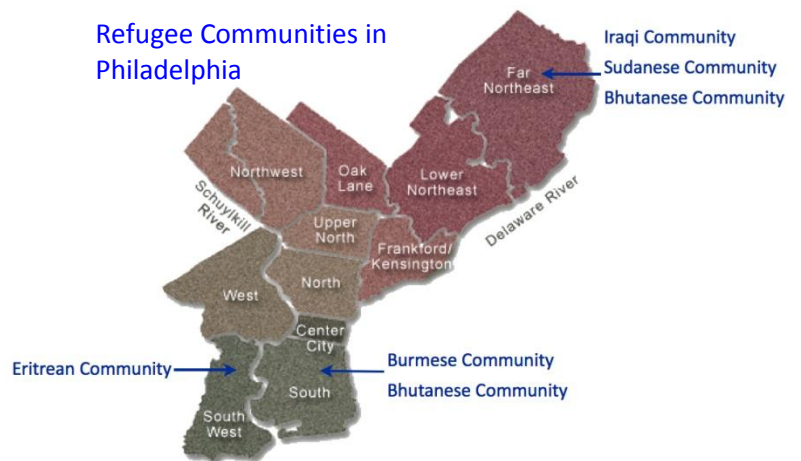


Refugee Resettlement

From 2003 to September 2013, approximately 21,042 refugees were resettled in Pennsylvania. Of this figure, approximately 5,793 resettled in Philadelphia (PA Refugee Resettlement Program, 2013). Refugees resettled in the United States come from many years of living in refugee camps or in urban slums with limited access to health care.

The 3 local resettlement agencies are resettling an estimated 800 refugees to the Philadelphia region each year. The main ethnic groups arriving in Philadelphia are Iraqi, Eritrean, Bhutanese, and Burmese refugees. These 4 groups plus Sudanese refugees comprise the sample for this mini-grant project.

Refugees in Philadelphia are diverse. Different ethnic groups arrive with unique life experiences and vulnerabilities, which affect their experience with resettlement and health care in Philadelphia. Iraqi refugees have been migrating to other countries for more than 30 years and the number of people fleeing Iraq increased greatly after 2003. Research demonstrates that much of Iraq’s population has experienced traumatic events, which has led to high rates of mental disorders among the refugee population (UNHCR,



2011). The majority of Eritrean refugees arriving in Philadelphia are members of the Tigrinya ethnic group. Eritrea has been experiencing political instability for decades due to ongoing war and border disputes with its neighboring country, Ethiopia. The new Eritrean government that emerged in 1991 suppressed freedom of speech, assembly, religion, and movement within the country. A border dispute between Eritrea and Ethiopia in 1998 caused war to open up again and young men were forced to conscript into the military for an indefinite amount of time (RHTAC, 2011). Many fled into crowded refugee camps in Ethiopia.

Bhutanese refugees are ethnic Nepalese and they speak a variety of Nepali dialects (U.S. State Department, 2011). When the Bhutanese government introduced a series of citizenship laws in the late 1970s and 1980s, the Nepali-Bhutanese people were politically, economically, and culturally excluded (U.S. State Department, 2011). This exclusion led them to refugee camps in Nepal. Bhutanese refugees exhibit disproportionately high rates of suicide, mental disorders, vitamin B-12 deficiency, and latent tuberculosis (Schinina et al., 2011; Bam et al. 2007; Thapa et al., 2003; Brennan et al. 2005). Burmese refugees come from many years of enduring conditions of displacement, isolation, war, lack of basic resources, and overcrowding in refugee camps. Burma is composed of several different ethnic groups; the two main groups resettling in Philadelphia are *Karen* and *Chin*. Many Burmese refugees did not receive adequate health care prior to arriving in the U.S. and exhibit high rates of disease, such as parasitic intestinal infections and tuberculosis (Cardozoa et al., 2004). A needs assessment conducted by Temple University and The Southeast Asia Resource Action Center reports that Bhutanese and Burmese refugees seek better access to health services, greater mutual support among the community, and empowerment to navigate American institutions (SEARAC, 2011).

Due to the North-South civil war, Sudanese refugees and the local community in eastern Sudan face acute poverty and lack of access to health care, education and employment. Post-independence issues have led to fighting and displacement in Sudan and South Sudan. Displaced individuals often suffer from malnutrition and lack of access to basic services (UNHCR, 2013). Studies on resettled Sudanese refugees indicate that both traumatic experiences and post-migration difficulties are significant predictors of lower mental health outcomes. Higher social support was significantly predictive of wellbeing. Among Sudanese refugees in Canada, higher psychological distress was associated with economic hardship, particularly when refugees' expectations for third country resettlement were not met (Tempany, 2009).

Refugee Health Care

Studies indicate that refugee vulnerability results not only from individual or population-specific characteristics, but also from systemic issues and services that refugees encounter upon resettlement (Shrestha, 2011). Health care utilization by immigrants and refugees is significantly lower than that of the national population. All refugees qualify for federally funded Refugee Medical Assistance (RMA) for 8 months from their date of arrival to the United States. However, research demonstrates that language access and difficulties navigating the health system act as major barriers to health access for refugees (Leduc & Proulx, 2004; SEARAC, 2011). Refugees have to fulfill a number of health requirements, such as vaccination shots, complete physical and gynecological examinations, and screening tests mandated by the U.S. Office of Refugee Resettlement. A study by Shrestha reveals that navigating the U.S. health care

institution is a major challenge for refugees, and greatly adds to their stresses during resettlement (2011). Burmese and Bhutanese refugees described particular difficulty dealing with the immunization process and expressed a lack of understanding about their medical insurance (SEARAC, 2011). After the RMA period ends, refugees are likely to face more barriers to health care because many do not have post-RMA insurance coverage. Empirical studies demonstrate that health insurance and health services utilization are positively correlated. Having insurance increases the probability of visiting an office-based care provider by nearly 25% (Meer & Rosen, 2004).

Health Services

Health services and case management provided by resettlement agencies vary greatly from state to state and from resettlement agency to resettlement agency. Many resettlement agencies in the United States provide health services to newly arriving refugees, which may include coordination of initial health screenings, escorts to medical appointments, scheduling of health appointments, and a health orientation. In Philadelphia, each resettlement agency has a health coordinator and health staff members to assist newly arriving refugees with health care access. The PRHC employs clinic liaisons, individuals who are employed by the resettlement agencies and are available on-site during refugee clinic hours at all PRHC clinics.

Other cities, such as in Minnesota and Texas, also provide specialized health services to refugees. The MN Department of Health's Refugee Health Program (RHP) employs medical social workers, who act as a shared resource for local voluntary agencies. Agencies can refer refugees with complex health concerns to RHP social workers and if a refugee is approved for services, the medical social worker will work directly with the client to assure adequate medication supply, schedule expedited health screenings, establish primary care, and ensure the client is connected to necessary medical care (Higgins, 2012). In February 2013, local partners in Houston, Texas piloted the Community Health Navigator Program, which intends to increase access to quality, affordable health and social services for Houston's Burmese refugees through culturally sensitive and linguistically appropriate means. This Houston-based program engages physician assistants and Health Navigators (individuals from within the refugee community) to work with refugees to assess needs and identify culturally appropriate solutions (Physician Assistant Foundation, 2013).

Health Orientation

Refugees receive a domestic health orientation as part of their core resettlement services upon arrival to the United States. According to a presentation funded by the Bureau of Population, Refugees, and Migration and the Office of Refugee Resettlement, the method of delivery, topics, and length of the health orientation vary greatly from state to state and from resettlement agency to resettlement agency (Cultural Orientation Resource Center, 2011). Across agencies, timing of the health orientation ranges from a few days to a few months after arrival. Not all newly arriving refugees receive a health orientation (Cultural Orientation Resource Center, 2011). The topics addressed in the health orientation include: an overview of the health care system, the initial domestic health screening, health insurance, medical bills, calling 911, roles and responsibilities, preventative health topics, immunizations, family planning, mental

health, dental, vision, nutrition, specific clients' health concerns, domestic violence, hand washing, bed bugs, caring for ill family members, and medications. A 2011 study conducted at Nationalities Service Center explored the efficacy of the health orientation and information pamphlets in improving refugees' knowledge about the U.S. health care system (Macenat, 2011). This study concluded through pre- and post-testing that the health orientation is correlated with a 15% increase in refugees' knowledge about health care in the United States.

METHODS

This project employed qualitative methods, in order to allow for an exploratory study on refugees' experiences accessing health services. In-depth interviews were conducted with 83 newly arrived refugees. The researchers also administered 3 open-ended surveys to the health coordinator of each PRHC resettlement agency. Telephone calls were made to each PRHC health clinic to determine the availability of language interpretation to callers seeking to schedule an appointment.

Intensive interviews are helpful in descriptive studies because they identify what the key dimensions of a problem are by allowing respondents to describe meaning. The researchers generated the in-depth interview guide (see Appendix) in collaboration with social service staff and clinicians in the PRHC. The interview questions focused on the refugees' perceived health access, health services utilization, health needs, and support received from resettlement agency health staff and health clinic staff. CDC Behavioral Risk Factor Surveillance System questions on health access were also included in the interview guide. The interviews were conducted over a period of 1 month. An interview, ranging from 30 to 90 minutes, was conducted with each participant household in their home—nearly all interviews were conducted in groups with an entire household. A total of 18 households were interviewed. Verbal and written consent was obtained prior to participation. An in-person interpreter was provided for the majority of participants; participants proficient in English did not require interpretation. Interviewees received no compensation for participation. Data was documented so that participants cannot be identified, directly or through potential identifiers linked to them. The interviewer had no prior relationship with the interviewees. Each of the interviews was audio-recorded and the tapes were reviewed for major themes and quotes. These notes were then condensed into the major themes discussed in this report. To establish dependability of the data, 2 researchers discussed and deliberated over the data as well as the themes that emerged during analysis.

A survey (see Appendix) was administered to the health coordinator at each PRHC resettlement agency; 2 researchers generated the survey questions. The 7 open-ended questions addressed health services provided by the agency. The responses were collected electronically and analyzed by a researcher. A researcher placed telephone calls to all 8 PRHC clinics in order to understand the appointment scheduling system for each clinic. The calls were placed to the telephone number listed for scheduling appointments at each clinic. The researcher asked the schedulers/receptionists whether the clinic provided language interpretation to callers with limited English proficiency to aid in scheduling appointments.

RESULTS

Interviews

Interviews were conducted with a total of 83 participants who comprised 5% of the total arrival number of each respective refugee ethnic group in Philadelphia in the past year. The purposive quota sample included Bhutanese Nepali, Iraqi, ethnic minorities from Burma, Eritrean, and Sudanese refugees. All 5 ethnic groups were proportionally represented to comprise approximately 5% of the total arrival numbers of the respective ethnic group in Philadelphia in the past year.

Interviewees by Resettlement Agency and Refugees' Country of Origin

	Bhutan	Iraq	Burma	Eritrea	Sudan	Total
NSC	13	4	3	1	4	25
HIAS	17	8	5	4	3	37
LCFS	14	0	3	0	4	21
Total	44	12	11	5	11	83

Interviewees by Health Clinic and Refugees' Country of Origin

	JFMA	Nemours	PCPC	CHOP	Fairmount	Einstein	Einstein Pediatrics	Total
Bhutan	9	1	14	8	12	0	0	44
Iraq	0	0	0	0	0	8	4	12
Burma	4	2	3	2	0	0	0	11
Eritrea	0	0	3	2	0	0	0	5
Sudan	2	2	2	1	0	2	2	11
Total	15	5	22	13	12	10	6	83

The quota sample ensured that clients of all 3 Philadelphia Refugee Health Collaborative resettlement agencies and patients of all 8 health clinics were represented in the study.

Interviewees by Resettlement Agency and Health Clinic

	JFMA	Nemours	PCPC	CHOP	Fairmont	Einstein	Einstein Pediatrics	Total
NSC	13	4	1	0	3	2	2	25
HIAS	0	0	19	10	0	8	4	37
LCFS	2	1	2	3	9	0	0	21
Total	15	5	22	13	12	10	6	83

The average age of participants was 28 years old and the age range was 4 months to 83 years old. 52% of the study sample was male and 48% was female. Of the 83 participants, 31% were minors under the age of 18 years. Minors were not interviewed directly; their parents responded with the children's health access information. There was 1 respondent who arrived in the United States alone, and was therefore interviewed individually.

Health Access

Of the 83 total respondents, 93% had health insurance through Refugee Medical Assistance (RMA); 7% were beyond the RMA period and were uninsured at the time of the interviews. The 7% of the refugees who lacked health insurance reported that they were unable to see a doctor when they needed to in the past 12 months. Nearly 50% of the clients interviewed expressed mild to severe concern over what to do after their initial 8 months of insurance coverage expires. Several respondents reported that they felt co-pays for appointments were expensive; 1 family reported dissatisfaction with the health coverage provided by their insurance company. 12% of the respondents reported that they have one person they think of as their personal doctor; 77% reported having more than one person. 11% of interviews stated that they do not have a clinician that they think of as their personal doctor. 100% of the sample had a routine check up within the past year. 7 families reported that at least 1 person in their household accessed a specialist provider; the other 11 households have not had a need for a specialist visit. 83% of the interviewees accessed dental care; 11% have not yet gone to the dentist but plan to do so. The most often reported barrier to accessing health care was the participants' inability to make their own medical appointments. For respondents who attempted to schedule appointments, the health clinics' automated telephone system was perceived as a significant barrier. 5 families felt that their health clinics were too far from their homes and would prefer one that was closer.

Role of the Resettlement Agency

Nearly all interviewees mentioned their appreciation for the health support services provided by resettlement agencies, including scheduling appointments, escorting, and advocacy. 13 households reported being satisfied with the services provided by their resettlement agency. When they were able to recall specific numbers about agency assistance, they reported an average of about 3 escorts per client to various medical appointments. There were 2 households

who expressed dissatisfaction with their resettlement agency's health services. 75% of respondents recalled little to no information from the refugee health orientation provided by each respective resettlement agency. The 2 health orientation topics most commonly recalled included: what to do in an emergency and that clients receive 8 months of free health insurance coverage as refugees.

Role of Health Clinics

Respondents overall reported feeling very pleased with their health clinics and doctors. Participants were especially pleased with the care provided by pediatricians. 14 households reported being satisfied with the health care that received. In general, interviewees reported phone interpretation services at medical appointments to be sufficient, but several interviewees described instances of incorrect phone interpretation during appointments. In-person interpreters are preferred when possible. The majority of respondents reported that doctors adequately answer their questions during health appointments. Several interviewees reported a lack of understanding of the referral process and paperwork that they receive at the health clinics. A total of 3 interviewed households expressed complaints about the care they received. Dissatisfied respondents described long wait times at the clinic, as well as the wait time for the follow up appointment. There was 1 family who changed health clinics because they were unhappy with the care received at the initial screening appointment. They reported that there was no follow up on their medical concerns and that requests for referrals were denied by the clinic.

Perceived Health Status

When refugees were asked to describe their health since coming to the U.S., 53 respondents reported that their health was better, 23 stated that it was the same, and 7 responded that their health worsened. The most common reasons stated for improvement in health status are the US healthcare system, availability of fresh food, and a more positive environment.

	BETTER	SAME	WORSE
Bhutanese	34	10	0
Iraqi	8	4	0
Burmese	11	0	0
Eritrean	0	1	4
Sudanese	0	8	3

Surveys

An open-ended survey was administered to the health coordinators of each resettlement agency in Philadelphia. At all 3 resettlement agencies, health services are provided by the health

coordinator and a combination of staff and volunteers. At NSC and LCFS an AmeriCorps member is an integral part of the agency’s health team and part of their job description is to serve as clinic liaisons. NSC and HIAS are both in need of additional support for medical case management. When asked to rank the level of priority that health is for clients on a scale of 1 to 10, 2 coordinators gave a response of 7 and the other a response of 10, averaging to 8.

All agencies provide assistance with scheduling appointments and escorting clients to appointments. The duration of health services provided by the agencies range from 3 to 8 months on average for all newly arriving refugees. All agencies offer extra services for clients with special medical needs, but only 1 agency reported having designated funding to provide intensive medical case management for refugees with complex needs. 2 agencies reported that all clients are given a discrete health orientation; the third agency reported that they include health information in the Reception and Placement orientation. 2 agencies reported that Bhutanese clients are encouraged to attend the monthly health orientation provided by the Department of Public Health.

Telephone Calls

Based on telephone calls placed to each PRHC clinic, 5 clinics provide language interpretation over the phone for callers seeking to schedule an appointment. The schedulers stated that if the caller stays on the line, a third party telephone interpreter can be connected for any requested language. 2 clinics do not provide language interpretation for callers. 1 clinic gave an unclear response— if patients call the clinic social worker directly, a telephone interpreter may be available to the caller.

Interpretation Provided for Callers	Interpretation May Be Provided for Callers	No Interpretation Available for Callers
5 Clinics	1 Clinic	2 Clinics

DISCUSSION

Health Access

In 2011, the CDC Behavioral Risk Factor Surveillance System (BRFSS) conducted 8,631 interviews across PA with a series of questions about health issues. This data provides state percentages for indicators of health access. Overall, PRHC’s surveyed refugee population reported better access to healthcare than the PA population as a whole: the rate of uninsured clients is less than half of the PA average; more of our clients have a consistent personal doctor/health care provider; the inability to see a doctor because of cost occurred almost 50% less for our clients than the PA average; all of our clients have seen a doctor within the past year.

The BRFSS found that 16% of respondents did not have any kind of health coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service. In this PRHC study, 7.2% of refugees lacked health coverage. 13% of respondents to the BRFSS study reported that they do not have one person they think of as their

personal doctor or health care provider. PRHC interviewees reported that 11% do not have one person they consider as their personal doctor while 89% reported having at least one primary care physician. 13% of the PA respondents reported having a time in the past 12 months when they needed to see a doctor but could not because of cost; 7% of PRHC interviewees reported having a time in the past 12 months when they needed to see a doctor but could not. The BRFSS found that 83% of their respondents had a routine checkup within the past 2 years. All of the refugees interviewed by the PRHC had a checkup within the past 1 year. The results from the PRHC study are due to the majority of the interviewees being within the RMA period and all participants having received a mandatory refugee domestic health screening occurred within 30 days of arrival.

Inability to schedule appointments was the most commonly reported barrier to care. Many refugees with limited English proficiency have difficulty navigating automated telephone systems and even those who speak English expressed difficulty understanding the automated prompts. Though 5 clinics reportedly provide language interpretation for people calling in to schedule appointments, no interviewees reported requesting an interpreter when calling in to schedule an appointment. It is likely that most refugees in Philadelphia do not know that this is an option at some clinics. It is also a possibility that the automated system presents too much of a barrier for callers who speak little to no English, making them less likely to call the clinics, or less likely to go through the proper prompts to get connected with a scheduler.

Health Insurance

This study's sample had a small percentage of uninsured individuals. The sample included mostly refugees who were still within their 8-month period of Refugee Medical Assistance. Nearly half of the clients interviewed expressed concern as to what to do after their initial 8 months of insurance coverage expires, even though the interviewer did not ask questions directly about this subject. Many clients see the 8 months of coverage as the only time they can see a doctor. Several Burmese respondents reported that, as a community, "when we don't have insurance, we don't want to go to the doctor" because of the cost. 1 client with a serious health condition expressed concern over affording his medication without insurance in the future; without treatment, his life expectancy is decreased and he worries about supporting his family. Many clients stated that 8 months of insurance coverage was not sufficient. Because they struggle with financial hardship, they are often unable or unaware of how to afford insurance on their own.

Health coverage had expired for about 7% of interviewed clients. Of the remainder of clients still insured, less than 8% were actively looking into options to ensure coverage after the 8-month period of RMA. Most respondents are not aware of how to seek insurance others do not plan to look into insurance options because they think believe health coverage will be unaffordable. Only 1 family was actively looking into options to ensure coverage, this was mainly because the family has several elderly members with high medical needs. 1 family has been without insurance for nearly 4 months. Because of health issues, the head of the family is unable to work and insurance is unaffordable. As a result, they do not have access to medical care; as a family member reported, "I used to visit the doctor when I had arm [shoulder] pain, but now I stay at home" because it is too expensive. Another uninsured interviewee currently has no

serious health concerns, but worries about future issues that may arise after the RMA period ends.

Role of the Resettlement Agency

Health Services

Nearly all interviewees expressed appreciation for the support they received from their resettlement agency. Of the 18 households interviewed, 13 reported being satisfied with the health services provided by the resettlement agencies. The majority of interviewees described the agencies as “helpful” and “good” organizations. 1 family reported being surprised and very pleased to find an agency staff member present at their medical appointment—very likely the respondents were referring to a clinic liaison. Health services such as escorts to health facilities, scheduling of appointments, and reminders of health appointments were described to be very helpful. Several interviewees reported feeling dependent on their resettlement agencies for appointments and escorts to medical facilities. However, with agency assistance, several respondents reported that they quickly became self-sufficient.

Respondents reported an average of 3 escorts per client to various medical appointments. Although this amount of escorting was sufficient for some, several respondents stated that they wished the support would last longer. The desired amount of time for extending this service varied, ranging from 2 weeks of total escorting to *all* appointments to several months of escorting to only medical appointments. Participants reported a need for assistance in going to new clinic locations for the first time, especially if they are far from home, if they speak little English or are not literate, or if they are elderly. 1 client stated that they felt the agency “was doing their best” but wanted even more assistance with medical matters. Several respondents expressed a wish to receive assistance from their agency for emergencies at *any* time, beyond the initial months of resettlement services.

There were 2 households who expressed dissatisfaction with the health services provided by their resettlement agency. These respondents reported that they received incorrect information from their agency and that they did not feel there were not enough escorts and health services, especially beyond 3 months of arrival. Many factors may have contributed to these respondents’ dissatisfaction. These households described unmet expectations regarding resettlement in the United States. Their pre-arrival orientations in Africa made them anticipate more financial and social support than what was provided. These findings are consistent with the literature, which demonstrates that financial hardship and unmet expectations can lead to negative experiences for refugees (Tempany, 2009).

Health Orientation

This project’s findings on the refugee health orientation are consistent with other reports. Similar to the results of NSC’s 2011 health orientation study (Macenat), this 2013 PRHC study discovered that the majority of respondents recalled little to no information from the refugee health orientation provided by resettlement agencies. Data from the 2011 focus groups indicated that NSC clients’ inability to recall the health orientation may be related to stresses of

resettlement as well as the early timing of the orientation upon resettlement to Philadelphia. The information that several clients were able to recall from the health orientation were that RMA lasts for 8 months and that they should call 911 in case of emergency. In the 2011 study, respondents stated that there was large amount of information given to them in a brief amount of time, making it difficult to remember (Macenat, 2011).

Role of Health Clinics

Respondents overall reported feeling very pleased with their health clinics and doctors; 14 out of 18 households reported satisfaction with their health clinics. Participants were especially pleased with the care provided by pediatricians. Several participants, particularly Burmese and Bhutanese respondents, emphasized the high quality of health care and technology relative to the health care they received pre-arrival. The majority of respondents reported that they were very satisfied with the clinicians' "friendliness" and capacity to answer their medical questions. Respondents with high medical needs accessed the most health care and generally expressed satisfaction with the medical procedures and treatment.

The majority of the respondents felt they had adequate access to primary and specialty care. Most participants accessed dental care, however, 2 households reported difficulty accessing dental care, particularly for follow up appointments. Though the majority of respondents felt interpretation was adequate at medical appointments, several respondents stated that an interpreter was not always available or that the telephone interpretation may have been inconsistent. Respondents stated that they would prefer in-person interpretation if available. Several respondents described an inability to understand paperwork given to them at the clinic as well as difficulty understanding the referral process. Overall, language seems to act as the most significant challenge to refugees when utilizing health services.

There were 3 households that reported dissatisfaction with the health care they received. Complaints involved long wait times during appointments, long waits for follow-up appointments, and difficulty getting test results. There was a family that switched health clinics because they were dissatisfied with the first clinic. They reported that there was no follow-up and that requests for referrals and records were denied; they described improved care at the second clinic.

Perceived Health Status

The majority of interviewees reported an improvement in their health status since arriving in the U.S. The most common reasons stated for improvement in health status include: the US healthcare system, availability of fresh food, and a positive environment with less psychological stress. Many interviewees reported that they believe health care to be significantly better in the U.S. than elsewhere; this was particularly true for Bhutanese and Burmese respondents. The interviewees who stated that their health worsened had high medical needs, and did not correlate their health status with their health access. For instance, one household with a member reporting worsened health status expressed high satisfaction with their health clinic.

FUTURE DIRECTIONS

This assessment elucidates many challenges and successes regarding health access that newly arrived refugees experience in Philadelphia. Important concerns to address include: decreasing the barrier that scheduling appointments presents for refugees, improving the efficacy of the health orientation, bolstering community-based support for refugees, and clarifying insurance coverage and options after RMA. When respondents were asked to provide suggestions for improved services, several themes arose. Regarding support from resettlement agencies, participants suggested: 1) more long-term health services, 2) more assistance scheduling appointments, and 3) more escorting and transportation assistance to medical appointments. Regarding improved clinic experiences, respondents recommended: 1) easier methods of scheduling appointments, 2) shorter wait times at appointments, 3) faster specialist appointment availability, 4) clarified and possibly translated paperwork.

The 2 PRHC clinics that do not provide language interpretation for callers seeking to schedule appointments may consider incorporating this capacity into their scheduling systems. The scheduling systems' language interpretation services will be further assessed by the PRHC. In addition to this, refugees need to be better informed about the scheduling system and to be more empowered to call the clinics on their own and to request interpretation. The PRHC is already exploring ways to improve the health orientation. Ideas include changing the health orientation into a module system, creating a culturally competent video, and incorporating Health Navigators to provide linguistically appropriate orientation information. Health navigator programs have been found to be successful for the refugee health orientation in other states (Cultural Orientation Resource Center, 2011).

Resettlement agencies may have the opportunity to bolster the capacity of their health teams through new funding opportunities and partnerships. For example, Preferred Communities funding may allow for the hiring of medical case managers to support refugees with complex medical needs, as well as Health Navigators, who are members of refugee communities. Peer support is beginning to emerge in Philadelphia, such as through community-based groups like churches and the Bhutanese American Organization-Philadelphia. PRHC partners are exploring ways to work alongside community-based groups. The Affordable Care Act will present many changes for refugees in Philadelphia. This may allay post-RMA uncertainty for some refugees, but the transition will most likely present new challenges for refugees as well as agency and clinic staff members. To address immediate post-RMA concerns, PRHC agencies are considering exit orientations for clients approaching the 8-month mark. The future directions will ensure that the PRHC will uphold its core mission "to create an equitable system of refugee health care in the Philadelphia region that ensures a consistently high standard of care for all newly arrived refugees."

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APPENDIX

Interview Guide for Refugee Participants

Demographic Information

- What is your age?
- What is your gender?
- What is your country of origin?
- When did you arrive in the U.S.?
- What resettlement agency arranged your resettlement in Philadelphia?
- Where in Philadelphia do you reside? (Northeast Philadelphia, South Philadelphia, Southwest Philadelphia, etc?)
- Did you graduate from high school? If not, what was the highest year of school completed?
 - Did you graduate from school post-high school? (Technical School, College/University, Graduate School, etc?) If not, what was the highest year completed?
- What is your current marital status?
- What clinic provided your domestic screening?
 - When did you receive your domestic screenings in Philadelphia?
- Do you have health insurance? If yes, what type of health insurance do you have?

Access to Care

- Do you have health insurance? If so, what kind?
 - Have you experienced any problems or challenges regarding health insurance?
 - Have you ever contacted your insurance company? If so, would you please describe the circumstances and outcome?
 - What do you understand health insurance to be?
- Please describe the health orientation and tell me what you remember from the orientation. (Interviewer may need to describe the health orientation in case interviewee does not recall what this is.)

- In the past 6 months, how many times did you visit a physician? (Do not include visits while in the hospital or the hospital emergency department)
- In the past 6 months, have you ever been to the emergency department? If so, how many times did you go to a hospital emergency department?
 - Please describe your experience at the emergency department.
- In the past 6 months, were you hospitalized for one night or longer?
 - How many times were you hospitalized?
 - Tell me about this experience.
- Have you visited a specialist doctor in the U.S.? If yes, what type of doctor?
 - Tell me about this experience.
- Please describe your health and the health of your family before you came to the United States.
 - Probe for chronic disease, and health concerns pre-arrival.
- Have you gone to the dentist? If so, explain the reason of your last dental visit, when and where it was.
 - Did you face any barriers while you were trying to access the dental care?
- Please describe any support you received from your resettlement agency.
 - What assistance was provided?
 - Was the agency helpful?
 - What do you think could have been improved?
 - Was there anything you needed that the agency did not provide?
- Tell me about any time you may have wanted to visit a doctor or get medical treatment but could not.
- How difficult has it been for you to pay for your basic needs (e.g. rent, groceries, gasoline, transportation, utilities, etc.) in the last year?

Health Care Utilization

- Please tell me about doctors and clinicians that treated you before you arrived in the United States.
- Tell me about any health clinics you visited in the past 6 months. Please describe your experience.
 - Why did you visit these clinics?

- What doctors did you see? Probe for specialist visits.
- What was your experience with the receptionists in the clinic? Probe for how they navigated the appointments.
- What are your thoughts about doctors, nurses, and health workers in the United States?
 - Were you satisfied with the care you received from your doctor?
 - Were you satisfied with the care you received from the other clinic staff—nurses, social workers, etc?
- Tell me about any interpretation that you used during doctor's visit.
 - Did you want an interpreter during the doctor's visit?
 - If interpretation was provided, what kind—in-person or telephonic?
 - How well did you understand the information communicated via interpreter?
 - Were you satisfied with the interpretation that you received?
- Do you ask questions during your medical visits? If you ask questions during your medical appointments, please tell me what kind of questions you ask.
 - Did you feel your questions were answered?
 - If you do not ask questions, were there questions that you wanted to ask the doctor?
- Please describe your experience receiving health care while you had Refugee Medical Assistance (if interviewee is beyond the period of RMA).
 - How have things changed for you since RMA ended?
- Have any of your thoughts about clinicians changed while you were in the United States?
- What are your thoughts about hospitals, doctor's offices, or clinics in the U.S.?
- Please describe any paperwork or instructions that your doctors gave you.
 - What was your understanding of the paperwork?
- Tell me about times you may have been worried about your health and/or your health care.
- Are you currently receiving medical treatment for any reason?
 - If yes, please tell me what you are being treated for and who is providing your health care.
- Tell me about any health concerns or conditions you may currently have (or had in the past).

- How would you describe your health and the health of your family since coming to the United States? Would you say your health is better, worse or the same?
 - Probe for health concerns, chronic disease, disease management
 - Why do you think these changes have occurred (probe for insurance status, cost of health care, other access issues, food access, safety concerns, etc.)
 - If health has improved why do you think this has occurred?
- What, if any, advice would you give to your doctors and clinic staff in order to better meet your needs?
- What, if any, advice would you give to your resettlement agency staff to better serve you?

Debriefing

- Do you think you are receiving all the medical care that you need?
- Is there anything I didn't ask that I should ask to help me better understand your experience with health care in the U.S. or your health care concerns?
- Is there anything else you would like to discuss or share regarding this interview?

Survey for PRHC Resettlement Agency Health Coordinators

1. What support for health does your agency normally provide for new arrivals (clients who have arrived within the past year)? I.e. Escorting, scheduling of appointments, advocacy?
2. Who at your agency provides health services to clients? I.e. Staff, volunteers, etc.
3. For how long does your agency provide health support for clients?
4. Does your agency provide health orientations for all new arrivals? If the answer is no, approximately how many new arrivals received a health orientation this past year?
5. Does your agency provide extra services for clients with special medical needs? If so, what type of support and for how long?
6. How high of a priority is health for your newly arrived clients on a scale of 1 to 10 (10 being highest)?
7. Do you feel that your agency has enough capacity to meet the health needs of your clients? Why or why not?