Connecting Newly Arrived Refugees to Health Care in North Carolina

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The domestic refugee screening is a valuable tool to link newly arrived refugees to the US health care system and can assist in providing a continuum of care from overseas to arrival. Beyond initial refugee screening, accessing general medical, dental, and mental health services can be significantly challenging.

North Carolina has much to offer refugees in the area of health care, yet many barriers to culturally and linguistically competent health care continue to exist. Most of North Carolina's newly arriving refugees are placed in housing near their sponsoring refugee resettlement agency; however, populations eligible for refugee services and benefits can and do choose to live in many cities throughout North Carolina. Sponsoring agencies are generally located in cities where there are many resources and opportunities for newcomers, including but not limited to language interpretation services, affordable housing, and readily available employment. Sponsoring agencies maintain a multitude of community partnerships to help support and integrate newly arriving refugees. These partnerships include local health departments, federally qualified health centers, private clinics and physician offices, hospitals, and numerous specialists.

Within the North Carolina Department of Health and Human Services (NC DHHS), there are three divisions that are involved in connecting refugees to health care in North Carolina: Social Services, NC Medicaid, and Public Health.

The Division of Social Services, and particularly the North Carolina Refugee Assistance Program [1], maintains Refugee Medical Assistance (RMA) funding. RMA is a federally funded and short-term medical insurance program available to eligible individuals to stabilize their health after arrival in the United States [2]. Since 2015, the Division of Social Services has maintained the Refugee Health Promotion Grant, a small grant that focuses on health literacy, access to health and emotional wellness services, and access to affordable health care beyond the services for the newly arrived clients [3].

NC Medicaid provides access to Medicaid care and services to many refugees and also administers RMA funds. RMA eligibility, like Medicaid eligibility, is assessed through North Carolina Families Accessing Services through Technology (NC FAST). RMA is administered through a fee-for-service system, so benefits for RMA parallel those of the NC Medicaid program. Claims are processed through the NCTracks [4] system of NC Medicaid and services and reimbursement mirror NC Medicaid with a few exceptions such as mental health. For mental health services, NC Medicaid recipients are under a managed care model, while RMA recipients remain under a fee-for-service model.

The Division of Public Health (DPH), and particularly the North Carolina Refugee Health Program, maintains refugee medical screening services. DPH contracts with several local health departments to provide the initial refugee medical screening either in part or in full depending on available resources, capacity, and capability within the local health department and in each community.

It is important to note the specific populations that may be eligible for refugee benefits and services and particularly RMA and refugee medical screening [5]. For the purposes of this commentary, the term "refugee" will generally encompass the various populations and immigration statuses as listed in Table 1.

Health Coverage for Refugees

Most refugees qualify for either RMA or a comprehensive Medicaid program upon arrival in the United States and North Carolina or at the time they are granted asylum or certified as a victim of human trafficking [2]. In North Carolina eligibility is determined through NC FAST, where applicants are first assessed for a comprehensive Medicaid program (eg, Families with Dependent Children; Aged, Blind, and Disabled; or Pregnant Women). If eligible, refugees must maintain eligibility and recertify as required. If a refugee is not eligible for a comprehensive Medicaid program, then eligibility for RMA would be assessed. Refugee adult singles or those married without children would be the typical clients eligible for RMA. RMA is limited to the first eight months in the country. When RMA or Medicaid eligibility end or the clients are not able to obtain health insurance through their

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TABLE 1.
Populations and Immigration Statuses Eligible for Refugee Services and Benefits

Immigration Status	Description
Refugee	Individuals granted refugee status overseas by the US Department of Homeland Security and admitted for resettlement by the US Department of State.
Asylee	Those granted asylum. Family members may also be eligible.
Cuban or Haitian entrant	Those granted parole status or those granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti.
Special Immigrant Visa (SIV) holders from Iraq and Afghanistan	Granted SIV status as related to service to the US government in Iraq and Afghanistan. Family members may also be eligible.
Amerasians	Individuals fathered by a US citizen and born in Vietnam after January 1, 1962, and before January 1, 1976. Spouses, children, and parents may also be eligible.
Victims of a Severe Form of Trafficking in Persons	Victims of human trafficking. Family members may also be eligible.

employer, refugees or those who obtained Lawful Permanent Status (former refugees or other eligible status) are eligible to apply for Health Choice and/or the health coverage options under the Affordable Care Act [6].

Sponsoring agencies typically assist refugees in applying for benefits and services such as Medicaid, generally within the first week after arrival in the United States and North Carolina. They often help the clients choose a primary care provider at the time of application. Primary care providers may be requested due to a variety of reasons such as previous experiences or partnership, proximity to the client's home or to public transportation, or ability to provide culturally and linguistically relevant services. Despite federal and state laws [7] requiring specific timelines for eligibility determinations, and despite efforts of clients, case managers, and local Division of Social Services offices, it sometimes takes weeks and at times months for Medicaid or RMA applications to be approved. This delay in approved coverage makes it extremely challenging to find health care providers, especially specialists, that are willing to even schedule an appointment. This then contributes to emergency department usage for non-emergency reasons.

Assessing Health of Refugees – Federal Oversight

Refugees are, in general, a high-risk and vulnerable population that faces special health challenges due to exposure to deteriorating conditions usually attributed to circumstances such as war, trauma, and forced migration. In many refugee camps overseas, sanitation, food supplies, and health care services are limited, which can have implications for malnutrition, infectious diseases, and chronic conditions. Therefore, depending on their country of origin, refugees are at an increased risk for many diseases, both infectious and noninfectious, not commonly seen in the native US-born population. Incomplete vaccination status, tuberculosis infection, parasitic infection, and common chronic conditions requiring medication management are some of the most frequent and immediate health issues in newly arrived refugees. It is important for refugees to receive domestic screenings soon after arrival to identify and treat health problems or follow-up on conditions identified during overseas examination. See Table 2 for an overview of various examinations.

The International Organization for Migration works together with the Centers for Disease Control and Prevention (CDC) overseas to administer medical examinations [8]. These examinations are typically performed several months before departure. The purpose of this examination is to identify any health conditions that could result in medical inadmissibility from immigrating to the United States under the provisions of the Immigration and Nationality Act [9]. Medical conditions that render a foreign national inadmissible on health-related grounds are divided into four categories: communicable diseases of public health significance (eg, untreated respiratory tuberculosis); physical or mental disorder with associated harmful behavior; drug abuse or drug addiction; and failure to show proof of required vaccinations. This exam can also identify both chronic and acute medical conditions that may need attention at the final destination. For refugees there can be additional appointments and health care provided such as vaccinations, presumptive treatment for intestinal parasites, and a determination as to whether the person is fit to fly or needs any type of medical escort or immediate care upon arrival at the final destination. They can be sent with a supply of medications to maintain them until they can seek care in the United States.

The examining physicians give refugees and immigrants at least one copy of their overseas medical examination documentation which they must carry with them and submit at a quarantine office at the first port of entry to the United States. Quarantine offices communicate the arrivals and documentation to CDC, which maintains a centralized electronic reporting system called the Electronic Disease Notification system (EDN) [10]. The overseas medical records for refugees as well as for immigrants with health conditions requiring medical follow-up are loaded into the

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TABLE 2.
Examinations Overview

Examination type and location	Performed by	Purpose	Timeline
Overseas medical exam *(required)* Performed in refugee camps, hospitals, health centers in host country	***Panel physicians*** designated by the US Department of State (DOS)	To assess whether there are any health-related grounds for inadmissibility.	Weeks to months before the refugee departs from his or her country of asylum.
Domestic health assessment *(recommended)* Performed in the United States	***Health care providers*** in state, county, or local health departments; community health centers; or private practices/clinics	To follow up on issues identified in overseas exam; to identify any public health concerns or personal health conditions that could adversely impact self-sufficiency; and to refer to primary care providers for ongoing care.	Within 30-90 days post arrival.
Adjustment of status (Green Card) medical exam *(required)* Performed in the United States	***Civil surgeon*** designated by the US Citizenship and Immigration Services (USCIS) ***or Health Department with Blanket Designation***	**Most refugees only need the vaccination part completed since they already completed overseas medical exam.** They must be up to date on their vaccinations.	Refugees, a year after US entry.
	Civil surgeon designated by the US Citizenship and Immigration Services (USCIS)	To assess whether there are any health-related grounds for inadmissibility.	Others, when applying for a change in their visa status.

system which then notifies US state health departments of their arrival. State health department officials may authorize EDN access for local health department officials as well as staff in medical offices that serve many refugees. In North Carolina, the DPH Tuberculosis Control Program receives all the EDN notifications for immigrants and refugees needing additional tuberculosis screening or evaluation. Likewise, the DPH Refugee Health Program receives EDN notifications of all the refugees. These programs then notify the local health departments accordingly.

To provide a continuum of care for newly arrived refugees, there are federal laws that address the concerns of the medical vulnerability of this population. For example, the Immigration and Nationality Act creates procedural guidance to states for refugee medical assistance [11]. Additionally, the Immigration and Nationality Act authorizes the US DHHS Administration for Children and Families Office of Refugee Resettlement (ORR) to fund states to cover the costs of providing domestic medical screening to refugees [12]. ORR provides guidance to create a minimum standard of care across states and to establish a framework for reimbursement. ORR holds that the purposes for domestic refugee screening are as follows: "to ensure follow-up with medical issues identified in an overseas medical screening; to identify persons with communicable diseases of potential public health importance; to enable a refugee to successfully resettle by identifying personal health conditions that, if left unidentified, could adversely impact his or her ability to resettle; and to refer refugees to primary care providers for ongoing health care" [13].

ORR refers states to CDC clinical guidance to determine refugee screening policies and practices at the state and local levels. CDC has provided protocols and guidelines for domestic refugee screening since 1995 and current guidelines are available on the CDC website [14]. The CDC guidelines were developed and are maintained based on available evidence-based data and a consensus process that includes input from subject-matter experts.

Assessing Health of Refugees – State Oversight

In North Carolina, the DPH Refugee Health Program oversees and coordinates refugee screening through providing targeted funding, technical assistance, and program guidance (see Table 3) to mainly local health departments. Contract funds for several local health departments are allocated based on the services they are able to provide, as there is variation in available resources and capacity in each community. North Carolina local health departments are tremendous partners in refugee screening for a number of reasons including, but not limited to, the following: 1) they maintain vaccine, vaccine-preventable disease, tuberculosis, and communicable disease expertise and resources; 2) they are able to see clients quickly and without approved medical insurance coverage; 3) they are familiar with many resources in the community to which they can make referrals; 4) they are generally easy to access and on bus routes; and 5) they have many other services to offer newly arrived refugees. It can be challenging and rewarding working with local health departments as each health department is quite different. Assisting health departments that do not have a contract and are not familiar with refugees or refugee screening is quite challenging; however, health departments always have much to offer this population.

Timeliness of refugee screening is crucial as any health concerns need to be identified and/or addressed quickly after arrival. The DPH Refugee Health Program requires contracted local health departments to initiate refugee screening ideally within 30 days but no later than 90 days after the refugee arrives. Vaccination doses also need to be initiated or continued as quickly as possible, which is especially important for school-age children. As state law now requires that every child entering a North Carolina public school for

TABLE 3.
North Carolina Refugee Health Assessment Protocol Components

The North Carolina Refugee Health Assessment Protocol includes the following (inclusion of many of the components is based on risk factors, age, gender, signs or symptoms, or comorbidities):				
History and records review	Immunization assessment and update	Tuberculosis screening	Hepatitis B testing	HIV testing
Syphilis testing	Hepatitis C testing	Chlamydia testing	Gonorrhea testing	Blood pressure screening
Nutritional status and growth	Physical exam	Mental status examination and screening	Female genital mutilation/ cutting (FGM/C) screening	Multivitamin recommendation
Hematology	Urinalysis	Serum chemistries and glucose	Infant metabolic screening	Cardiovascular and lipid disorder screening
Cancer preventive screening	Blood lead level testing	Intestinal and tissue invasive parasite testing and treatment	Malaria testing	Pregnancy testing

the first time must have a health assessment, the refugee screening can be key to accomplishing this as quickly as possible for refugee children and preventing educational delays. Adult refugees will be expected to attend English classes and start employment as quickly as possible, further accentuating the importance of timely refugee screening.

The refugee screening is a valuable tool to link refugees to our health care system and can assist in providing a continuum of care from overseas to arrival in North Carolina. Beyond initial refugee screening, accessing general medical, dental, and mental health services can be significantly challenging for many refugees due to cultural differences, lack of transportation, language interpretation issues, and limited understanding of our complex health care system. Many refugee service providers express challenges with finding health care and mental health providers that are willing and able to accept refugee clients. One of the most common reasons given by health care providers is not having any language interpretation service or not having funds to pay for interpretation services. The DPH Refugee Health Program has been able to assist health departments with some interpretation funding for refugee screening appointments and is preparing a pilot project to extend resources for interpretation to various clinics and private providers, which may help with accessing some services for newly arriving refugees. In many ways, the complexities of systems can work against some of the most vulnerable populations. However, NC DHHS and its partners continue to work to find strategic ways to overcome the many barriers to culturally and linguistically competent health care for refugees. NCMJ

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