

NWX-OS-OGC-RKVL (US)

**Moderator: Sima Michels-Dembo
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1:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session you may press star then 1 from your touchtone telephone.

Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I'd like to turn the conference over to Miss Sima Dembo. Ma'am you may begin.

Sima Michels-Dembo: Hi. Hello everyone. Welcome to the Webinar Meeting The Needs of Refugees in the Family Planning Setting. I would like to turn this over to Susan Moskosky who will take the microphone.

Susan Moskosky: Thanks Sima and thank you everybody for joining us this afternoon. This Webinar is being hosted by the Office of Population Affairs in HHS and the Office of Refugee Resettlement in the Administration for Children and Family at HHS.

Refugees come to the United States often under the most dire circumstances such as escaping warfare, escaping violence including sexual violence,

extreme poverty and other trauma. And they often come for many years in refugee camps or urban environments with limited access to food, clean water and basic hygiene.

Often they have not received much medical attention and come with multiple health needs including mental health needs. Refugees also often need to learn our language, our culture and how to navigate our health care system. They're expected to find employment and begin contributing to society economically within a year which is really a daunting task.

Despite physical circumstances refugees have proven to be a remarkable and resilient group as a whole. And we're honored to be able to serve them in our program and help them on their journey to rebuilding their lives in this country.

Many Title 10 families planning providers have a track record of serving individuals of many diverse backgrounds as we all know and furthermore Title 10 regulations require that professional interpretation services be available in the client's language.

We pride ourselves in Title 10 on practicing culture competency in seeking to meet our often diverse community's needs. We anticipate that this Webinar will provide additional tools to help family planning providers build on your expertise and skills reaching and meeting the needs of the different populations that come into your communities and into your clinics.

Please note that this Webinar will be archived on the OPA Website within the next couple of weeks. So we're delighted this afternoon to have three excellent and knowledgeable speakers today to discuss this topic and I'll be introducing them shortly.

So first I'd like to talk a little bit about our agenda. These you can see on your screen that we'll first be hearing from Dr. Curi Kim who will be discussing who the refugees are, the U.S. role in refugee resettlement and the intersection between Health and Human Services and Refugee Resettlement and health disparities that are being experienced by refugees.

And we'll also be hearing from Gretchen Shanfeld from the Philadelphia Refugee Health Collaborative who will address a topic on refugee health needs perspectives from the Philadelphia Refugee Health Collaborative. And she will address the question if there's not a collaborative what can you do to support refugee needs within your family planning clinic.

And she'll also address identifying and addressing particular challenges, helping your patients navigate the health system and making community linkages and referrals as well as maximizing resources in order to server more refugees.

Finally we'll be hearing from Dr. Sandra Wolf who will provide the Title 10 providers perspective on what to expect from refugee patients, what the particular challenges are in serving refugees, how to best meet refugee needs and what adjustments need to be made in order to effectively serve refugees in the family planning setting.

And then we'll conclude with Q&A which will be at the end and the operator will come on after Dr. Wolf's presentation to give you instructions on how to ask your questions by either phone or by chat.

So let me start by introducing our first speaker Dr. Curi Kim who is the Director for Division of Refugee Health at the Office of Refugee Resettlement

within the Administration for Children and Families or ACF at HHS. And the Division of Refugee Health works to promote refugee health and emotional wellness by providing better leadership, partnership and resources.

Dr. Kim also provides medical and public health guidance to the Unaccompanied Alien Children program within the Division the Division of Children Services at the Office Refugee Resettlement.

Sorry about that. Dr. Kim started working with ORR in 2012 as the Center for Disease Control and Prevention Medical Officers second to provide health related technical assistance. She's been involved in the health issues of mobile populations since joining the CDC in 2007, serving as the Quarantine Medical Officer at the CDC Detroit quarantine station in Michigan.

The acting surveillance team lead of CDC Refugee Health Program in Kenya and the quarantine and border health service branches science and policy medical officer at CDC headquarters in Atlanta.

Prior to her federal career she practiced medicine in the state prison in Michigan and she currently holds the rank of Commander in the U.S. Public Health Service and sees patients at a clinic for the uninsured in Arlington, Virginia. So with that I'd like to turn it over to Dr. Curi Kim.

Curi Kim: I thank you very so this opportunity to present. Let me -- so I wanted to start off on the first slide by talking about our populations in ORR. As this slide shows ORR serves more than just refugees and it's more than just about resettlement.

Some of our populations preceded the creation of our office. ORR was established in 1980 by the Refugee Act. And we serve refugees,

unaccompanied refugee minors, Cuban Haitian parolees or entrants. In 2000 we started serving asylees, people who are granted asylum in the United States. We have the survivors of torture program.

We serve adult foreign victims of human trafficking. In 2003 the Unaccompanied Children Program came into our purview as I'll talk about in just a minute. Many of -- well not many but some of those children may receive special immigrant juvenile status and we serve them too.

And in 2007 to 2009 we started serving the Iraqi and Afghan special immigrant visa holders, people who are persecuted or threatened in their home countries for helping the United States government. Some of them had the opportunity to resettlement in the United States.

In addition legislation was passed for children -- for child foreign victims of human trafficking who fall under our office now as well. This slide on the unaccompanied children, I just include it here because over the spring and summer I'm sure many people have heard about the influx of children across the Mexican border into our country and ORR's role.

And as you can see this program is not new to ORR. We've had it for over ten years. It was inherited from the INS once that agency was disbanded through the creation of the Homeland Security Act in 2002.

The numbers have always been very stable for, you know, for, you know, over a decade with about 6000 or so unaccompanied children coming annually into ORR's custody. But in fiscal year 2012 we started seeing a doubling of numbers.

And that had escalated until this past fiscal year of 2014 when we closed out with almost 60,000 UC referred in a single year. During the spring and summer we were seeing as many children referred to us in one month as we would see in one year previously. So as you can imagine it was quite a challenge for our office.

Most of these children are coming from Central America. Most primarily Guatemala, El Salvador and the Honduras but they can come from any other country as well. Sometimes in the Office of, in our office of refugee resettlement we may talk about the refugee side of the house, the other populations that I had mentioned.

All have benefits even though, you know, they might not technically be refugees, asylees, Cuban Haitians, parolees, foreign victims of human trafficking, SIVs, they all have benefits that are similar to what a refugee would have and are eligible for those services.

The unaccompanied children fall into, you know, a different category so, you know, it's kind of a different -- another side of the house where other benefits are very different.

While they receive health care and education and services while in ORR custody, once they're released into the community since most of them are undocumented they will only receive those services for which other undocumented people are eligible for in the community. Moving onto the next slide. I wanted to provide a quick overview of the U.S. refugee program.

The U.S. refugee program follows a specific process that involves the coordination of several agencies starting off with the United Nations High Commissioner for Refugees or the UNHCR which is mandated by the United

Nations to lead and coordinate international actions for the worldwide protection of refugees and the resolution of refugee's issues worldwide.

Applicants of refugee status are located outside the U.S. often in refugee camps operated by UNHCR but they can also be in urban settings. The UNHCR coordinates the initial claims for refugee status along with managing overseas refugee camps and provides refugee referrals to receiving countries.

The U.S. receives -- of countries that we settle refugees by far the United States takes -- the United States takes in the most numbers. So there's three main U.S. Cabinet departments that are also involved in the U.S. refugee program.

The Department of Homeland Security, the Department of State and where we're located in the U.S. Department of Health and Human Services. Each part operates independently with some overlapping programs and jurisdictions.

And we have separately got authority and budgets for operations as well but it does involve a degree of coordination. The applications for U.S. refugee status are processed overseas by the Department of State and the Department of Homeland Security.

As I mentioned the U.S. asylum applicants apply from within the U.S. The status is granted by the Department of Homeland Security and in some cases by Immigration of course within the Department of Justice.

Within the Department of Homeland Security the U.S. Citizenship and Immigration Services or USCIS has the statute authority to determine which

applicants meet the requirements of refugee status and are otherwise admissible to the U.S. under U.S. law.

Within the Department of State is the Bureau of Population Refugees and Migration or PRM that coordinates refugee policy and manages overseas processing, cultural orientation and transportation to the U.S.

They're also responsible for the initial reception and placement activities in the U.S. which takes place within the first 30 and 90 days. So it's after the DHS and DOS process for incoming refugees and after they determine the admission status and placement that HHS specifically the Office of Refugee Resettlement kicks in on the domestic side.

We serve as a bridge to facilitate the initial resettlement and transition of newly arriving refugees and other populations who qualify for refugee benefits through time limited targeted funding and programs.

So moving on to the next slide I just wanted to talk a little bit more about who are refugees. Per the Immigration Nationality Act refugees are defined as a person -- or refugees is defined as a person who is outside of their home country of residence and is unable or unwilling to return due to a well-founded fear of persecution.

And lack of protection on account of race, religion, nationality, political opinion or membership in a particular group. As I mentioned asylees are a separate population. They meet the same standard of persecution.

But again they received the grant of asylum inside the U.S. Refugees are -- they can be children, youth, adults of all ages, they can be from all sorts of

ethnicities, they can be LGBT population, some of them arriving as unaccompanied minors.

Refugees are in every community including yours, they can be entrepreneurs, farmers, medical professions, artists, childcare clients, the list goes on. Going on to the next slide. This is an aerial view of the Dadaab Refugee Camp in Kenya. It is known as the biggest refugee camp in the world.

Close to a half a million refugees and displaced persons are spread across a complex of these five camps that were originally designed for only 90,000 refugees, highlighting some of the, you know, conditions -- unstable conditions -- overcrowded conditions that refugees may be experiencing.

Refugees and asylees and other ORR populations they have to be incredibly strong survivors to persevere and to help them in their long journey to the U.S. overcoming many obstacles, exposures to threatening situations and navigating complicated bureaucracy. Overall in the world there are over 16 million refugees right now.

This is the highest number of displaced persons since World War II. However, of that number 16 million less than 1%, about half a percent are resettled annually to a third country. In terms of refugee countries of origin this slide shows for fiscal year 2013 the countries that most refugees that the U.S. took in are coming from.

This is -- the demographics continue to change over time. For example when ORR was first established we worked primarily with one or two primary refugee populations but now we work with a much more diverse group and there are actually over 60 refugee populations. This slide shows our total estimates for fiscal year '15 of ORR's case load.

As you can see refugees make up about 40% of the overall service population but they are only part of the population that we have, that we serve, that we know will arrive when and where.

The other populations, you know, we can make estimates for but we don't -- their entrance isn't really controlled for as it were. As you know with the unaccompanied children they just come. We have no control over that. Same for the Cuban Haitian parolees.

When they come in they'll come in, when they come in. Asylees they're difficult to predict although we do make estimates. Each year though the President issues the determination that provides the projections for the goal for refugee arrivals for fiscal year '15 it was 70,000 which is the same as it was for last year, in the last previous years as well.

Again all these populations that are listed are all eligible for mainstream public benefits and basically, you know, the same services that refugees are entitled to. This slide shows the ORR's resettlement network.

We work with various stakeholders, including nine voluntary agencies known as VOLAGs. They have approximately 350 affiliates as well as community based organizations. We fund state refugees coordinators as well as state refugee health coordinators. It's really less than a village and more of a nation.

That's what makes the refugee resettlement network so strong and unique. The next slide shows ORR's regional rollout. We are starting to align with the HHS regional structure and have ORR regional representatives embedded in that structure.

Right now we have ORR regional representatives in the Boston in Region 1, Atlanta in Region 4, Chicago in Region 5, Dallas in Region 6, Denver in Region 8 and San Francisco in Region 9. We hope to have more representatives in more regions in the future as well.

We hope that this structure can help facilitate more state and regional meetings and coordination between local and mainstream agencies and with the state refugee coordinators and resettlement agencies. The next slide shows the different affiliate voluntary agencies across the country as previously mentioned there are over 300.

This map shows -- this is accessible through ORR's Website. You can -- if you go to that Web link at the bottom of the slide you can see an interactive map. The different colors refer to different models of refugee resettlement across the United States.

And if you click on any state you can see how much funding was awarded and to who in each state. This slide talks a little bit more about the intersection between resettlement and mainstream health and human services.

Again unlike other non U.S. citizen populations who are barred from accessing public benefits for five years refugees and other populations that are refugee like may immediately access mainstream public benefits upon arrival if they are categorically eligible for them.

This includes Medicaid, CHP, TANF, the temporary assistance for needy families, SSI, Supplemental Security Income and SNAP, Supplement Nutrition Assistance Programs. For those who are not categorically eligible for some of the mainstream programs ORR also provides refugee cash and medical assistance.

That's supposed to -- that kind of mirrors TANF or Medicaid. In addition we award grants to states for a wide range of social services including employment services, English as a second language, orientation, transportation, interpretation and translation, skills training, health related services and other.

We also have other resettlement specific models of program such as Assets for Independence, Micro Enterprise and home based child care programs with eclectically and culturally appropriate services.

I mentioned earlier many newly arrived refugees have immediate health care needs upon resettlements. Refugee displacement often means waiting years even decades, sometimes entire generations for a chance at resettlement.

Whether that time is spent in a refugee camp or in urban settings resources such as food, supplies, access to health care sanitation can be limited which obviously has implications for malnutrition and infectious and chronic diseases.

Resettlement offers hope, provides opportunities and restores dignity. Let me move on now to talk a little bit more about the Division of Refugee Health.

We recognized that the lack of the health and emotional wellness poses barriers to self-efficiency. As noted earlier a refugees are expected to become self-sufficient within a year.

Obviously a daunting task but if you are not healthy it's difficult to work, to go to school and to become self-sufficient. So the Division of Refugee Health was created by our Director in 2012.

There's a couple of programs that fall under our Division including Refugee Medical Assistance, or RMA which is the Medicaid look alike a program for refugees who are not eligible for Medicaid. Refugee medical screening.

We have two grant programs, the Refugee Health Promotion Grant that goes to states and services for survivors for torture. That funds about 30 centers and two TA providers to serve that population. Continuing on other activities that the Division is involved in include outreach.

We have materials posted on our Website and resources. We host Webinars and have created videos promoting health education. Our first video that's posted on our Website is geared towards Somalia refugee women and specifically talks about refugee women's health issues.

And we recognize that many refugee women have not received, you know, reproductive health care education in their home countries or refugee camps so it talks about, you know, just basic education on how our bodies work, aspects of family planning and other information that we hope will give refugee women the tools to make the decisions that are right for them.

We also are involved in policy issues. We are very -- starting to become active in reaching out to other federal partners to share our work and to collaborate with them. We have several projects ongoing to increase our ability to systematically collect data on refugee health. And we have several initiatives on emotional wellness.

This slide is just look over it briefly is about advancing health equity, addressing barriers to health care access. A lot of times refugees are eligible for Medicaid but may have difficulty getting timely access due to ID proofing barriers in the marketplace.

Promoting shared resources and initiatives supporting refugee health both inside and outside of ORR that increasing health literacy which we support with our refugee health promotion grant supporting culturally and linguistically appropriate systems through our work with also which is supported through our refugee health program grant.

And we're working with the Office of Minority Health and we're starting to explore more health disparities as well as we continue to work on collecting data systematically. This slide talks about the top ORR challenges in linking refugees to mainstream resources.

There's a lack of awareness in general about refugees and some confusion about understanding the U.S. role in refugee resettlement. In addition there has been a lack of mainstream institutionalized structure for refugees.

But I'm really pleased to announce that most recently there was a Presidential memorandum that was released by the Whitehouse that talks about -- establishes a task force for newly arrived American including immigrants and refugees.

It's called Creating Welcoming Communities and Full Integrating Immigrants and Refugees. So through this memorandum the President has indicated his commitment to integration and new Americans including refugees which, you know, we're very pleased about.

And have been circulating this memorandum to our partners and we hope that the task force will help other parts of the U.S. government all focus on this issue as they need to report back to the Whitehouse on all of these activities.

I think I'm just about out of time so I just wanted to leave you with this slide. Sorry, this slide on how you can be a refugee champion by helping to elevate refugee issues and concerns and in partnership help to promote refugee integration.

And one way is to always ask how might newly arriving foreign-born populations, such as refugees and asylees be impacted by your programs and through other activities that you're clinics and programs may be involved in? And with that I thank you very much for this opportunity to present.

Susan Moskosky: Thank you very much Dr. Kim. So now we'll be hearing from Gretchen Shanfeld and Sandra Wolf both of whom work as part of the Philadelphia Refugee Health Collaborative. It was formed in September 2010 and the Collaborative is a regional coalition consisting of three refugee resettlement agencies and eight refugee health clinics.

The mission of the collaborative is to create an equitable system of refugee health care in the Philadelphia region and ensures a consistently high standard of care for all newly arrived refugees. Each year the collaborative provides domestic health screens, primary care including newborn, pediatrics, adult medicine, geriatrics, obstetrics and gynecologic care.

And access to laboratory, radiology and some specialty services to 800 newly arrived refugees. So we'll be first hearing from Gretchen Shanfeld who's the health coordinator for the Philadelphia Refugee Health Collaborative and the Health Coordinator at the Nationality Service Center or NSC.

Miss Shanfeld's career has focused on working with vulnerable adults. As a member of the Nationality Service Centers health team she will expand health

resources and develop processes to ensure that refugees have access to a full range of health services.

She currently also serves as the coordinator for NSC refugee health and unaccompanied alien children programs. She has also served as a case manager for the survivors of torture program at NSC.

And she also coordinates the Philadelphia Refugee Health Collaborative which brings together refugee resettlement agencies and health providers to increase the timeliness and quality of care available to refugees in the region. So Gretchen I'll turn it over to you now.

Gretchen Shanfeld: Great. Thanks so much for the opportunity to speak with you all today. So I wanted to kind of jump right in and talk a little bit about, you know, how you can get involved with serving refugees.

And do that in mostly practical terms, in terms of some tips and ideas for things that you might utilize in your practice or things like training items for your staff. And do it all through the lens of what we've been doing in Philadelphia and kind of where we've -- some of the ideas and things we've been working on here in Philadelphia.

And so kind of following up on our presentation about kind of refugees in your community. There tend to be some common questions that come about now that, you know, once you realize, okay, yes I likely have refugees in my community and I may be serving them already.

One of the first questions is how do I get the background? How do I kind of get up to speed on populations are in my community, on what they're background is, on their health backgrounds and things of that nature.

And so I wanted to recommend a few resources. Obviously ORR's Website is great and I highly recommend that you look at that state map that Dr. Kim showed which shows, you know, who is resettling refugees in your area.

You'd be surprised at some of the different, you know, here in Philadelphia we have three refugee resettlement agencies and some cities there is as many as eight and in some places, you know, just one agency that's resettling refugees.

And then once you know kind of who's there you can look begin to look at what are the background of those refugees. And here's really two main sites that can be really helpful. One is here. It's the CDC Website has a great refugee health backgrounds an including particular health profiles for many of the arriving refugee communities.

As well there's links on the ORR Websites to the cultural orientation resource center which can provide really -- really key information about the social cultural background of refugees which are just as important as the health background.

So I would really recommend that you begin to look at those in tandem with the looking at the refugees that are arriving to your community. The second question then often is health insurance. And Dr. Kim touched on this briefly, you know, do refugees have health insurance and what does that process look like is a common question that I get.

And so yes, most refugees -- all refugees have health insurance in the initial time period and many have it for the long term. So refugees can receive up to eight months of that special Medicaid look-a-like, refugee medical assistance which covers all of the same services that Medicaid programs cover.

Additionally refugee eligible refugee patients can continue on medical assistance through expansion in some states. We're very happy here in Pennsylvania that our state has expanded Medicaid as of this year and so we will no longer have refugees who fall off after that eight months -- fall off of coverage but will have coverage continuing through Medicaid expansion.

And then refugees are also eligible for enrollment in the Affordable Care Act for coverage. And so many refugees -- most refugees will have health insurance coverage which is key. Then the third question is something that Curi also touched on is what health care do refugees receive both overseas and domestically?

So overseas refugees receive a health screening prior to departing for arrival here in the United States. And that's a screen to really rule out any infectious disease that would prevent travel and is really kind of basic system overview. Then it's also then mandated that refugee resettlement agencies connect refugees to a domestic health screening.

Traditionally that health screening has really focused on the first three bullets here kind of follow up screening for infectious disease and tuberculosis, getting refugees caught up with the immunization schedule that we recommend here in the United States.

So catching up children so they can go to school. And catching up adults so they come in line with the current best practice here. But refugees also have additional needs within that -- within their health care kind of realm.

And that begins to look at chronic disease, screening for histories of trauma and torture as well as access to preventative health care and women's health

care. We find that many of the patients we're working with have had limited to no access to preventive care and may only have had access to targeted women's health services during pregnancy or something like that.

And we feel that these areas are particularly important because of the situations that Dr. Kim described that refugees are coming from. They may have been coming from a refugee camp situation, an urban situation where they had limited access to this type of care.

And so it's important to focus beyond those initial screening items but really look holistically at the person's health and how we can really support their health so that they can achieve long term -- their long term goals and self-sufficiently.

So I just wanted to touch briefly on kind of how this works in Philadelphia and then work into -- move into some of those practical things that I said I would get to. So in Philadelphia, you know, we previously had a model that really focused on getting people caught up in those first three areas on the screening and immunizations.

And we among the three resettlement agencies realized that, that was not really enough. That people had more needs than that. We really, you know, owed it to our clients to begin to address those in a systematic and equitable way. And so that has developed into what we now call the Philadelphia Refugee Health Collaborative.

And this is basically a group that came together in 2010 as we mentioned in the introduction of the three agencies here in Philadelphia that are doing refugee resettlement and what was at the time just a few clinics doing refugee care.

But is now eight soon to be nine clinics who are providing not only that initial screening services but really holistic care serving as long term medical homes for refugees. So that they can get the screening things that they need but also the long term care of their chronic disease.

A long term place to monitor preventive care and things of that nature. So I recognize that, you know, certainly not, you know, as many places around the country have very different models. There may be one agency doing refugee resettlement and one clinic doing refugee resettlement and that's fine.

But just, you know, even within the models, even with this extensive model that we have all refugees face certain challenges. And I think it's important to kind of drill down into these challenges and figure out how we can support refugees in overcoming them.

And so we can talk about these categories of barriers faced by refugees in kind of a few different ways. The first is language and cultural barriers so we'll talk a little bit -- I'll talk briefly about those. Health issues, lack of context in navigating systems.

And I'd really like to look at these through the lens of, you know, how can you -- can an individual, how can your clinic and your staff help folks overcome these barriers and kind of move down the road.

And it should be noted that though we're talking particularly about refugees today that many of these same barriers are also encountered by many vulnerable populations as well as -- including many immigrant populations and so some of these tips and ideas may be applicable to multiple populations.

So it's also important to recognize for refugees and for many of these populations that it really takes as Dr. Kim said a village or a nation to provide support and to really help people move down that road to self-sufficiency.

And so I think it's important to really frame that work that, you know, refugee resettlement agency down here at the bottom is -- our services are time limited, you know, most of the organizations doing this work around the country are all of them are non-profit agencies that are resource limited.

And we really see ourselves as just a spoke in the wheel that's supporting refugees. We understand that we can't be the only support but instead really encourage our clients to make connections with other resources including community family to do support them in the long term.

And we see health care providers like yourselves as really a critical spoke in that wheel as something that can really encourage people and help people move down the road. So just to drill down a little bit to what resettlement services are provided upon arrival.

The resettlement agencies so the nine voluntary agencies that Dr. Kim mentioned with 350 affiliates are actually the folks going out to pick up refugees at the airports, orienting to their home on the first night and then beginning to get them connected to the core services that they will need here in the United States as they begin their new lives.

Things like a social security card and connections to their local benefits office to enroll in health insurance. Connections to English classes as well as connections to medical screening. We're also responsible to do a lot of orientations as you can imagine kind of picking up and moving yourself and your family to a very unfamiliar place, there's a lot to learn.

And so we -- all resettlement agencies provide a lot of health orientation -- of orientation about health care, culture norms, the role of the agency, budgeting, finances, this wide breathe of knowledge that folks need as they begin their new lives.

So within that context I want to come back to these barriers and talk a little bit about some of them in depth and how we can kind of overcome some of these barriers. So the first one is culture -- cultural barriers.

And very often when folks talk about culture you hear the idea of cultural competence. And certainly cultural competency is a hugely important concept and something that, you know, as you begin to work with particular refugee or immigrant communities in depth is important to develop.

But I also want to present today of this idea of culture humility which I feel is equally as important. In my work here in NCS and as part of the Philadelphia Refugee Health Collaborative I and my staff have the opportunity to work with a wide diversity of refugees on a daily basis.

And so the idea of becoming a really an expert in each culture is a bit daunting. And so we have started to think about and read about this idea of cultural humility of really analyzing our own concepts as a way of approaching folks as we may see as familiar as the context that they're coming from.

As a way of more of a framework for valuing the refugees and immigrants that we're serving and as a way of kind of exposing ourselves to their experience, to what they're bringing to the table and partnering with them to -- as a way of understanding their culture.

So it's a little bit different than culture competency where we might usually, you know, seek to read a lot about a particular culture to understand instead it's more of a framework of approaching someone from a different culture where you're first looking at yourself.

And identifying your own culture family, belief, values really analyzing where you're coming from on a cultural level, you're own biases and assumptions and then challenging yourself to, you know, to figure out how those might impact your interactions with a particular client. Sorry.

So there's a lot of really good literature about cultural humility and I would really encourage you, I'm going to provide some sites later, to think about using this context particularly our -- particularly if you are working in a very diverse setting where you may be working with two or three or four different refugee groups or different diverse communities.

So one of the other barriers that was identified on that -- those previous slides was really context and this also has to -- it links right in with cultural humility. But recognizing that our refugee community comes from different context where they may have different ideas of even something as in depth as women's health.

For example, you know, in one of the refugee communities we work with are ethnic minorities from Burma and there's actually been some recent and emerging literature about their views on ultrasounds.

And has been very enlightening for our providers here in Philadelphia to learn how what we consider a very routine and normal procedure particularly or test

as part of pregnancy or as part of a diagnostic tool that has -- is much more loaded in terms of their culture.

And so again kind of applying that cultural humility lens to the context that your refugee patient is coming from. So some ideas for kind of -- my tips is covered up, sorry about that -- for kind of looking at these various contexts is obviously to look at the literature just as a bit of a promotion for our health collaborative Website.

But we do attempt to maintain a really pretty wide breadth of citations for guidelines and literature to things like that study on Burmese refugees and ultrasounds to, you know, the resources on cultural humility.

So really looking at what does the literature say about this particular community? Why might this patient be having this reaction? I would also really recommend that you look at connecting with other providers.

I think one of the most helpful things here in Philadelphia is we do have this network of eight clinics and providers do connect with each other and kind of balance ideas or challenges or problems off of each other.

There's a great listserv listed here from the University of Minnesota. It's a clinical listserv that you can join and talk specifically about refugee health issues including mending women's health issues.

And then the third kind of jump back to the cultural humility of really asking your patient of really letting them be the expert to guide you through the process. Letting them kind of let you know what their framework has been.

Have they ever, you know, have they ever had a PAP smear and what was their experience with that. So really kind of just allowing them to guide you through that. So the final barrier that was on those flashing that we identified was really navigating systems.

And I think this is vitally important to remember in everything that you're doing with refugee and with immigration populations is that, you know, navigating what we consider to be kind of second nature of systems can be difficult and become even more difficult when we're looking at something as complex as our health system.

So, you know, if you can imagine yourself moving, you know, somewhere else very different in the world you can imagine you might struggle with simple things like how do I get my child enrolled in school. You know, how do I -- what is health insurance?

And that may be even a concept as kind of innate to our experience is very different for most of the refugees that we worked with. They've never had a system of health insurance let alone a system as complicated as ours.

And so it's helpful to kind of just understand that but also then to really look at what that means for our refugee's lives. In terms of navigating systems, many of our systems here in the United States are not linear and in fact may be circular. And so this is a representation of what applying for public benefits may look like to a refugee woman.

So perhaps she applies, she has to turn in some documentation, you know, wait for a response from kind of the agency that makes the decision, appeal that response if it's not approved and as a service she needs so it can be very complicated for folks to navigate those.

And thinking about working with those patients and how you can support this process I think it can be very helpful to remember that folks are coming from a different context to ask if they are familiar with, you know, the service you're referring them to, the process that you're planning to walk them through and really explain the big picture.

Why is this important? Why do we do an ultrasound as part of a person's care? You know, really take that step back and take the extra time even realizing that everyone is -- all that you're working in very busy clinical practices but really taking that time to explain what's happening and why it's happening and what the big picture looks like.

It can also be very helpful to manage expectations. So particularly in the medical setting but in many settings, you know, how long will this take, you know, does it take a long time to get the authorization that's needed to get this test done.

What can the individual expect as an outcome? So, you know, will this procedure -- is it diagnostic or is this going to relieve the individual's pain. Really, you know, again taking that extra time to manage what are the expectations of this procedure, what is that big picture? And then I really encourage you to connect with available supportive services.

There are likely supported services both particular for refugees and mainstream services available but it really takes that extra investigative work to figure out what's out there and how you can connect with those providers. And I see many of you have taken that first step by kind of getting on this call today and begun thinking about this.

And then encouraging refugee patients to build their own navigation skills. So really looking with your patient about how can you encourage them to increase self -- their self-sufficiency even with something as simple as how do they call your office and making an appointment.

That may be a teaching -- a teachable moment where you can help them access care, you know, get needed follow up but really build their skills for that long term self-sufficiency. These last two slides are just a few resources.

And the second one has a lot of Websites on it so I believe we'll be able to make as was mentioned on the beginning of the call we will make these slides available. But I wanted to just use this suggested reading or viewing to talk a little bit about staff training.

Very often, you know, those of you who are on this call today or, you know, partners within our collaborative, you know, we have champions who are really excited and motivated to serve these patients and that's great.

And I think that it's also important to engage the rest of your office, the rest of your staff in that process. So even from -- even something as simple as engaging your front desk in who refugees are, where they're coming from, you know.

Talking them a little bit about some of those cultural humility skills can do a lot to make sure that, that these populations that are particularly vulnerable feel comfortable coming into your office and really feel supported by your practices.

And so I would really encourage you to think about not only educating yourself but also educating and -- those around you. So many of the resources

that I mentioned previously including our health collaborative Websites, some of the refugee health, the technical assistance center and the information that works with a lot of those links to the backgrounders are on there.

As well as some particular advocacy and information about torture treatment centers. So I encourage you to kind of use these as -- use these in this call today as really launching point for future work with this population. And with that I'll turn it back over.

Susan Moskosky: Thank you very much Gretchen. So our final presenter for the Webinar this afternoon is Dr. Sandra Wolf. And Dr. Wolf is the Executive and Medical Director of the Women's Care Center of Drexel University College of Medicine which is part of the Philadelphia Refugee Health Collaborative.

The Women's Health Care -- the Women's Care Center provides comprehensive reproductive health care to an underserved urban population and hosts over 20,000 patient visits each year.

Dr. Wolf holds a full time faculty position in the Department of Obstetrics and Gynecology and is the principle investigator of the Women's Care Center Title 10 family planning grant.

Her clinical and academic focus is in providing reproductive health care to underserved minority and vulnerable populations. Women's Care Center has been caring for immigrants and refugees for over ten years.

In 2008 Dr. Wolf created the Immigrant and Refugee Women's Health Project section of WCC to be able to track improved care and implement best practices and care for these women. And in 2011 Dr. Wolf and the Women's

Care Center were one of the original members of the Philadelphia Refugee Health Collaborative.

Dr. Wolf is recognized as having successfully created and established innovative models of care, robust safety net services and as having built a network of strong community partnerships. And with that I'll turn it over to Dr. Sandra Wolf.

Sandra Wolf: Thank you so much for having me. Today I'll be talking from the provider's perspective about this very interesting and gratifying part of our Title 10 services. So as directed to refugees.

I'll touch on how our experiences as Title 10 providers makes us well suited to providing care for refugee women and I'll review what is different in our services for refugee women and some additional skills you might need.

I'll touch briefly on cultural competency and what it means in the real world to us and spend some time or most of the time on the practical steps that we've discovered to be helpful. And I'll touch on steps about getting prepared, adjustments to the history and physicals that we've made as well as some suggestions for follow up.

And I will touch on a few key critical issues that Title 10 providers will most commonly face. So as Title 10 providers we are certainly well versed in taking care of underserved populations. And we understand barriers to care as well as the value about having wrap around services like our counselors.

So while it would seem that we are -- that taking care of refugees would fall right in our comfort zone observational studies have shown then that this isn't

always the case. The health care providers sometimes reports that they struggle with feeling they have a lack of knowledge or abilities.

And they may even admit that their own attitude interfere with providing high quality health care. As health care providers it seems who don't have some preparation express less satisfaction in clinical encounters with ethnic populations.

And maybe frustrated by things such as the patients lack of understanding of preventive medical care or management of chronic diseases or even issues such as filling a prescription. But we found with just a little preparation and some practical information from experienced providers that we can turn this around.

So that caring for immigrants and refugees becomes a truly gratifying experience as well as an effective encounter for the patients. And I think there really are a few things that need to be addressed and one is cultural competency, taking it pretty seriously.

And the second is learning a little bit about your particular population of refugees and Gretchen already gave us some resources for that. And that's very important because if it's as you'll learn the country of origin is a bigger determinant of health than health status, then is race or ethnicity.

And we're used to looking at it at the opposite direction for most of our long standing residence. And I'll go over some practical steps as well. So cultural competencies. There are lots of definitions and we -- and Gretchen has touched this beautifully.

But my favorite one is that it's a set of behaviors and attitudes that come together into a system that allows us to work in cross cultural situations. And so it really describes just how we provide services without having cultural differences hinder our care.

And simply it's just that we are thinking about health services that are responsive to beliefs and practices that are different from our own. And what I'll do today is point out examples of things that we learned as we've gone along.

Gretchen really talked about ways to get to know your region and would also send you to the U.S. Commerce Department -- U.S. Department of Commerce and Economic and Statistics and your Census Bureau information.

So while across the United States you've already learned that there's a huge increase number of refugees coming here. It's certainly been true for Philadelphia and we've had to -- all institutions of Philadelphia have had to face this challenge of these influx.

I think as a general starter there are some good overview texts. The one I like the best is referenced here while from 2007 it's an invaluable resource for front line clinicians and other health care professionals as well. It's very comprehensive. It's practical.

It's very clinical relevant and it has a great easy to use format. Sort of drilling down Gretchen mentioned the backgrounders. These are monographed published by the Cultural Orientation Resource Center and they're also invaluable.

These backgrounders in cultural profiles go over a population's history, their culture, and religion, everything from language to education as well as some specific resettlement needs. As Gretchen mentioned the most important thing we learned earlier on was orienting our staff, explaining who refugees are and also addressing prejudices up front.

One way to help that is to have tools to help them with the very real problems of negotiating in a visit with a non-English speaking newly arrived person. So to that end we have developed a series of tools. We have IC cards up at the front desk if perhaps this person can't even identify a language perhaps these can help the clients point out her own language.

We have a lot of signage around as well as information in different languages. And some as are referenced here is a good resource for reproductive health care information and languages. As Title 10 provider we are very versed with our requirements that have interpreters.

And how to use them but that doesn't mean that all of your staff is always as well versed or in our situation we have students and lots of trainees coming through so at each of our translation phone lines we have clinical pearls about how to work with refugees and it has six pointers on it and I would say that number 1 and 6 are really the most important.

I can't tell you the number of times I've asked an interpreter a question that has really helped me out. In one case with the ethnic Bhutanese coming from Nepal I was repeatedly having trouble getting them undressed fully and it turned out the interpreter was interpreting what I said asking her to take off skirts, shirts and undergarments.

But in the native dress there are numbers of layers of undergarments and without naming them all the client didn't take them all off. So after speaking to an interpreter and working this out I was then been able to not get frustrated and help the client have a better experience as well.

So the clinical history initially I thought tried and true would work and after some experience have had all of our providers have really changed the clinical history a bit. We make sure to introduce the visit type to make sure that we've clarified with the patients from the beginning what she is arriving at our site for.

And asking she has had a GYN exam before and explaining what it is and why it's done in the United States. We also introduced the health history likewise in some detail including explaining that some questions are very personal and if something bothers them to have them let us know and we will just discuss it further and not discuss at that visit.

We also make sure that we know from the very beginning something about the country of origin and length time the patient had been in the U.S. I think from the recent Ebola issue we've all learned just how important that can be.

We also touch on very early who they arrived with and how is everyone in the household doing. It can give us some sense of adjustment and that can affect her health care. There are some special consideration for women's health care and the first is to be aware of a woman's autonomy in decision making.

And that there may be a role with a spouse or even a matriarchal family member may have the decision making. They may be right there with your clients and the whole family maybe there and you may need to include them in most aspects of her care.

And also refugee women and girls are particular vulnerable groups with high exposure rates to sexual violence and with very little access in most case to contraception based prenatal care. We are seeing women from the DRC and millions have been displaced and 100,000s are now in refugee camps and are arriving in the United States.

It's listed by the U.N. as one of the least safe places for women in the world to live. At this point it's very important to communicate with the local community organization and resettlement organizations about how to address experiences of torture or sexual assault and utilize your community resources as much as possible.

The social history going from the backgrounders about smoking that it may include chewing tobacco or betel nut use and again lots adjustment mental health issues are key. We also explain the physical (unintelligible).

We have cue cards that you'll see here, picture cards while we're interpreting. We bring out these cards and we explain exactly where to put your clothes and the position you'll be in for your exam.

We also respect modesty and we use our largest exam room gown for even the tiniest of the Asian women so that they can feel as protected as possible. We do have male and female providers here.

Anyone with a history at all of trauma both automatically to a female provider but we do introduce male providers and educate our team approach to care and then in certain situations such as in the operating room or for labor and delivery they may meet male providers.

And in general there are not a lot of evident based guidelines that are specific to specific groups of refugees but there are three areas that we really consider lack of cervical cancer screening and contraception as well as the one I've mentioned country of origin specific to diseases.

There is a very good evidence based clinical guidelines Monograph out of Canada that I've referenced here but before that was published they surveyed they're primary care practitioners and asked about high priority conditions.

And you'll see the last two here, cancer of the cervix and contraception were two high priority conditions identified by providers taking care of refugees. I think you might -- as you might expect cervical cancer screening is a new concept for many refugee women and the rates of screening tend to be low in our arriving refugees.

So consequentially, not for all groups but for many the burden of cervical cancer is higher as is mortality. So going on to contraception just briefly again there's not a lot of evidence based guidelines for specific groups.

But we know that unmet contraceptive needs among refugees can be as high as 60% and it does vary widely by country of origin. And studies suggest that unintended pregnancy rates are much higher for refugee women than native born and highest in the first three months during that transition time.

And refugees may be unaware of the emergency contraception or even that abortion might be legal -- or is legal in this country. There is some special consideration for contraception.

There may be little exposure to any contraceptive method or there may be exposure to only one. It's good to know your background for instance IUDs

for most Asian women that may be familiar with IUDs and have some experience with them.

In some countries condoms actually promote infidelity and promiscuity so you may get a reaction you might not expect when you talk about condoms. And depending on the culture again a patient may wish for the male partner to actively participate in every conversation she has with you. There are hosts of other clinical issues.

I love our primary care partners because they take care of things for us and as with the history and the physical we try very much to focus on anticipatory side. Means we review what we've done, outline next steps very clearly.

And one of the most important steps that we do is ask about coordinating care with a refugee's case worker. We ask specifically ask for permission than we put it right up on her chart that we can -- we ask permission to contact a case worker to help with coordination of care.

We always end our session by asking the patient did we help her today and what questions does she have that may not have been answered. We have a lot of written information in languages. The Office of Women's Health has plenty and they really are resources out there.

They do take some looking for. So best practice, I think that clinical care should be informed by our person's country of origin and their migration history especially for the most new arrivals and we do take cultural competency seriously and try to learn with humor often as from our mistakes.

We provide -- I think providing GYN and family planning screen as soon as possible after arrival is best practice. On the other hand a GYN exam can be a lot to absorb for new arrivals. So there is a balance here.

Introducing PAP smear screen and preventive health concepts early is important. We review that frequently since preventative health care can be a concept that's quite new. And screen for unmet contraceptive needs among refugee women should begin very early after arrival. Challenges I think Gretchen described this beautifully.

We also have the challenges of provider time and no additional reimbursement for our interpretation, translation and clinical additional appointment time. These are things that all of our providers struggle with. So why care for refugees?

For the refugee receiving reproductive health care in a culturally competent matter is really invaluable. For many women the significance of having this exam done attentively and with respect is just amazing. They often come away thanking you.

And so providers we really get a global view of health. We get rare knowledge, experience and meet just a whole host of great people. And certainly for society refugees will contribute more, integrate more successfully if they are healthy.

And I'm going to skip this but the last slide this group of -- this photo is from Gretchen and this happens to be the first set of women who I met through the Philadelphia Health Collaborative work and I remember them all and they were great.

So I encourage you to take on this challenge and call with any questions. And I'll turn it back over to our moderator.

Susan Moskosky: Thank you and thank you to all of the presenters. If we were all there in person we would be giving you a big round of applause. And we'd really want to thank you for your participation. This time I would like to turn it back over to the operator who can facilitate the Q&A and instruct you how you can ask your questions. Thank you.

Coordinator: Absolutely. We'll now begin the question and answer portion. If you'd like to ask a question just press star then 1 from your touchtone telephone. Remember to make sure your phone is unmuted and record your name clearly when prompted. One moment for our first question.

Susan Moskosky: We have -- we have one question in the Chat box from (Lois) and a number of people have been asking how they can get the slide set. So the Webinar and we will also post the slide set on the OPA Website and we can type that in the Chat box in just a minute so you can copy it down.

Coordinator: And our first question comes from (Cathy). Your line is open.

(Cathy): Hi. This is (Cathy) from Region 1 and I have two questions actually and they're basically for the providers. And one is how much extra time does it actually take to take care refugee patients?

And the second question and I'll let you answer both of them together is have you any of you used community health workers or other cultural brokers? I know interpreters sometimes serve that purpose in your clinics. But people specifically to help people along through the visit. Thanks.

Sandra Wolf: This is Sandra Wolf. It takes about double the time to take care of, at least on an initial visit. And by and large -- and we also have more frequent visits. We do a lot more time and we have people to come back to complete visits if it's going way over.

Gretchen Shanfeld: And this is Gretchen. I can talk about the community health worker. That is not a model that we've used. We're exploring it here in Philadelphia now. It certainly something that we think could be very useful. But we haven't yet explored that.

There is a model program in Arizona. They have a refugee women's health clinic that uses that model of even beyond community health workers. I'm not sure the title they use for their staff but they have part time staff from a number of refugee communities and a lot of good literature on their Website.

If you just Google Arizona refugee women's health. It's I believe Dr. Crista Johnson.

(Cathy): Thank you very much.

Coordinator: The next question comes from Anne Ryan. Your line is open.

Anne Ryan: Thank you. Hi. I'm actually in Arizona so in just in responding to the last question in addition to Crista Johnson's wonderful program in Phoenix, Arizona, the international rescue committee also has a program using community health promoters bilingual refugee women through their programs.

So through the IRC in Tucson as well. I have two questions. My first question is on the ARMAP program. We've heard that there've been some changes to

ARMAP in that it may no longer be used to cover services until people are on Medicaid. Is there anyone that's aware of those changes and if so are there any documents you can refer us to about that?

Curi Kim: This is Dr. Kim from ORR. Are you referring to RMA, Refugee Medical Assistance? The...

Anne Ryan: Yes. We've been told that there's, but not seen anything in writing that it may only be cover the infectious disease screening and not cover anything else until people wait through the 45 or more days that are needed to get approved for our version of state Medicaid.

Curi Kim: So, it's actually states may be, you know, the way they are operationalizing the way they use RMA maybe different but the regulations have been in place for -- really for decades and it's always been that if you're eligible for Medicaid you have to be put on Medicaid and you can't be on RMA.

So that might be something maybe that we're clarifying that with states because, you know, our funds are limited and if patients are eligible for Medicaid they really are not eligible for RMA except for the medical screening part.

So, I'm not sure if that's something that is being clarified with states right now but and I know that there are some issues with timely access of getting Medicaid and we're encouraging states and VOLAGs to work with their clinical partners.

Because, you know, Medicaid should be backfilled to the time the person applied which should be immediately although I know that providers don't like to see patients with pending Medicaid.

Anne Ryan: All right. I think that is a huge problem.

Susan Moskosky: We have a question here in the Chat box from (Tacara Turner). I am in Louisiana which chose not to opt into Medicaid expansion. We're struggling to find reasonable health care options for our clients.

We currently use two community health clinics with long wait times and lack of resources. Could you offer any suggestions? I'm wondering Dr. Kim if you might have anything to suggest.

Curi Kim: Yes. We're aware that there have been issues in Louisiana. And for states that have not opted into Medicaid expansion it's kind of still the status quo. Those patients, those clients who are not eligible for Medicaid are eligible for RMA.

Unfortunately they'll only have the RMA for eight months so, you know, it's important especially for those people on RMA who have health care needs to get seen early because their time for, you know, guaranteed insurance through RMA is limited.

We -- I know often do encourage people to see, you know, the community based clinics, the federal qualified clinics just because it's kind of the safety net. But really any physician's office that accepts Medicaid will -- should be able to see patients that are on RMA so as long as they have insurance Medicaid or RMA.

I know not, you know, some physicians limit the amount -- the number of Medicaid patients they see. But a lot of offices, you know, do take Medicaid clients so would treat patients on RMA.

And so, you know, if you're finding that it's difficult to get people into the community clinics the safety net clinics you can explore private physicians who may of course limit the number of Medicaid patients they have.

But RMA can be, you know, it reimburses at the same rate as Medicaid. So as long as they take Medicaid they should take RMA. It looks the same on the provider's side.

Coordinator: Again if you'd like to ask a question just press star then 1 from your touchtone telephone. One moment for our next question. Our next question comes from (Tacara Turner). Your line is open.

(Tacara Turner): Okay. Maybe I wasn't too clear in my question that I asked on the Chat box. Our options for Medicaid for private doctors are pretty much non-existent. A number of people on Medicare and Medicaid in Louisiana are already very, very high. So the possibility of seeing a private doctor is not a viable option at all.

Curi Kim: Yes, I'm sorry to hear that. That is definitely a struggle kind of nationally for anyone native born and immigrant who are on Medicaid to find -- it's one thing to have insurance. Another to find a physician that will accept the insurance you have especially if it's Medicaid.

And so, you know, the federally qualified health clinics and the look-a-likes are the clinics that we encourage people who serve refugees to go to but we're aware that -- those maybe bursting at the seams in some locations as well.

We have heard from the refugee health coordinator, or the refugee coordinator in Louisiana on some of these issues and we're planning on working a little bit more closely to understand all the challenges.

So hopefully, you know, I know it's not a great answer but in the coming year especially in this state we hope to try to work with the state in exploring all options.

Coordinator: Again if you'd like to ask a question just press star then 1 from your touchtone telephone. I'm showing no further questions in queue.

Susan Moskosky: Thank you and I think at this time we will conclude the Webinar. I want to thank everyone for your participation this afternoon. I want to thank again our three presenters and for all of the information that they provided.

And just to let participants know that this Webinar will be archived within a couple of weeks on the Office of Population Affairs Website. You can actually go to that Website just by Googling Office of Population Affairs which is often the way that I find it.

So again thank you so much for your participation. I hope everybody has a wonderful weekend and hopefully all of you have gained some information that will help you in better serving refugee populations that need our services. So thank you very much and good afternoon.

Curi Kim: This is Curi from ORR. If I could just say one thing at the end. If anyone wants to contact us directly we can help troubleshoot or at least work with you on some issues as well as share some additional resources.

And also if you want to sign up for ORR's listserv if you can go to ORR's main Webpage and scroll all the way down there's a way to sign up and have my colleague Mariestella Fischer with me. She's a good point of contact if anyone wants to reach us. I'll let her give you her email address.

Mariestella Fischer: Sure. It's like Marie and Stella together. M-A-R-I-E-S-T-E-L-L-A.Fischer.
F-I-S-C-H-E-R @ ACF.HHS.Gov.

Curi Kim: Thank you.

Susan Moskosky: Thank you very much you all. And once again have a wonderful afternoon
and thank you for your participation.

Coordinator: Thank you for your participation in today's call. You may now disconnect. I'll
ask the speakers to standby for post-conference.

END