Refugee Health: A New Perspective for Infection Prevention and Control

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Hosted by Dr. Pierre Parneix
Hôpital Pellegrin, Bordeaux, France

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Objectives

• Describe the process of refugee resettlement in the US
• Review existing surveillance processes for refugee health and the conditions identified
• Explore the impact of refugee health from the perspective of the refugee as a patient, as a community member, and as an employee
What is a “Refugee”

"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country."

(www.unhcr.org)
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Where do Refugees come from?

Where do refugees come from?
Top 20 Countries 2004 - 2013

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How many refugees settle in the US every year?


Process for Entry into US Resettlement

Violence/Persecution → Flight → Refugee Camp/Secondary Country

UNHCR

Voluntary Agencies (VOLAGs)

KRM or Catholic Charities resettles locally

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Refugee Resettlement in the US

- Resettlement process managed differently among the US states
- Some have the program managed through the state, usually the state health departments
- 13 states have refugee resettlement funds administered privately (Wilson-Fish States)
- Kentucky is Wilson-Fish and resettlement managed by Catholic Charities (Kentucky Office for Refugees)

Health Assessment Prior to Resettlement

- Cultural orientation
- Overseas medical examination
- Some receive immunization
- Some receive presumptive treatment for parasites
- Some are found to have health conditions that prevent them from entering resettlement
  - Class A conditions
  - Class B conditions

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From Overseas to Quarantine

- All refugees go into quarantine at the first “port of entry” into the U.S.; each airport has a CDC quarantine officer who clears them for the next flight.
- 20 U.S. ports of entry have quarantine stations, including New York City, San Francisco, Miami, and Chicago.
- Final Destination State

Local Resettlement Agencies

- Designated by the U.S. Government to provide direct resettlement services—Self-sufficiency is expected
  - Starts before arrival with apartment set-up, and airport pick-up
  - Provide furnished housing
  - Mental health services
  - ESL classes
  - Employment assistance
  - Provide case management
  - Cash assistance
  - Cultural orientation
  - Health Assessment
Resettlement Services

- Refugees are eligible for all social programs for which U.S. citizens are eligible.
- Refugees are eligible to work as soon as they arrive in the U.S. Self-sufficiency is the expectation.
- Refugees are placed on track for citizenship.
- Refugees receive intense services for 8 months but can access some level of service beyond that time.
- Refugees must pay back the cost of their plane ticket to Homeland Security.

Health Assessment Upon Arrival

- Each refugee eligible to receive a comprehensive health assessment upon arrival. This assessment is based on CDC guidelines and includes the following:
  - Review of overseas medical records
  - Testing for communicable diseases and parasites
  - Evaluation of immunization records and referral for vaccines
  - Screening for mental health issues (RHS-15)
  - Referral to subspecialties as needed
- Assessment serves as a bridge to primary care
Critical Junction

- Diverse refugee population from diverse countries experiencing diverse health issues
- Refugees assigned an “Alien” number. Not yet a citizen and no other identifying number such as social security
- A numbers not included as an identifying number, therefore long term tracking is extremely difficult
- Eligible for Medicaid or private health insurance through employer
- No national health database and no standardized way to follow the health issues present or those that develop (e.g., reactivation of MTB)

State of Refugee Health in Kentucky

- Each year approximately 3000 refugees resettled in KY
- Health assessments performed in Louisville (85%), Lexington, Owensboro, Bowling Green
- Approximately 75% of the health assessment data are submitted for inclusion in state report
- State of Refugee Health in Kentucky reports available for review at http://globalhealth.center/rhp/state.php
Arriving Refugee Informatics
Surveillance and Epidemiology (ARIVE)

ARIVE Database

Overseas Records
Domestic Health Screen
Vaccination

Refugee Electronic Health Record

Refugee
Payers
Healthcare Providers

ARIVE database maintained in REDCap™

Refugees Screened Jan-Dec 2016
A total of 2047 adult and pediatric refugees were screened in Kentucky

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State of Refugee Health in Kentucky
Demographics: Primary Language

- Spanish: 32%
- Kiswahili: 14%
- Arabic: 13%
- Somali: 10%
- Nepali: 8%
- Chin (Falam, Haoka, etc): 5%
- Kinyarwanda: 4%
- Karen: 2%
- Dari: 2%
- Rohingya: 1%

State of Refugee Health in Kentucky
Top Health Conditions: All Refugees

- Dental abnormalities: 10%
- Decreased visual acuity: 7%
- Overweight/Obesity: 6%
- TB exposure: 6%
- Parasites: 5%
- Anemia: 4%
- RHS 15 positive: 3%
- Hyperlipidemia: 3%
- Hypertension: 2%
- Eosinophilia: 2%
State of Refugee Health in Kentucky
Top Health Conditions: Bhutanese

State of Refugee Health in Kentucky
Top Health Conditions: Congolese

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State of Refugee Health in Kentucky
Class B TB Conditions

17% of resettled refugees in 2016 had identified Class B TB condition

Class B Conditions: health conditions that may interfere with the wellbeing of the refugee and necessitate follow-up care soon after arrival in the US

- B1: Abnormal chest x-ray with latent TB infection treated or untreated
- B2: Latent tuberculosis infection
- B3: Recent contact with an infectious case of TB

17% of resettled refugees in 2016 had identified Class B TB condition

State of Refugee Health in Kentucky
Class B TB Conditions

- Burma/Myanmar: 27%
- Bhutan: 24%
- Democratic Republic of the Congo: 21%
- Somalia: 15%
- Iraq: 6%

% of Refugees Screened

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State of Refugee Health Kentucky
Mental Health: RHS-15 Screen Positive

Mental health concerns are present across the entire refugee population.
This is a complicating factor for all care and impacts all settings in which care is delivered.

State of Refugee Health Kentucky
Mental Health: Torture

Consider the impact of witnessing or experiencing torture.
Influences abilities to ride public transportation, accept medical care, interact and communicate with providers, and general trust.

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State of Refugee Health Kentucky
Infectious Diseases: HIV and Syphilis

HIV

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<tr>
<th>% of Refugees Screened</th>
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<tr>
<td>Non-reactive</td>
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<tr>
<td>90%</td>
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<tr>
<td>Reactive</td>
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<td>1%</td>
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Syphilis

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<th>% of Refugees Screened</th>
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<tr>
<td>Negative</td>
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<tr>
<td>99%</td>
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<tr>
<td>Positive</td>
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<td>1%</td>
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Meet Maria

- Refugee
- Herbal remedies
- Not FDA approved in the US
- She does not know what she is taking
- Did not bring her medication from overseas
- On multiple medications
- Insulin dependent Diabetic
- Hypertension
- Hyperlipidemia
- Palpable breast mass
- History of breast cancer
- Chronic back pain

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Meet Maria

Can’t sleep at night
Tearful
Anxious
Overwhelmed
Depression
On some antidepressant she does not know name
Separated from family in home country

Meet Maria

Does not know how to use public transportation
No job
Doesn’t understand US healthcare system
No personal transportation
Insurance pending
No childcare
Doesn’t know services available to help her
Does not speak English
Special needs child

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Insured status of Refugees seen from January of 2015-September 2015 at UL-GHC

Insurance status of Refugees seen from January of 2015-September 2015 at UL-GHC

MCO Enrollment

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Refugees: As Patients

• Chronic health conditions that differ among population groups
• Obesity, malnutrition, metabolic syndrome
• Anemia (etiologies parasitic and non-parasitic)
• Lack of understanding of US healthcare system
• Difficulties with finding primary care providers
• Cultural drivers of care

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Refugees: As Community Members

- Expected to get a job, learn language, acculturate, become self-sufficient
- Often in jobs that are totally unaligned with existing skill sets
- Inclination is to stay in groups which slows acculturation and hinders economic self-sufficiency
- Cultural isolation may also maintain unhealthy practices (e.g., lead contaminated products)
- Lack of knowledge regarding the public health impact of illness
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Refugees: As Employees

- Have had access to health screening providing baseline health information
- No database to access to employers/insurers may pay again (or not)
- May have underlying health issues that are important for employment and safety of self and other workers
- Without links to those with knowledge about conditions in countries of origin, public health at risk
- Cultural contexts as they relate to job responsibilities

Global Medical Home

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Refugees as Security Risks

- Vetting occurs overseas
- Majority of those applying are not accepted
- Just because resettlement occurs in US does not mean refugees think like or act like ‘us’ (who is ‘us’, anyway?!?)
- Integration into society is important for successful resettlement

Take Home Messages

- Refugees are legal members of our communities
- Health assessments before entry into US and eligibility for same once they arrive
- Without organized process, refugees may be difficult to follow in order to monitor and impact health and health outcomes
- Without followup, addressing health issues, health outcomes, and community risks may be difficult

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<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker</th>
<th>Institution</th>
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<tr>
<td>February 21, 2016</td>
<td>Improving the Knowledge and Receptiveness of Medical Students Towards Hand Hygiene. Exploring New Approaches</td>
<td>Dr. Rajneesh Kaur, Research Associate, University New South Wales, Australia</td>
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<td>February 22, 2016</td>
<td>Root Cause Analysis to Support Infection Control in Healthcare Premises</td>
<td>Dr. Anna-Gaëlle Venier, University Hospital Centre of Bordeaux, France</td>
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<tr>
<td>February 28, 2016</td>
<td>Why Leadership Matters for Effective Infection Prevention and Control</td>
<td>Julie Storr, World Health Organization</td>
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<td>March 8, 2016</td>
<td>Infection Prevention in Nursing Homes and Palliative Care</td>
<td>Prof. Patricia Stone, Columbia University, New York</td>
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<td>March 15, 2016</td>
<td>Clostridium Difficile Asymptomatic Carriers – The Hidden Part of the Iceberg</td>
<td>Dr. Yves Longtin, McGill University, Montreal</td>
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