FROM THE MARGINS TO THE MIDDLE:

A PATIENT-CENTERED APPROACH TO PRIMARY CARE FOR REFUGEES IN UTAH

by

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ABSTRACT

In a country where even English-speaking minorities are often at a disadvantage, refugees' circumstances – especially as a result of social instability, language and cultural differences, level of education, and income – can render the American health care system frightening, inaccessible, incomprehensible, and ineffective. While many organizations in Utah work diligently to meet the needs of the state's refugee population, the funding is inefficient and caseworkers are stretched to a breaking point, leaving many refugees ill-equipped to navigate the unfathomable waters of bureaucracy. This paper reviews and assesses the current refugee health system in the state of Utah and makes recommendations for possible improvement: an application of the concepts of "P4 medicine," or an approach that is personalized, predictive, preventive, and participatory, as well as the concept of patient-centered medical homes originally proposed and advocated for by the American Academy of Pediatrics, and most recently recommended for all patients in the U.S. by the Patient Protection and Affordable Care Act. While current efforts to help refugees are praiseworthy, new approaches are needed to help refugees build their own capacities and enhance their self-reliance, breaking from the current trend of dependency. Integral to refugee health is their ability to engage and participate in their new communities. Combining the core principles of P4 medicine with medical homes could form the framework for a health system in which refugees would be included, connected, and empowered, allowing them to reposition themselves from the margins of Utah's communities back to the middle of human society.

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INTRODUCTION

Many factors play both direct and indirect roles in determining an individual's health, for example his or her neighborhood or residence, occupation, education, wealth, access to acceptable and adequate health care, personal behavior, and his or her own family's health and well-being. In the United States, research has indicated the presence of significant health disparities between different races and ethnicities, often due to the factors stated above and as a result of institutional structures that have propagated—and sometimes now maintain—some of these trends throughout the years. On top of that, the general system for primary care is overburdened, understaffed, and seen by many as untenable, making the health care environment that much more difficult to navigate for disadvantaged patients. One U.S. population that struggles against particularly difficult odds is refugees, for in a system that has already disadvantaged English-speaking minorities, refugees' circumstances—especially as a result of social instability, past mental and physical trauma, previous health problems, language and cultural differences, education, and low income—can render the American medical system frightening, inaccessible, incomprehensible, and ineffective. While many changes are taking place in the United States in regards to health care, several ideas—some new and some old—could potentially be a boon to resettled refugees struggling to survive.

The process that forces people to become refugees essentially strips human beings of their identity, taking away whatever societal and political rights and roles they once had and forcing them to live between the boundaries that define human society. Though refugee camps can help refugees maintain their biological lives, it almost always comes

with the expense of blurring the lines that define their own cultural or ethnic identities, forcing them into small waiting rooms that may be their home—isolated from educational pursuits, economies, political engagement, indeed nearly every aspect of life besides mere survival—for periods of time that can even span multiple generations. Provided aid is the only authorized source of sustenance permitted to refugees in the camps, and they are hence forced into a cruelly draining and depressing dependence, denied the right to even work the land upon which they are confined (Agier 47-49). As the French anthropologist Michel Agier writes of his experiences with three refugee camps around the Kenyan city of Dadaab, "In a repetitive way, the refugees express above all feelings of impotence and uselessness" (Agier 53). Refugees forced into camps truly find themselves on the margins of society. After possibly living in refugee camps for years, it is no small wonder that many of those who are admitted to the United States to begin the resettlement process are true survivors with incredible tenacity, but all the same, trying to regain and maintain a foothold in a radically different society can be an enormous challenge.

While significant and praiseworthy effort is constantly being exerted to help refugees become self-sufficient in the Salt Lake Valley by many state and private organizations and interested individuals, it is in the refugees' best interest to be heard, included, and empowered in as many sectors of their new lives as possible, including health care. In the face of these challenges it is appropriate to consider alternatives and new approaches. For instance, personalized (or P4) medicine has recently begun to take shape as a form of medicine that is "predictive, preventive, personalized, and participatory" (Healthcare of the Future). Though these concepts are commonly

explained in reference to genomic medicine it is a potential framework for patient- and community-centered approaches to improving health outcomes and quality of life for refugees. Allowing refugees themselves to engage in the process permits them to assume greater power in their new environment, help them realize a capacity for influence that was often nonexistent before arrival in the U.S., and as Agier writes, helps to "...return those who are nameless and voiceless to our common world" (Agier 103).

Another innovative though older idea—medical homes—meshes very well with the principles that govern P4 medicine. First outlined by the American Academy of Pediatrics four decades ago for the treatment of children with special health care needs—or children "...who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally" (Martin et al. 917) —the idea has continued to evolve and has been assimilated into the other primary care specialties. Medical homes are not necessarily specific care facilities, but were originally defined as systems that provide:

> 1) geographic and financial accessibility to health care, 2) continuity of care from the prenatal period through early childhood and adolescence, 3) coordination through identification of needs and linkage of the family to services needed by the child, and 4) community orientation of awareness of child health problems and resources in the community. (Martin et al. 917)

In 2007, the American Academy of Family Practice, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association collaborated to rename the medical home the "patient-centered medical

home" (PCMH) along with a publication defining its principles and its potential for improving the primary care system (Pawlson). A wealth of research has shown that patient-centered medical homes make a huge difference in the lives of all children, and the American Academy of Physicians recommends that all children be included in a PCMH that provides care that is "...accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective" (The Medical Home 184), allowing individuals and families to build a strong relationship with their health care providers and all other interested community members, fostering a spirit of teamwork, unity, and patient empowerment.

This review puts forth two main recommendations concerning the refugee health experience here in Utah. Both recommendations stem from the principles that govern P4 medicine, refugees' particular social ecology, and community engagement efforts to allow refugees to be included in their new environments and empower them to not only express their voices, opinions, and priorities, but also actually influence their communities and teach others from their own rich experiences and perspectives.

1) Encourage the Utah Refugee Services Office to initiate work with refugee community leaders and their fellow community members—perhaps through the continued training and input of refugees who currently act as medical interpreters, health navigators, or peer health advisors—to encourage refugee participation through an exploration of what different refugee communities perceive of the health care system, what their own health priorities are, and any potential ideas for improvement refugees themselves might have; and

2) House all primary care services in the same facility that refugees access from day one (including their initial domestic health screening) to foster a truly personalized and preventive approach to refugee health, laying the foundation for patient-centered medical homes for all refugees in the Salt Lake Valley.

BACKGROUND

The United Nations defines a refugee as any person who

> …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 unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to fear, is unwilling to return to it. (Convention 14)

It needs to be stressed that refugees do not choose to become refugees, but are literally forced from their homes and hence should not be confused with the terms "immigrant" or "asylee," both of which indicate a voluntary wish to leave (though some asylees are sometimes later reclassified as refugees). Every year, the U.S. Department of State regulates the number of refugees permitted to enter, and in 2010, the United States accepted 73,311 refugees for resettlement and projected that by the end of 2011, 54,000 more arrived. The proposed ceiling for 2012 is 76,000 refugees (Proposed Refugee Admissions 5). The decade between 2000 and 2009 saw the arrival of 618,090 of the

nearly 2 million refugees that have come to the U.S. since the Vietnam War (Eckstein 429).

Utah itself has witnessed the arrival of approximately 25,000 refugees, mostly from Somalia, the Sudan, and Iraq; recent numbers from the past several years have shown a significant increase in refugees arriving from Burma, Bhutan, and Iraq (Statistics at a Glance). Nearly all live in the Salt Lake Valley where various refugee communities have begun forming noticeable presences in the public school systems—Mountain View Elementary School in the Salt Lake School District has estimated that its student body is about 20% refugees—and it is increasingly common for health care providers to see refugee patients with needs and backgrounds in stark contrast to those of Utah's general population.

The Somali and the Somali Bantu are excellent examples of this. They are two of the largest refugee groups in the state with 1,432 of the 8,103 refugees resettled in Utah between 2000 and 2009 having originally fled Somalia (Refugee Services Office). Transitioning to the United States can be more difficult for these groups than refugees from regions with social structures, economies and educational opportunities similar to those found in the U.S. The Somali and Somali Bantu also speak radically different languages from English (Arabic and many tribal dialects) and many are illiterate, even in their native languages. The International Office for Migration (IOM) actually estimates that only 5% of Somali Bantu refugees are able to speak any English upon arrival, and most of these are male (Carroll et al. 338). They are also predominantly Muslim and have had little or no formal education, making integration particularly difficult in an American social atmosphere.

The Somali and the Somali Bantu encounter a large number of diseases and conditions before coming to the United States in addition to adhering to many cultural beliefs and practices that affect their health. Tropical diseases such as schistosomiasis, giardiasis, and other parasitic diseases are common in addition to tuberculosis, malaria, and hepatitis B (Parve 51), and upon arrival many refugees have still not had adequate treatment. They also commonly practice polygamy, which translates to a large number of refugee women in the United States being classified as single mothers though their husbands actually do live in the U.S. and are attempting to care for several families at once; this also increases the likelihood of STD transmission. Some traditions such as using burning with heated metal as a traditional healing method for drawing out infection and others like female circumcision can be surprising to American health care providers who have not encountered these beliefs and practices or who do not understand their motivations (Parve 52). Common cultural practices like female circumcision (nearly 100 percent of Somali Bantu women have undergone the procedure, and sometimes have it multiple times following each child birth) contribute to a host of other health problems, for example making pelvic examinations more difficult and increasing the likelihood of urinary tract infections, pelvic inflammatory disease, and obstetric complications. Somali Bantu can also be hesitant regarding surgical repair after resettlement due to potentially strong cultural stigmatization in their communities.

While the Somali and the Somali Bantu certainly present some distinctive characteristics, these two populations by no means represent the full extent of challenges refugees face upon arrival in the United States. While most refugees share many of the same struggles such as language, affordable housing, education, steady employment, and

transportation, each population also has its own particular trials stemming from their unique experiences as refugees. In the past 10 years, the state of Utah has welcomed refugees from over 42 different countries and geographic regions, all with unique cultures, languages, beliefs, and conditions that forced people from their homes. Incredibly, some estimates put the number of refugees worldwide who have suffered torture as high as 35%, resulting in many refugees who suffer from stress-related disorders and other long-term psychological consequences relating to their previous experiences (Services for Survivors of Torture). Others nurse chronic conditions resulting from war-related trauma. Migration is stressful and that itself can lead to depression, anxiety, and substance abuse. Still others attempt to cope with the loss of loved ones as they work several jobs to care for their remaining family members. Some refugees have experienced it all. To group all refugees together is impossible; their incredible breadth of experiences and diverse histories make it so, and finding ways to accommodate each of their own health needs is a puzzling task.

CURRENTLY IN UTAH

In 2007, Macleans Geo-JaJa and Garth Mangum published "Struggling at the Golden Door: International Refugees in Utah," a policy in-depth that attempted to summarize the entire refugee resettlement process in Utah. At the time, the International Rescue Committee (IRC) and Catholic Community Services (CCS) only provided case workers for refugees for their first six months after arrival in the U.S. before refugees were referred to the Asian Association of Utah (AAU) or left to fend for themselves with

the possibility of help from other private organizations. The authors made many recommendations, for example calling for an increase in state funding to allow resettlement agencies to have enough case workers and staff to handle the newly-arriving refugees as well as advocating for increased ESL availability and aid in finding employment. Perhaps most importantly, the authors called for the creation of a single state agency and policy board "…to oversee the coordination of all state agencies and private organizations involved in refugee resettlement to see that the highest possible quality of service is provided by and to all" (Geo-JaJa 1). After the release of their summary as well as further demand from the community, the Utah Refugee Services Office (URSO) was established by Governor Jon M. Huntsman, Jr. in 2008 to promote refugee integration into the communities in Utah.

Further improvement was seen in 2009 when the IRC decided to increase its refugee management jurisdiction to two years, providing refugee families with an extra 18 months of aid from their case workers and accepting refugees initially resettled by CCS after their first six months come to an end. Amy Wylie, Program Specialist with the URSO, has estimated that since 2009 there have been 3,000 refugees that have been able to benefit from extended case management. Unfortunately, each caseworker has the responsibility of approximately 30 cases, and with each case representing either an individual or an entire family it is nearly impossible for all the needs of every refugee to be met. Luckily, the AAU is available and continues to assist refugees with employment, interpretation and translation resources, and many supportive services such as childcare and preventive counseling after refugees lose their original case management. Another huge milestone in the improvement of the resettlement process here in Utah was the offer

of Dr. Mara Rabin and Dr. Paul Swoboda to conduct 100 percent of refugees' initial health screenings at the Salt Lake Family Medicine Clinic, which has been extremely helpful in coordinating medical interpretation services for appointments and forwarding screening results to resettlement agencies. Refugees with serious health problems are referred to providers before their Refugee Medical Assistance (Medicaid) is terminated, typically at the end of eight months after arrival. Too often, Refugee Medical Assistance is cut shorter than that because the "first month" of eligibility ends on the last day of the month of arrival; if a refugee flies into Salt Lake City on the 31 of May, one month of Medicaid is already spent. Refugees without serious illness are lined up with a primary care physician at one of over 15 clinics or 10 hospitals, all in the Salt Lake Valley. There are also several mental health facilities, such as Valley Mental Health as well as multiple dental clinics like the Family Dental Plan Salt Lake Clinic that accept Medicaid and provide certain free or discounted dental services on specific days of the week.

Under the current Refugee Health Plan organized by the URSO, resettlement agencies coordinate Medicaid cards and act as liaisons for the refugees and the health care system. They help each refugee family choose a provider that accepts Medicaid and coordinate interpreters for those families with language barriers (which are paid for through Medicaid), as well as refer them to programs like Primary Care Network (PCN) and Health Access Project (HAP) after individuals or families have lost their Medicaid coverage. PCN is only an option when funding is available and enrollment is open; it covers primary care expenses with an emphasis on enrolling adults without dependents, who are typically the first refugees to lose health insurance coverage. HAP has an URSO case manager for refugees that lines up uninsured refugees with primary care physicians

and essentially performs the same screening services as case workers with the resettlement agencies by assisting refugees in applying for public health insurance, scheduling medical appointments and follow-up, and coordinating medical interpretation. Refugee children from uninsured families may also be eligible for the Children's Health Insurance Program (CHIP) just like any other legal resident in the United States. Refugees with severe health problems may apply for SSI as well.

Medical interpreters are largely trained and certified through the Utah Department of Health (UDOH) program Bridging the Gap (BTG), a biannual training for individuals committed to using their language skills in a medical setting and who are either already practicing as an interpreter or who already work in a clinical setting that serves patients in need of medical interpreters. Priority is given to individuals who already work with refugees, tuberculosis control, or other preventive clinical settings. It is a five-day/40 hour training that covers basic interpreting skills, an introduction to the health care system and basic clinical information, culture in interpretation, appropriate advocacy and communication skills, and professional development. BTG reports that about 30 to 40 individuals complete the training per year (Pasalic), and conversations with the health and medical coordinators at both IRC and CCS indicate that medical interpretation is nearly always available for the refugees they are managing. In addition to the resettlement agencies, AAU advertises interpreters and translators who speak 45 different languages and dialects.

Both the IRC and CCS refer refugees to clinics located in areas that are as accessible as possible in relation to their places of residence. The clinics that receive the most referrals from both agencies are mostly the University of Utah community clinics

like the Redwood Health Center, the Sugar House Health Center, and the Greenwood Health Center, though a few others like the West Ridge Clinic and St. Mark's Family Clinic do receive some refugee referrals as well. Several new clinics also exist to provide services to Utah's uninsured, such as the Maliheh Free Clinic in South Salt Lake, which opened in 2005, and the Hope Clinic, which opened its doors in 2010. Despite the best intentions of health care providers at these clinics, none of these centers truly exists as a refugee health clinic where refugees are afforded continuous care from the same physician and access to on-site mental health services or social workers. One of the chief obstacles is simply creating a stable resource stream that allows initial efforts to continue. For example, an attempt was made to create a volunteer refugee health clinic at the Redwood Health Center, but this unfortunately has proved to be unsustainable.

DISCUSSION

In the face of the unique challenges faced by Utah's refugee communities, it seems appropriate to bring into focus several concepts whose core principles align with some of refugee populations' best interests. P4 medicine's components are often only considered in the context of health care provision and medication prescription, as opposed to creating a true health system that is personalized according to individuals' and communities' social needs and circumstances. P4 medicine is in fact as much about understanding the genetic predispositions of disease and ways to tailor specific and precise drug treatments to a patient's genotype and drug metabolism rates as it is about finding ways to tailor health care access, provision, health education, and disease

prevention to people in unique communities. It seems that a system that is "predictive, preventive, personalized, and participatory" will initially impact overall health much more rapidly if it is initially applied on a social, rather than a biological, level, and considering approaches to refugee health in this light is helpful. "Healthcare is on the verge of a major revolution," writes the P4 Medicine Institute. Using information generated through the convergence of human biology, networking patients and utilizing continually improving communication between providers, P4 Medicine explains that "[u]se of this actionable information will not be the sole province of physicians; it will also be used by activated and networked patients, with the assistance of coaches and other support mechanisms, to better manage their health and to implement physician-prescribed disease treatment regimes" (P4 Medicine). Today, many refugees in Utah can hardly be called "activated and networked patients," though as previously explained they of course benefit greatly from the host of resettlement agencies and other support organizations that work to smooth out the resettlement process. Under the recommendations of P4 medicine, action needs to be taken that considers the social context of refugees living in the Salt Lake Valley. These efforts should be ecologically personalized in that they appreciate the unique circumstances surrounding refugees and their places in Utah's society.

It is helpful to consider refugees' health in the context of their new—and for many refugees in Utah, not so new—environment. The theory of social ecology takes into account multiple levels of an individual's influences and behaviors, beginning with the intrapersonal level. This consists of the ensemble of personal characteristics that directly influence an individual's personal choices regarding health, including his or her

knowledge, attitudes, beliefs, and even personality traits. For example, this could be a refugee's religion or personal core beliefs, education, political ideology, or even preferred recreational activities. At an interpersonal level, an individual interacts with and is influenced by primary social groups such as their immediate family, friends, and peers that all act to help define an individual's identity and role as well as provide them needed social support. In the context of refugees, this could relate to family in the United States or abroad, fellow refugees, other friends, and extended family that contribute to both ethnic and social identities. Finally, an individual's behavior can be analyzed from a community level, from the institutional factors and public policy that either restrict unhealthy behaviors, promote healthy ones, or provide access to needed health resources through both formal and informal means, to community factors like social networks and standards that dictate accepted behavior among a community's individuals, groups, and other organizations (Theory at a Glance). For refugees, the community level can be understood as refugee resettlement agencies, health clinics, auxiliary organizations providing interpretation services and employment or preventive counseling, programs that provide preventive care coverage for the uninsured, the laws and policies governing refugee resettlement and funds that support various aspects of the resettlement process, and especially, refugees' own local community organizations and group dynamics.

It needs to be understood that refugees, precisely because of their previous and continuing hardships and challenges, are survivors. Though of course many struggle with language, cultural differences, education, frustrations like professional licenses that are not recognized in the U.S., transportation, and many different health problems, fellow community members should not make a mistake in thinking that refugees are somehow

incapable or inadequate in participating in society and that they do not have the capacity to enact positive changes in their own lives. Any approach to improving the refugee health climate in Utah must adhere to the principles that govern community engagement and community-based participation. Community engagement is the "…process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people" (Principles of Community Engagement) and is an approach that "…involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (Fawcett et al.). Community engagement stresses mutual respect and appreciation for all parties involved and also places an emphasis on bi-directional learning.

One example of recent community engagement efforts in the Salt Lake Valley is the Honors College Global Health Scholars Refugee Partnership. Following an expressed concern over the lack of involvement from the University of Utah by the URSO, a partnership was proposed that links together students participating in the Global Health Scholars (GHS) under the University of Utah Honors College, the URSO, and refugee families who have resided in the Salt Lake Valley long enough to have lost case management services and are still exhibiting a need of further assistance. Though the partnership was largely designed and approved by the GHS and the URSO, as it moves forward refugee families also become active partners and find the opportunity to engage in their local community by expressing continuing needs, news, and feedback regarding the resettlement process to participating students in GHS, who are then able to

communicate information, priorities, and families' progress to the URSO. As participating families work together with students and forge new bonds in their communities, new refugee families are given the opportunity to enter the partnership, make their voices be heard, and have the opportunity to gain community advocates and further coordination with the URSO. It is a three-way partnership in which all participants both contribute and benefit.

With all of these concepts in mind, an approach that has been proven to substantially improve the lives of patients with unique health challenges—patient-centered medical homes—has the potential to create a sustainable infrastructure that will persist with refugees regardless of whether or not they have the assistance of resettlement agency caseworkers. The medical home was initially designed for all children, but the concept was first implemented for the benefit of children with special health care needs, providing both coordinated and specialty care (DePalma). Participating children were shown to greatly benefit from having a medical home, such as significant decreases in ER visits (Martin et al.) and decreased rates of hospitalization (Long et al.).

The Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, recommends that all children have the opportunity to benefit from medical homes. Studies have since shown that this recommendation is warranted because children without special health care needs who had a medical home had more preventive care visits, less outpatient sick visits, and decreased emergency department visits. Having a medical home also was associated with an increase in "excellent/very good" child health as assessed by parents and also was associated with an increase in family health-

promoting behaviors such as being read to daily, helmet use, and decreased screen time (Long et al.).

Medical homes should be available for all patients of any age, and refugees are no exception. Some of the general criteria that originally determined which children with special health care needs qualified for acceptance into a medical home program were medical needs, such as complex illnesses and treatments, social needs, such as children living in families with histories of abuse or financial problems, school needs, such as children with behavioral problems or those who had difficulty in managing attention deficit disorders, or mental health needs (Martin et al.). When considering the list, it is immediately apparent that many refugees fit into one or several of these categories, and some may even fit into all of them regardless of their age.

Several areas in the U.S. have already attempted to create medical homes for refugees, though it seems that efforts have focused on prenatal care and refugee children. For example, the C.A.R.E. (Culturally Appropriate Resources and Education) Clinic, a branch of the Family Center at the Saint Alphonsus Regional Medical Center in Boise, Idaho, opened in 2009 and provides refugees with continuous pediatric and maternal health care. It is a "…nurse-led clinical program that provides convenient one-stop access to a seamless continuum of healthcare services and education provided in a group setting" (Reavy et al. 2). The clinic also highlights the fact that a new role not found in many other clinics was created—the C.A.R.E. Clinic Health Advisor—whose responsibility is to contribute to "…a culturally safe infrastructure, thereby providing a physically, mentally, culturally, and educationally safe context wherein refugees are

empowered with voice, understanding, and trust for the purpose of active engagement in their health care" (Reavy et al. 4).

The health advisor has separate and distinct roles from certified medical interpreters though there is a lot of overlap. Legally, medical interpreters must provide only a literal translation of any words spoken between patient and provider, whereas the health advisor has a much wider array of influences; these include assisting and educating health care professionals in cultural appropriateness and humility, assisting maternal and pediatric patients with scheduling appointments and educational classes, navigating barriers in the access of health care for refugees, advising and educating refugees about Western medicine, partnering and building relationships with other community members to increase refugee referrals, following up with refugees after specialty care referrals, assisting refugee families with the self-identification of their health needs and other needed resources, and ultimately supporting refugees in any way they can as they transition into a medical home (Reavy et al. 7). They teach, organize classes and workshops, and essentially perform all of the services that a resettlement agency caseworker is normally charged with. In this particular case, the C.A.R.E. Clinic only trains women who are bilingual in both English and refugee patients' primary languages to try and create as safe an environment as possible as their patients are uniquely expecting mothers and children.

The Refugee Health Clinic at Hasbro Children's Hospital at Brown University is another facility that has tried to create medical homes for refugee children. The clinic opened in 2007 to address poor follow-up and lack of continuity for refugee children, building on three themes: refugee children and their families need interpreters who can

also navigate the health care system, patients need to be able to trust their providers, and the refugee community is grateful for those who work to support their health and transition to their new communities. Funding for the clinic was received in 2007, allowing the facility to develop specific examination approaches to meet refugee children needs, a "coalition of providers," increased training of medical interpreters, and also planned for ongoing needs assessments. This particular medical home is made up of refugees, primary care providers, certified medical interpreters, mental health professionals, dental health professionals, and the International Institute of Rhode Island, the volunteer resettlement agency in the area (Temu et al.).

Several key aspects of the clinic should be noted. First of all, the same primary care provider that conducts each refugee's domestic health screening continues to see the same child and can thus efficiently coordinate further care. This has allowed the clinic to develop a tracking system to identify the some of the needs of their different refugee populations. Second, mental health professionals conduct screenings at six months after arrival for each child and are available at the clinic at all follow-up appointments. The clinic sees nearly 100% of arriving refugee children in Rhode Island and also conducts extra follow-up appointments at one, three, six, and twelve months after their initial screening. Third, medical interpreters from each refugee community are trained and are able to fulfill many of the same roles as the C.A.R.E. Clinic Health Advisor, including being trained as a resource for their communities in common pediatric diseases and dental problems. They act as education and health promoters and are community health workers that are able to act in a culturally appropriate and timely way. They too are navigators of the health care system and are able to answer refugees' questions about

pharmacies, medications, illnesses, vaccinations, and transportation. Perhaps most importantly, the clinic's medical interpreters as well as its providers participate in quarterly meetings, allowing the medical interpreters to truly act as bi-directional educators who assist both providers and refugees (Temu et al.).

CONCLUSIONS

Refugee medical homes elsewhere have made progress in supporting and empowering refugees as they transition to their new homes. However, efforts have thus far been focused on pediatric and maternal health. While funding may constrain the expansion of medical homes to all refugees regardless of age, it is important that those involved with refugee communities be aware of the potential strength in building and partnering with refugees and have goals to create medical homes in the future. The two clinics discussed could serve as potential models for efforts here in the Salt Lake Valley. The primary care clinic should become the locus of care; both refugee and provider should coexist in a "therapeutic, social, and economic relation of mutual and highly interwoven prerogatives" (Bardes 783), and the development of one or more refugee health clinics in the Salt Lake Valley would go far in better meeting the needs of local refugees and preparing them for the future.

The first step in improving the refugee health system here in Utah is for the URSO, resettlement agencies, and the refugee communities themselves to come together and establish meaningful goals for change. The current system is fragmented and struggles to provide continuous care even to those refugees with insurance coverage.

Perhaps one approach could be to work with existing medical interpreters from the refugee communities together with community leaders to explore refugee conceptions of the current system, their own priorities, and finally, any ideas that they themselves have for improvement.

It should also be noted that the PPACA encourages the expansion of primary care services in general and has established the Community-based Collaborative Care Network Program to "…support consortiums of health care providers to coordinate and integrate health care services for low-income uninsured and underinsured populations" (Focus on Health Reform 10), for which funding has been set aside until 2016. Further changes also exist that directly benefit refugees, including the fact that after 2014 Medicaid will be available to all legal residents of the U.S. who meet income criteria and not just families with children. Medicaid reimbursement rates for services provided by primary care physicians will also be increased to 100 percent of Medicare reimbursement rates in 2013 and 2014 (Cunningham), and while this is currently limited to the next two years it is a step in the right direction as it provides further incentives for primary care physicians to accept more patients with Medicaid.

These recent changes as well as other anticipated improvements in the access to and provision of primary care services could serve to support the initiation of the second recommendation this review proposes: to begin work on the development of one or more designated refugee health clinics through existing health centers in the Salt Lake Valley. While previous efforts have been based largely on volunteer efforts, this review proposes that clinics be developed that use the C.A.R.E. Clinic as well as the Refugee Health Clinic at Hasbro Children's Hospital as models and to employ interested primary care

providers full-time. This will allow all primary care services for refugees to take place under one roof—an infrastructure should exist which allows all refugees to have the opportunity to see one primary care provider and establish lasting relationships with them. While all refugee domestic health screenings in Utah do take place at one clinic, it is in all refugees' interests to conduct their health screenings in clinics equipped to continue their preventive screenings and hence to be able to provide them with true medical homes. As the C.A.R.E. Clinic and the Refugee Health Clinic have done, perhaps existing refugee medical interpreters could be hired and trained as refugee health advisors. The participation of on-site social workers as well as mental health professionals would also aid refugees who otherwise struggle with transportation to other clinics and will reduce the number of appointments they need to balance.

Many refugees who already reside in Utah and many of those continuing to arrive here come from refugee camps that have essentially trained them to live lives of dependence. They have been denied education, the right to work, the right to political engagement, and often, even basic health care services. Aid is usually the only authorized resource in refugee camps and the constant frustration and feelings of impotence present in many camps would be difficult for anyone to endure. Refugees in Utah already have a strong web of social services and support from resettlement agencies, volunteer organizations, and other interested parties who are attempting to help refugees regain their self-reliance, but allowing them to access primary care in environments that place an emphasis on continuity of care, patient empowerment, and community engagement could add energy to this endeavor and contribute to the creation of even stronger bonds in Utah's communities. Refugees need to be included in the conversation of their own health, and

integrating refugee-centered medical homes into the fabric of Utah's existing clinics is one more way to help refugees regain their homes and come back from the margins of human society.

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