
Recommended Best Practices for Domestic Health Assessments and Medicaid Enrollment for Refugees and Eligible Haitians

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Introduction

Florida is the recipient of a large number of foreign arrivals¹ admitted to the United States (U.S.) each year. These individuals come from different countries and a variety of cultures that may affect their current health status. Additionally, these individuals may have been exposed to communicable diseases, which could potentially threaten the health of U.S. citizens. For this reason the federal government recommends a domestic health assessment (DHA) be conducted on all new arrivals and has afforded them Medicaid or Refugee Medical Assistance (RMA) benefits to ensure health needs are met for at least the first eight months after the date of arrival.

Over 128,000 arrivals entered Florida between January 1, 2003, and December 31, 2006.² These large numbers make it crucial that the state of Florida and its county health departments conduct appropriate and timely DHAs aimed at detecting and treating conditions posing a threat to the public's health, as well as, ensuring these arrivals enroll in Medicaid or RMA in order to maintain their health. These DHAs, along with enrollment in Medicaid, will help identify health concerns and increase the opportunity for preventive health care to the arrivals, thus, contributing to a successful path to self-sufficiency.

The purpose of this report is to provide recommendations on best practices for use by refugee health clinics in county health departments (RHCs), voluntary resettlement agencies (VOLAGs), and other providers to ensure incoming arrivals, specifically those classified as "refugees", as well as, Haitian asylum applicants enroll in Medicaid and receive appropriate and timely domestic health assessments.

Interviews with stakeholders were conducted in key refugee resettlement counties to obtain information on current processes and procedures regarding Medicaid enrollment and the provision of DHAs. The results were analyzed to serve as a basis for recommendations to the Florida Department of Health (DOH) for their use in increasing access to health care for refugees and eligible Haitians.

Definitions

Refugees - Individuals who have fled their country due to a well-founded fear of persecution based on their race, religion, nationality, social group, or political opinion. These individuals apply for and are granted this status prior to entry into the U.S. They are eligible for DHAs, Medicaid benefits, and refugee benefits beginning the date the individual meets the definition of a refugee and arrives in the U.S.

Asylees - Individuals who leave their home country for reasons similar to those of refugees (fear of persecution based on their race, religion, nationality, social group, or political opinion), but travel to the U.S. on their own. Once in the U.S., these individuals apply for asylum protection. They are eligible for DHAs and Medicaid benefits but not refugee benefits beginning the date the individual is granted asylum. Cuban and Haitian asylum applicants are eligible for DHAs and Medicaid benefits during the asylum application process.

¹ In this report the term "arrival" refers to the following groups – refugees, asylees, Cuban or Haitian entrants, all of whom are foreign individuals with an immigration status eligible for refugee benefits.

² Markiewicz, B., Baugh, K., Tutwiler, M., Vazquez, J. (2009). *Refugee Health Status and Health Care Utilization Report*. Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida. Prepared for the Bureau of Tuberculosis and Refugee Health, Florida Department of Health.

Parolees - Individuals granted parole for humanitarian reasons or for emergent of compelling reasons of “significant public benefit.” In some cases, parole is authorized prior to the individual’s arrival in the U.S. Parole may also be granted at the port of entry once the individual has arrived. Only Cuban and Haitian parolees are eligible for DHAs, Medicaid benefits, and refugee benefits.

Cuban or Haitian Entrant - Individuals from either Cuba or Haiti whose immigration status is either a parolee, asylum applicant, or an individual in removal proceedings. They are eligible for DHAs, Medicaid benefits, and refugee resettlement benefits beginning the date the individual meets the definition of an entrant.

Regulatory Mandates

As required by the U.S. Office of Refugee Resettlement (ORR) and the Department of State (DOS), all arrivals are eligible for and should receive a DHA and/or immunizations, at no charge, within 90 days of arrival.³ Through an annual cooperative agreement with the DOS, VOLAGs are responsible for ensuring all of their clients are receiving their DHAs within a preferred timeframe of 30 days. If a DHA is not completed within this preferred 30-day timeframe, the VOLAG must provide a written explanation of the reason for the delay. However, some arrivals are not sponsored by a VOLAG, and thus, do not receive the services and assistance from a VOLAG to obtain a domestic health assessment.

Arrivals are eligible to receive health care benefits through Medicaid or Refugee Medical Assistance funds for up to eight months beginning on the date of entry, date asylum is granted, or until their financial eligibility changes.⁴

Caveats

Data analyzed for the selection of interviewees is based on arrivals from January 1, 2003 until December 31, 2006. However, the interviews were conducted between November 13, 2009 and January 28, 2010. Therefore, the current procedures acquired from the interviews conducted may not be reflective of those in place during the timeframe the data capture. Thus, it could be possible that an interviewee who performed well during the data’s timeframe may no longer be performing well and vice-versa.

Methods

Data gathered and analyzed from over 128,000 arrivals that entered Florida between January 1, 2003, and December 31, 2006, served as the basis for our specific research goals.⁵ All of these arrivals were eligible and should have received DHAs, as well as, Medicaid benefits if financially qualified.

Refugees, in particular, are eligible for resettlement assistance from a VOLAG. VOLAGs take contractual responsibility to ensure the refugees they serve obtain assistance in Medicaid enrollment and in scheduling domestic health assessments. However, the VOLAGs’ methodologies in completing these tasks vary. Thus, studying the process utilized by several VOLAGs, as well as,

³ 45 CFR 400.107

⁴ 45 CFR 400.93

⁵ Markiewicz, B., Baugh, K., Tutwiler, M., Vazquez, J. (2009). *Refugee Health Status and Health Care Utilization Report*. Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida. Prepared for the Bureau of Tuberculosis and Refugee Health, Florida Department of Health.

their success in ensuring their clients obtain DHAs and are enrolled in Medicaid, provides useful information in determining best practices.

When compared to any other group, incoming Haitians have the lowest rates (16.7%) of completing domestic health assessments.⁶ This low figure indicates problems in access to health care for the Haitian population. Additionally, most Haitians (72%) arrive under the immigration status of asylee and thus, are not afforded the resettlement benefits and assistance provided by a VOLAG.⁷ This leaves the RHCs with the responsibility of reaching out to the Haitian population to ensure DHAs are completed. Thus, RHCs are a critical stakeholder due to the relationship with VOLAGs in administering the DHAs of refugees, as well as, the responsibility in ensuring Haitians obtain domestic health assessments.

This report specifically focuses on two distinct groups, refugees and Haitians, and how each enrolls in Medicaid and receives appropriate and timely domestic health assessments. Based on the roles of VOLAGs and RHCs in providing these services, the staff were interviewed to determine and establish best practice guidelines to reduce barriers to health care access so more arrivals enroll in Medicaid and seek domestic health assessments.

Selection of VOLAGs and RHCs for Interviews

The interviewed parties were selected based on specific performance criteria. The criteria consisted of: number of clients served, percent of clients enrolled in Medicaid, percent of clients with DHAs completed, and median days from arrival until completion of the domestic health assessment.

It is essential to compare the practices of those agencies performing well on these indicators with the actions of those not performing well to filter out useful techniques and procedures for recommendations. To concentrate on the specific research goals, data for arrivals entering Florida between January 1, 2003, and December 31, 2006, were separated for refugees and Haitians, as well as, by geographic location across the state. VOLAGs and RHCs from various locations were then selected for interviews based upon the specified criteria and performance. Those with low numbers of arrivals served were eliminated. VOLAGs and RHCs who were consistently better than and consistently worse than the selected performance criteria average values for both refugees and Haitians were considered for interviews. To minimize travel time and costs, VOLAGs and RHCs based in the same county, meeting the specified criteria were selected for interviews.

Table 1 compares refugee data for the average VOLAG with refugee data from the three VOLAGs interviewed. Data for the average VOLAG is comprised from data for all VOLAGs in all Florida counties where refugees settled. Due to confidentiality, the identities of the three VOLAGs interviewed are masked by labels VOLAG-1, VOLAG-2, and VOLAG-3. Table 2 compares Haitian data for the average RHC with Haitian data from the three RHCs interviewed. Data for the average RHC is comprised from data for all RHCs in all Florida counties where Haitians were served. Due to confidentiality, the identities of the three RHCs interviewed are masked by the labels RHC-A, RHC-B, and RHC-C. Data for RHC-B and RHC-C is comprised of multiple counties' RHCs, as well as, the RHCs interviewed.

⁶ Ibid.

⁷ Ibid.

Table 1 – Refugee Data for VOLAGs

Refugees entering Florida between 1/1/03 and 12/31/06

	Average VOLAG	VOLAG-1	VOLAG-2	VOLAG-3
Number Served	210	478	1736	814
Percent Enrolled in Medicaid	99.23	99.8	99.3	99.4
Percent with Assessment	91.38	96.9	95.5	80.5
Median Days (arrival until assessment)	30.4	29	14	46

Performance can be gauged from these tables. Overall, out of the three agencies interviewed, VOLAG-2 was the best performing VOLAG, while VOLAG-3 was the lowest performing VOLAG in providing timely assessments. The average VOLAG did very well in enrolling arrivals in Medicaid. However, improvements can be made in the percent of arrivals receiving a DHA and in the median number of days it takes for assessment completion. Since VOLAG-1 and VOLAG-2 performed better than the average VOLAG in percent of arrivals completing DHAs, it will be beneficial to study their specific procedures and possibly recommend them to the Department of Health. However, because VOLAG-3 performed far below average on this indicator, their specific procedures will be studied but not recommended. VOLAG-2 performed very well in having their clients complete the DHAs within the 30 day period. VOLAG-1 had an average equal to that of the preferred 30 day period which makes its performance sufficient. However, VOLAG-3 seemed to struggle, with average median days much larger than the average VOLAG. This suggests processes used by VOLAG-1 and VOLAG-2 should be recommended and those used by VOLAG-3 should be avoided. However, it must be recognized that county health departments are a key partner in the timely provision of DHAs. Delayed assessments may be due to county health department practices. Therefore, this evaluation also interviewed county health department staff to examine their practices.

Table 2 – Haitian Data for RHCs

Eligible Haitians entering Florida between 1/1/03 and 12/31/06

	Average RHC	RHC-A	RHC-B	RHC-C
Number Served	702	206	7760	318
Percent Enrolled in Medicaid	75.4	80.6	79.9	73.6
Percent with Assessment	13.08	8.7	18.6	3
Median Days (arrival or asylum granted until assessment)	54.17	38.5	53	59

Related to screening Haitian arrivals, RHC-C was the overall lowest performing RHC, performing below the average RHC in every category analyzed. RHC-A and RHC-B performed better than the

average RHC in enrolling Haitians in Medicaid. RHC-B was the only RHC to perform better than the average RHC in getting Haitians in for a domestic health assessment. While, on average, none of the three RHCs interviewed were able to complete the DHA within the preferred 30 day period for Haitians, RHC-A performed the best out of the group.

Table 3 and Table 4 summarize the outcomes of the VOLAGs and the RHCs, respectively, based on the selection criteria.

Table 3 – VOLAG Outcomes for Refugee Data

	<i>Good Outcomes</i>	<i>Poor Outcomes</i>
Percent Enrolled in Medicaid	VOLAG-1, VOLAG-2, VOLAG-3	
Percent with Assessment	VOLAG-1, VOLAG-2	VOLAG-3
Median Days (arrival until assessment)	VOLAG-1, VOLAG-2	VOLAG-3

Table 4 – RHC Outcomes for Haitian Data

	<i>Good Outcomes</i>	<i>Poor Outcomes</i>
Percent Enrolled in Medicaid	RHC-A, RHC-B	RHC-C
Percent with Assessment	RHC-B	RHC-A, RHC-C
Median Days (arrival or asylum granted until assessment)	RHC-A	RHC-B, RHC-C

Interview Process

Organizations were selected for interviews based on the above comparisons to average performance for VOLAGs and RHCs for the specified criteria.

Face-to-face interviews were scheduled and then conducted with selected VOLAGs and RHCs. Two questionnaires were developed for use in the interviews with the selected parties. The first questionnaire focused on evaluating the process utilized by the VOLAGs (see Appendix A for VOLAG sample questionnaire). Questions for the VOLAGs were designed and selected based upon their federal contractual responsibilities. The second questionnaire focused on evaluating the process utilized by the RHCs (see Appendix B for RHC sample questionnaire). Questions for the RHCs were designed and selected based upon their state specified responsibilities. One staff member from the Refugee Health Program in the Florida Department of Health and one staff member from the Lawton and Rhea Chiles Center for Healthy Mothers and Babies conducted the interviews. Interviews were conducted between November 13, 2009 and January 28, 2010 with the following individuals:

Table 5 – Interviewees

County	Agency	Staff Interviewed
Duval	Refugee Health Clinic	Case Manager Nurse
Duval	World Relief	Medical Coordinator
Palm Beach	Refugee Health Clinic	Nurses (3) Health Service Representative (2) Health Support Technician
Palm Beach	United States Conference of Catholic Bishops	Program Administrator
Hillsborough	Refugee Health Clinic	Program Manager Nurses (3)
Hillsborough	United States Conference of Catholic Bishops	Case Manager

Follow-up correspondence was conducted to clarify any of the interviewees’ experiences. The main topic for the follow-up correspondence involved the RHCs and whether or not they received notification of individuals who were granted asylum.

Interview Results

Goals and Responsibilities in Providing Health Services to Arrivals

It is important to understand the stated goals and responsibilities of VOLAGs and RHCs, as they direct their focus, which should ultimately drive the actions so that program goals are met.

VOLAGs

Completion of the DHA within 30 days of arrival was identified as a goal by all VOLAGs. They understand their responsibility in making sure these refugees obtain DHAs within the preferred timeframe specified by the DOS. An additional identified goal is getting refugees needed medical help due to the fact that some refugees arrive needing prompt medical care. This need makes the timely enrollment of refugees in Medicaid paramount.

RHCs

Assessment of the refugees’ current health, providing services to ensure health and quality of life, and protecting the general public from disease were all common goals among the RHCs interviewed. RHC representatives identified several services including DHAs, immunizations, linkage of the refugee to a primary care doctor, and follow-up with those refugees who have referrals for additional treatment, including conditions identified in the overseas assessment.

Explanation of Health Benefits

Adequate and timely exchange of information between VOLAGs and RHCs is crucial to the overall process, as well as, the path to self-sufficiency. For the most part, arrivals enter the country with

little or no knowledge of what their new life entails. Therefore, proper and prompt explanation can facilitate the overall process of obtaining a DHA and Medicaid coverage.

VOLAGs

Each of the three VOLAGs interviewed explain available health benefits during an orientation class for the refugees. Additionally, VOLAG-2 divides the \$425 check available to the refugees into multiple checks in order to induce them to come into the VOLAG office multiple times. This facilitates more interaction time between the VOLAG and the refugee. During these visits, more in depth information regarding benefits and available services is shared. Each refugee or refugee family is assigned a caseworker. In order to facilitate communication, the VOLAGs attempt to match the refugee with a caseworker who speaks the refugee's native language. VOLAG-1 and VOLAG-2 specifically stated the importance of staffing their organizations with employees who experienced the refugee process first-hand and who can communicate with the different populations being served. VOLAG-3 currently only provides services to Cuban refugees due to the specifics of their contract. All of their staff members are bilingual and, thus, can communicate with the population served. VOLAG-1's caseworkers speak Arabic, Burmese, Spanish, French, Swahili, Russian, and Ukrainian.

All VOLAGs wait a couple of days after the refugee's arrival to conduct the orientation and provide an explanation of benefits. This is done to give the new arrival some time to settle down and become familiar with the VOLAG staff. Understandably, the refugees may be very quiet and shy upon arrival, so the VOLAG staff finds it beneficial to wait a couple of days to conduct the orientation. The VOLAG staff also noted that they facilitate the application process for a variety of benefits by providing help with computer and paper applications.

RHCs

In explaining health benefits, RHC-A has the advantage of staffing a case manager who acts as a liaison between the refugee and local health care services. This case manager explains all existing health benefits, as well as any other available benefits that the refugee may be eligible to receive. Additionally, the case manager can provide case management assistance to refugees for up to five years after the initial arrival date. The case manager is available to assist refugees with information on available community resources and benefits. It is worth noting that this case manager was not present during the evaluation period (2003-2006). The case manager was hired during 2009 so the impact of this position has not yet been analyzed. However, information gathered from the case manager regarding their activities may prove to be beneficial.

The other RHCs provide information on available services in the community should the refugee need it. They are willing to answer any questions the refugee has and may provide information on a case-by-case basis but the information shared is by no means uniform or standard. They believe the explanation of health benefits is the responsibility of the VOLAG.

Refugee Domestic Health Assessments

Contractual agreements with the DOS require VOLAGs ensure their refugee clients receive domestic health assessments.

VOLAG

According to all VOLAG representatives, advanced notification is received of a refugee's arrival date. With this prior knowledge of the arrival date, the VOLAGs begin completing the required

paperwork necessary to schedule the domestic health assessment. This paperwork is then sent to the RHC to schedule the appointment. According to the VOLAG representatives, they will usually have an appointment scheduled by the first week after arrival. However, the actual appointment date may vary depending on the availability of the RHC to conduct the domestic health assessment. Within a few days of arrival into the country, the refugee visits the VOLAG office for an orientation. During this visit, the refugee is given their DHA appointment date.

All VOLAG representatives noted the important role of the family members who sponsor a refugee, known as an anchor family, throughout the entire process. They believe these family members are extremely helpful because they are usually former refugees who understand the process and know of the resources in the community. These family members are usually able to provide transportation to the DHA appointment scheduled for the newly arrived refugees. Additionally, the VOLAG staff attempts to house individuals with similar backgrounds together. They have noticed that those refugees who have been in the country longer are helping out the newly arrived refugees. If the refugee does not have transportation to their DHA, the VOLAG staff themselves will provide the necessary transportation. While all three VOLAGs stated the use of buses in the past, only VOLAG-2 continues to issue month-long bus passes to the refugees while VOLAG-1 only issues bus passes to those who attend English classes.

All VOLAG representatives believe they communicate well and have a good relationship with the local RHC. Any missed appointments are promptly communicated back to the VOLAG so they can get in touch with the refugee. Additionally, since the VOLAG sometimes provides the transportation, they are aware when a refugee misses an appointment. A second appointment is promptly set up by all the VOLAGs and the date is passed on to the refugee. Missing an appointment is usually not a problem. VOLAG-1 identified transportation as the only reason someone would miss an appointment; however, they provide bus passes so it is usually not a very common issue. Thus, according to the VOLAG representatives, there has been no need for incentives to get the refugees in to complete the domestic health assessment. VOLAG-1 uses the green card as an incentive. Telling the refugee the DHA is required for other important paperwork and documentation, such as their green card and residency within a year, seems to work as an incentive to complete the domestic health assessment. According to VOLAG representatives, differences in nationalities were not noted when it came to attending the domestic health assessment. The VOLAGs did not have concerns about any particular country of origin.

While the initial DHA has not been seen as an issue by the VOLAG representatives, the subsequent visits required to complete immunizations are reportedly more difficult for refugees to attend. One of the main reasons identified is that the refugee has begun employment and does not want to create a negative impression by missing work so early on. For this reason, walk-in appointments are frequently made available by the RHCs but only for the subsequent set of immunizations.

During the mandatory orientation, VOLAGs inform refugees of the required and free domestic health assessment. However, details regarding the DHA are not provided during this orientation. Usually, the RHC is the party that explains what the DHA entails.

RHCs

Communication between the VOLAG and the RHC is crucial in the DHA process. RHC-A and RHC-B reported that they participate in monthly meetings with the VOLAGs that serve their respective areas. At these meetings they discuss how to best collaborate and facilitate how refugees access health care. They assign responsibilities to ensure efficiency and that work is not duplicated.

When it comes to scheduling appointments, the RHCs attempt to schedule a date as soon as the required paperwork from the VOLAG is received. Receiving the appropriate paperwork promptly results in the RHC providing appointment dates in a timely manner.

RHC-C reports scheduling appointments sometimes months after all required paperwork has been received from the VOLAGs due to lack of staff and increasing clientele. The RHC-C clerk is responsible for scheduling the appointments but is also tasked with conducting preliminary measurements on clients in order to provide the staff nurse additional time to conduct the assessments.

The schedules of the RHCs are particularly different. RHC-A and RHC-C are open for clients Monday through Friday from 8:00 am until 5:00 pm. RHC-B only operates three days a week from 7:30 am until 5:00 pm. Additionally, all the representatives report open dates available for walk-ins.

Medicaid Enrollment

Refugees are eligible for Medicaid benefits as soon as they arrive in the country.

VOLAGs

Refugees are assisted by the VOLAGs throughout the Medicaid application process. The VOLAG staff usually begins the application process the day the refugee arrives at the VOLAG office and the application is typically completed before the DHA appointment.

The VOLAG representatives expressed concern over denial of Medicaid benefits to some refugees. Each of the three VOLAGs interviewed have experienced problems with a refugee mistakenly denied Medicaid benefits. All describe contacting Department of Children and Families (DCF) employees to resolve the issue. All the VOLAGs expressed the importance of building and maintaining a relationship with a DCF employee who can be reached quickly to resolve Medicaid eligibility issues when they arise. The representatives each had the e-mail addresses of a specific DCF employee they were confident in contacting if any problems were experienced.

The VOLAG-2 representative described a current proposal under consideration with DCF, which would allow a DCF employee to be housed in the VOLAG office with the capability of approving or denying Medicaid applications. The VOLAG representative believes this will be beneficial in reducing the number of applications that are incorrectly denied.

VOLAG-1 expressed concerns regarding Medicaid. Specifically, the time between application and enrollment were, at times, particularly long. Additionally, the county which houses VOLAG-1 requires Medicaid recipients to enroll in a specific plan and select specific primary physicians. Change of physicians will sometimes require changing of plans which might take considerable time and, thus, reduce the actual overall length of Medicaid benefits for the refugee. There have also been situations where Medicaid will drop a refugee from a specific plan and this individual will not be aware of this until they show up to their appointment with the doctor where they are then told they are no longer part of the physician's approved plan. These individuals must then select a new plan, find a doctor, and schedule a new appointment. These particular situations lead to a gap in coverage for refugees and limit the overall amount of time they actually receive Medicaid benefits.

RHCs

All RHC representatives ask the refugee if they have already applied for and/or enrolled in Medicaid. The case manager housed in RHC-A explains the entire application process to the refugee if they have not yet begun the application or if they have any questions. However, the case manager

does not have access to the Medicaid application in the clinic so the refugee must find another location to fill out the application. The county health department where RHC-B is housed is staffed with a financial counselor that usually helps refugees with questions or concerns regarding Medicaid. The financial counselor can help with the application and also with any Medicaid denials. RHC-C does not have the resources of a case manager or a financial counselor as do RHC-A and RHC-B, respectively. However, the RHC-C representative explains that their staff attempts to explain the purpose of Medicaid and the importance of applying for it in order to be able to enroll and receive the benefits. They, however, do not provide any further services in regards to Medicaid enrollment.

Haitian Domestic Health Assessments and Medicaid Enrollment

Haitian asylum applicants, as well as, asylees are eligible for DHAs and Medicaid benefits. However, low numbers of Haitians are obtaining DHAs and enrolling in Medicaid.

VOLAGs

VOLAG-2 was the only VOLAG with experience providing services to Haitians. The other two VOLAGs reported rarely providing services to Haitians. VOLAG-2 described the Medicaid application process as a prior issue for Haitians. Lack of computer skills was identified as the main barrier in getting them to complete their applications. However, once the VOLAG-2 office became equipped with computers, the staff was able to help the Haitians apply and the Medicaid application process was no longer an issue. Additionally, the VOLAG-2 representative believes having Haitian staff in their office, as well as, in the RHC has resulted in an environment of comfort and trust for the Haitian population. Due to this cultural connection, the Haitian applicant feels safe throughout the process and is willing to take part in what the staff suggests. Furthermore, this relationship allows for staff to help with cultural beliefs regarding the medical system. For example, some Haitians may not be particularly familiar with the medical system and may have cultural beliefs, as reported by the VOLAG-2 representative: “not washing hair for 30 days after having a baby.” The Haitian staff strives to share appropriate information to the incoming Haitian population and create an environment which facilitates the entire DHA process. Additionally, this VOLAG believes there are many Haitians who do not apply for asylum because they are well aware of the low success rate of being granted asylum from their community.

VOLAG-1 does not report serving Haitians in particular, however, they provide certain services to individuals granted asylum. These individuals are provided the same services as refugees, except they do not receive resettlement benefits. Even though VOLAG-1 provides services to individuals granted asylum, they are not certain how these asylees are directed to the VOLAG for services. The VOLAG-1 representative believes information is shared from individuals in the community who have previously received services and are now referring the new asylees to the VOLAGs. VOLAG-1, however, does not provide services to every person granted asylum who inquires about their services. At times, they turn some of these asylees away because there are limited resources which must be used for refugees, their primary responsibility in allocation of resources.

VOLAG-2 also provides services to some individuals granted asylum. They provide these services to the asylee as long as the asylee inquires about services within 31 days of asylum being granted. This VOLAG will provide services for 180 days and, if it is past the 31 day period, they will refer the asylee to other available community resources. The VOLAG-2 representative believes the asylees interested in services from the VOLAG are informed of these services by others in their community.

Due to the fact that VOLAG-3 only provides services to Cuban refugees, any asylee inquiring about services from them get referred to other community resources.

RHCs

RHC-A reported not serving many Haitians the past few years. RHC-B has experience providing health-related services to Haitians. They place telephone calls the day prior to the scheduled DHA to remind the patient of their appointment, review what the DHA entails, and provide directions to the clinic. Often times, patients call the clinic to speak with the “Creole-speaking nurse.” This nurse remains in contact with the patient and if they do not show up for their scheduled appointment, she calls them to reschedule. If needed, RHC-B encourages Haitians to apply for Medicaid by referring them to their in-house financial counselor. RHC-C reports serving a “handful of Haitians within the past few years.” However, they report awareness of the local Haitian population and attempt to reach out to them by placing ads on the local radio stations to encourage these Haitians to seek health care services at the clinic.

The lack of services reported, during the interviews, by RHC-A and RHC-C is consistent with the data from January 1, 2003, through December 31, 2006, from a previous report which illustrated that only two percent of all Haitian arrivals relocated to the region served by RHC-A and three percent of all Haitian arrivals relocated to the region served by RHC-B.⁸

None of the RHCs receive notification when an individual in their area has been granted asylum. This however does not prevent the RHCs from providing services to these individuals. Asylees are believed to be notified of services in the RHCs by the community and/or by the VOLAGs. A collective concern was expressed regarding the lack of information provided to asylees by the U.S. Citizenship and Immigration Services and the immigration courts that deal with the asylum granting process. The RHCs believe asylees are not provided enough information regarding the DHA, where to obtain an assessment, or who to contact.

Additional Information for Both Populations

All RHCs agreed transportation should not be a limiting factor in the DHA process. A refugee sponsored by a VOLAG should not miss any appointments due to lack of transportation because, according to the RHCs, that is the responsibility of the VOLAG.

RHC-A noted a particular practice used by certain VOLAGs which causes potential gaps in Medicaid coverage benefits. This practice involves VOLAGs utilizing their own address in a refugee’s Medicaid application. According to the RHC-A case manager, this causes Medicaid to select a primary care physician located near that VOLAG address which often times may be too far and may become troublesome for refugees to obtain timely health care. Additionally, the RHC-A case manager discussed clients who experienced gaps in Medicaid coverage of up to a month due to a change of address.

RHC-A and RHC-C described the need for in-house materials in multiple languages for clients to be better informed about benefits and the health care system. Additionally, RHC-C believes it would be helpful for them to send out reminders to the clients of their upcoming appointments with a letter describing what is expected in the domestic health assessment. According to RHC-C, some of their

⁸ Markiewicz, B., Baugh, K., Tutwiler, M., Vazquez, J. (2009). *Refugee Health Status and Health Care Utilization Report*. Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida. Prepared for the Bureau of Tuberculosis and Refugee Health, Florida Department of Health.

clients arrive at the clinic fasting when it is not necessary. The clinic believes it could be a cultural habit, but sending a reminder letter with an outline of what is expected should be enough to inform the clients that fasting is not required. The staff from RHC-C believe these letters will help the overall process; however, they do not currently have the staff available to dedicate the time needed to send out the reminder letters. Their clerk is currently tasked with taking preliminary measurements of all clients at the clinic, as well as, scheduling new appointments, answering the telephone, and following up with client questions.

Clients Served and RHC Staff

The Refugee Domestic Health Assessment Systems (RDHAS) data show a steady increase in the number of clients served by the RHCs interviewed. Table 6 represents the total number of clients served from 2003 through 2009. The RHC in Miami-Dade is included as an example due to their known efficient performance with large numbers of clients. All of the RHCs interviewed experienced a significant increase in the number of clients they serve from 2003 through 2009.

Table 6 – Number of Clients Served by RHCs

	2003	2004	2005	2006	2007	2008	2009
Miami-Dade	11937	17053	15466	17214	17920	17866	16442
RHC-A	235	549	487	400	628	767	1034
RHC-B	423	538	566	474	574	692	721
RHC-C	430	968	918	902	1055	1210	1287

Source: Refugee Domestic Health Assessment System

Table 7 represents the percent increase in the number of clients served between the years 2003 and 2009. RHC-A experienced an increase in clients more than 4 times the amount served in 2003. RHC-B experienced a smaller increase; however, at more than 1.5 times the number served in 2003, the increase is still significant. RHC-C’s clientele increased three-fold from that of 2003.

Table 7- Percent Increase in Clients Served

	2003	2009	Increase
Miami-Dade	11937	16442	138%
RHC-A	235	1034	440%
RHC-B	423	721	170%
RHC-C	430	1287	299%

Source: Refugee Domestic Health Assessment System

With this boost in clientele experienced by RHCs, it is important to analyze the number of staff on hand. These large increases among the three RHCs indicate a possible burden on the staff members in the respective clinics. It is important to note that RHC-B is open for service only 3 days per week. This was taken into account when calculating their respective FTE staff size. RHC-A hired a case manager in the first months of 2009, raising their FTE staff size to 3.5, and RHC-C hired an additional nurse toward the end of 2009, which sets their current FTE staff size to 3. The increase in clientele and lack of increased staff for the past six years created a major rise in the number of clients served per staff member. Table 8 represents the number of clients per FTE staff member and also the number of staff for the given year. This ratio increased dramatically for each of the

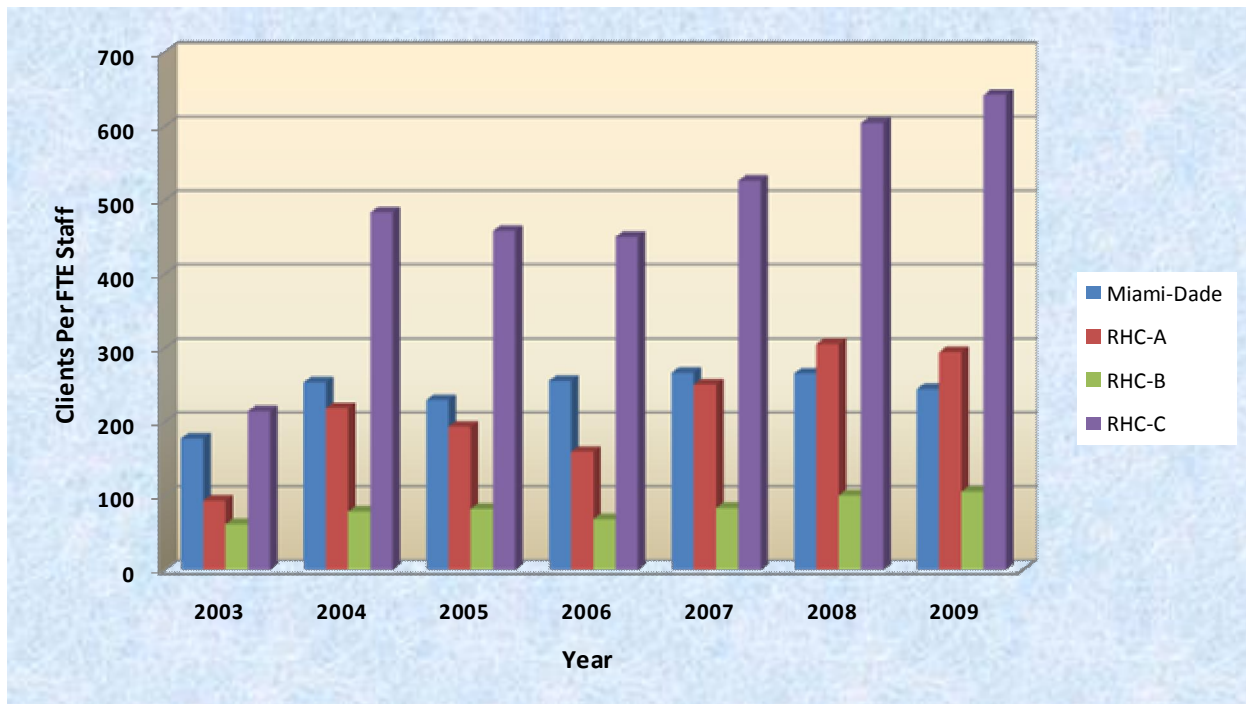
RHCs interviewed. RHC-A and RHC-C experienced ratio increases of over 300 percent, while RHC-B is approaching an increase of 200 percent. However, with the additional nurse recently staffed by RHC-C, their ratio should experience a decrease in 2010.

Table 8 – Client Per FTE Staff / FTE Staff Size

	2003	2004	2005	2006	2007	2008	2009
Miami-Dade	178 / 67	254 / 67	230 / 67	256 / 67	267 / 67	266 / 67	245 / 67
RHC-A	94 / 2.5	219 / 2.5	194 / 2.5	160 / 2.5	251 / 2.5	306 / 2.5	295 / 3.5
RHC-B	62 / 6.8	79 / 6.8	83 / 6.8	69 / 6.8	84 / 6.8	101 / 6.8	106 / 6.8
RHC-C	215 / 2	484 / 2	459 / 2	451 / 2	527 / 2	605 / 2	643 / 2

Chart 1 clearly demonstrates the increases in the client per staff ratio of the RHCs from 2003 through 2009. RHC-C has been heavily burdened by the increase in clients since 2003. The additional hiring of a nurse in late 2009 should alleviate some of the burden due to rise in number of clients.

Chart 1 – Clients Per FTE



Summary of VOLAGs and RHCs

Tables 9 and 10 provide a summary of specific VOLAG and RHC practices, respectively, gathered from the interviews.

Table 9 – Summary of VOLAG’s Activities

	Percent Enrolled in Medicaid	Percent with Assessment and Timely Assessments
VOLAGs with Good Outcomes	<ul style="list-style-type: none"> • Explanation of available health benefits during orientation • Division of \$425 into multiple checks • Matching of languages between caseworker and refugee • Staff with prior experience of the refugee process • Multi-lingual staff • Conduct orientation class after arrival settles • Begin application process early • Establish a relationship with a contact in the DCF • Knowledgeable of the existing resources in the local area • Establish a relationship with the resources of the local area 	<ul style="list-style-type: none"> • Begin required RHC paperwork as soon as arrival date is known • Have an appointment date set and given to the refugee at the end of the orientation class • Establish relationship with anchor family members • House refugees from similar backgrounds in the same areas • Be certain the refugee has transportation • Provide transportation or bus passes if needed • If appointments are missed, prompt communication and rescheduling with RHC • Motivate refugees to obtain DHAs by notifying them it is required for green card and residency • Utilize the walk-in appointments made available by the RHCs for the subsequent visits required for completion of DHA
VOLAGs with Poor Outcomes	<ul style="list-style-type: none"> • All VOLAGs performed well in terms of enrollment in Medicaid 	<ul style="list-style-type: none"> • DHAs are scheduled weeks and sometimes months after arrival date • Lack of staff at the local RHC might be responsible for the delayed appointment date

Table 10 – Summary of RHC’s Activities

	Percent Enrolled in Medicaid	Percent with Assessment and Timely Assessments
RHCs with Good Outcomes	<ul style="list-style-type: none"> Staffed with case managers who able to provide additional assistance Staff inquires about Medicaid during the visit Financial counselor provides assistance 	<ul style="list-style-type: none"> Establish relationship with local VOLAGs Participation in local VOLAGs’ monthly meetings Reminder telephone calls prior to appointment Review the DHA procedure with clients Provides direction to the clinic
RHCs with Poor Outcomes	<ul style="list-style-type: none"> No financial counselor on staff 	<ul style="list-style-type: none"> Reported not serving many Haitians Data shows very small percentages (2% for RHC-A and 3% RHC-C) of Haitians settle in these regions

Recommendations

The following recommendations stem from the interviews conducted with VOLAGs and RHCs. These recommendations should be considered for implementation in all county health department RHCs and should be shared with VOLAGs throughout the state.

Refugees

Issue: Low Percent of Medicaid Enrollment

All VOLAGs interviewed performed well in terms of ensuring their clients were enrolled in Medicaid. Overall, the data shows that the average VOLAG is performing this duty well.

Recommendations:

The good performance in refugee Medicaid enrollment by the VOLAGs interviewed, as well as, the average VOLAG, indicates enrollment in Medicaid for refugees sponsored by a VOLAG is not a concern.

Issue: Low Percent of Assessments Completed

A low percentage of assessments completed by refugees was seen in the performance of VOLAG-3. When compared to the other two VOLAGs interviewed, as well as the average VOLAG, VOLAG-3’s performance was significantly lower. Federal contractual obligations with the DOS require VOLAGs to ensure their clients are obtaining domestic health assessments.

Recommendations:

To increase the number of refugees obtaining DHAs, it is important for refugees to be housed with other refugees from similar backgrounds. This allows for more experienced refugees to share their

knowledge with newly arrived refugees. The VOLAG should inform the refugees that the DHA is required to obtain additional immigration documentation.

For those individuals with an anchor family, it is crucial for the VOLAG to establish a good relationship with the members of that family to ensure the refugee is being provided transportation to the clinic for their appointments. For those individuals sponsored solely by the VOLAG, the VOLAG needs to ensure transportation is available for the refugee on their appointment dates.

If appointments are missed, the VOLAG must promptly communicate with the local RHC to reschedule. Additionally, the VOLAG should utilize the walk-in appointments made available by the RHCs for the subsequent visits which may be required in order to properly complete the assessment. All RHCs should set a day for walk-in appointments. These walk-in appointment days would be beneficial for the VOLAGs in not only completing the assessment but doing so within the 30 day timeframe.

Completion of DHAs is dependent upon the cooperation between VOLAGs and RHCs. One agency's failure to perform its' duties might negatively impact the overall performance of the other agency. VOLAG-3's poor performance may be due to the large client to staff ratios of RHC-C, VOLAG-3's local refugee health clinic. An increase in the staff size of RHC-C may result in an improvement in performance for VOLAG-3. In late 2009, RHC-C hired an additional nurse to their staff. The impact of this addition to the RHC-C should be assessed to determine if VOLAG-3's performance improved.

Issue: Difficulty Completing Assessment within 30 Days

An additional stipulation in the contractual obligation with the DOS, is for VOLAGs to ensure their clients receive DHAs within 30 days of arrival. On average, VOLAG-3's clients are not receiving their DHAs within the preferred timeframe.

RHC-C's large client to staff ratios has hindered VOLAG-3's overall performance in ensuring their clients obtain the assessment within 30 days. The recent hiring of an additional nurse in late 2009 should provide the additional staff necessary to improve VOLAG-3's performance.

Recommendations:

VOLAGs are notified of a refugee's arrival date at least several days prior to entrance into country. As soon as the VOLAG receives notification of a refugee's arrival date, they should begin completing the required RHC paperwork needed for the assessment. As soon as the paperwork is complete, the VOLAG should submit all paperwork to the RHC and obtain a DHA appointment date. The refugee should be notified of their appointment date during the mandatory VOLAG orientation class which should be attended by the refugee a few days after arrival.

VOLAG-3 should be evaluated at a later date to determine the impact of RHC-C's recent staff increase. Overall, an analysis of all RHCs' client to staff ratios should be conducted throughout the state to ensure all RHCs have appropriate staff levels. Those RHCs with large ratios resulting in delayed appointment scheduling should hire the appropriate additional staff necessary for their respective needs. However, it will be necessary to determine the most efficient and appropriate staff ratios in order to properly conduct a statewide analysis.

Haitians

Issue: Low Percent of Enrollment in Medicaid

Haitians are eligible for Medicaid benefits as soon as they apply for asylum. Due to the fact that VOLAGs do not receive federal funding to provide services to asylees or asylum applicants, VOLAGs do not help these individuals in the application process. RHC-C performed worse than the average RHC, while RHC-A and RHC-B performed better than the average RHC in enrolling clients in Medicaid but there is much room for improvement.

Recommendations:

The addition of a case manager, as well as a financial counselor, to provide a detailed explanation of benefits and help with obstacles during the application process has resulted in good outcomes. Individuals without sponsorship from a VOLAG will benefit immensely from the help of a case manager or financial counselor at the clinic. They will, in a way, take the place of the VOLAG as a liaison to additional community resources and services.

It is important for the staff at the RHCs to be able to speak Creole and French in order to properly communicate with the Haitians. If there is no staff that can speak the Haitian's native tongue, translation services over the phone will need to be utilized. However, using these translation services has proven to be time-consuming and will decrease the overall efficiency of the clinic. If the RHC is providing services to many Haitians, it will be beneficial to hire an employee who can communicate effectively with the Haitians.

Other steps RHCs may consider to increase the number of Haitians enrolling in Medicaid are:

- Building a relationship with a DCF employee who can be promptly reached to resolve any Medicaid enrollment and eligibility issues.
- Staffing a DCF employee in the county health department, where the RHC is housed, with the authority to approve and deny Medicaid applications.
- Adding a case manager to RHC staff in part to facilitate Medicaid enrollment and utilization or, if hiring an additional staff member to function as a case manager is not feasible, train staff to inquire about current Medicaid status for clients without VOLAGS.
- Having a computer available in the RHC for clients without Medicaid so they may complete the online Medicaid application while in the office.
- Making information regarding Medicaid benefits and the DHA, in multiple languages, available in the clinics. This will be extremely beneficial for the lower staffed clinics where the employees may not have much one-on-one time with the clients.

Issue: Low Percent of Assessments Completed & Difficulty Completing Assessment within 30 Days

Haitians are also eligible for DHAs as soon as they apply for asylum, however, a very low number are actually receiving them. VOLAGs are not contractually obligated to help asylees or asylum applicants obtain assessments so it is up to the RHCs to ensure the DHAs are completed. RHC-B performed better than the average RHC, while RHC-A and RHC-C performed worse.

The DOS has set a 30 day preferable timeframe for the provision of a domestic health assessment. This timeframe is crucial to the health of the arrivals and the rest of the community. On average, none of the RHCs interviewed performed within the 30 day timeframe.

Recommendations:

Increasing the number of Haitians who receive DHAs could be facilitated by coordinating efforts with USCIS and DOJ to provide a handout in an appropriate language with information pertaining to the DHA with the notification granting asylum. On this notification it should be stated that the asylee is eligible for a free DHA and that it must be completed in order to obtain additional documentation.

However, waiting until asylum has been granted may take considerable time so it may be beneficial to contact these individuals as soon as they submit their asylum applications. Since Haitians are eligible for the DHA as soon as they apply for asylum, the RHC needs to reach out to this population during that time. Waiting until asylum has been granted can create obstacles to healthcare access, such as employment, which has traditionally inhibited arrivals from obtaining DHAs because the individuals do not want to miss work.

All RHCs should provide a day where walk-in appointments are made. These walk-in days would be beneficial for asylees and asylum applicants because these individuals are likely to have been in the country for some time and employed. A walk-in appointment will allow these individuals to fit the assessment into their schedules.

In order to locate Haitian asylum applicants and asylees, the RHCs should conduct outreach events that will attract the population. The RHC staff should be aware of any local Haitian heritage festivals and contact those individuals and/or organizations in charge of the event for permission in setting up a table with information on the DHA and Medicaid benefits.

Once the population is reached and made aware of the DHAs, appointments should be made and followed by reminder phone calls before the assessment date. A reminder letter may be sent out with the appointment date, as well as, information regarding the DHA process and tips for the clients, such as fasting is not required.

Appendix A

Refugee Health Status and Health Care Utilization Project Interview Questions

Name:

Organization:

Position:

Interview Date:

We are from the Lawton and Rhea Chiles Center under contract with the Florida Department of Health Refugee Health Program. The purpose of this interview is to determine and establish best practice guidelines to reduce barriers to health care access so more arrivals enroll in Medicaid and seek domestic health assessments. The information gathered from this interview will be used to develop a best practices implementation guide for use across the state by providers.

Volags

Introductory Questions

1. What health services are you responsible for providing to new arrivals?
2. What are your organization's goals when it comes to providing health services to arrivals?
3. How and when do you explain the health benefits available to arrivals?

Refugees – Domestic Health Assessments

4. How long after a person arrives do you wait to schedule a domestic health assessment?
5. What steps do you take to ensure that a domestic health assessment is completed?
6. Do you make a domestic health assessment appointment for the arrival or do you just give them the information and let them do it themselves?
7. What is your procedure when it comes to getting an arrival a domestic health assessment?
8. Do you provide incentives to get the arrivals to get a domestic health assessment?
9. Do you see a difference between the different nationalities for domestic health assessments?
10. Do you provide transportation to the domestic health assessment?

11. Do you tell the arrivals that the domestic health assessment is free?
12. Are you notified if an arrival failed to get a domestic health assessment after making an appointment?
13. What is done if you know about the missed appointment?
14. Do you explain what a domestic health assessment entails?
15. Are all domestic health assessments scheduled or are there walk-in appointments?

How does that work?

16. What if an arrival misses his/her scheduled appointment? What do you do to ensure the domestic health assessment occurs?
17. How do you ensure they attend the appointment?

Refugees – Medicaid Enrollment

18. Do you assist arrivals to apply for Medicaid?
19. How long after arrival do you begin the application process for Medicaid with the arrival?
20. What is done if the arrival is denied Medicaid?
21. How do you encourage arrivals to apply for Medicaid?

Haitians – Domestic Health Assessments

22. How do you encourage Haitians to get their domestic health assessments?
23. What is the process you have in place for Haitians to get domestic health assessments?

Haitians – Medicaid Enrollment

24. How do you encourage Haitians to apply for Medicaid?
25. What is the process you have in place for Haitians to apply?

Closing Questions

26. Do you provide services to people who have been granted asylum?
If so, how do asylees find out about your services?

27. What is done about language and cultural obstacles to facilitate an arrival's understanding of medical benefits?
28. What kinds of help would be useful to get arrivals in for domestic health assessments and enrolled in Medicaid?
29. In an ideal world, how would the process for obtaining domestic health assessments and enrolling arrivals in Medicaid work?
30. How many staff members work directly with arrivals?
31. How many arrivals do you serve in a year?

Appendix B

Refugee Health Status and Health Care Utilization Project Interview Questions

Name:

Organization:

Position:

Interview Date:

We are from the Lawton and Rhea Chiles Center under contract with the Florida Department of Health Refugee Health Program. The purpose of this interview is to determine and establish best practice guidelines to reduce barriers to health care access so more arrivals enroll in Medicaid and seek domestic health assessments. The information gathered from this interview will be used to develop a best practices implementation guide for use across the state by providers.

County Health Departments

Introductory Questions

1. What services are you responsible for providing to new arrivals?
2. What are your organization's goals when it comes to providing health services to arrivals?
3. How do you explain the health benefits available to arrivals?
4. Do you distinguish between refugees and asylees? (Provide different services or information)
5. What is your relationship with VOLAGS? How do you communicate?

Refugees – Domestic Health Assessments

6. How long after a person arrives do you usually conduct a domestic health assessment?
7. What steps do you take to ensure that a domestic health assessment is completed?
8. Do you provide incentives to get the arrival to get a domestic health assessment?
9. Are all domestic health assessments scheduled or do you offer walk-in appointments?

How does that work?

10. What if an arrival misses his/her scheduled appointment? What do you do to ensure the domestic health assessment occurs?

11. Do you do anything different for arrivals that are sponsored by VOLAGs as opposed to unsponsored arrivals?

Refugees – Medicaid Enrollment

12. Do you assist arrivals in applying for Medicaid?

13. If so, how long after arrival do you begin the application process for Medicaid with the arrival?

14. What is done if the arrival is denied Medicaid?

15. How do you encourage arrivals to apply for Medicaid?

Haitians – Domestic Health Assessments

16. How do you encourage Haitians to get their domestic health assessments?

17. What is the process you have in place for Haitians to get assessments?

Haitians – Medicaid Enrollment

18. How do you encourage Haitians to apply for Medicaid?

19. What is the process you have in place for Haitians to apply?

Closing Questions

20. Do you receive notification of arrivals that are not sponsored by a VOLAG? Who do you receive notification from?

21. Are you notified when asylum applicants have been granted asylum?

If, so what is done after notification?

22. How do asylees find out about the availability of refugee health services?

23. Are you notified of Cuban and Haitian asylum applicants?

24. What is done about language and cultural obstacles to facilitate an arrival's understanding of medical benefits?

25. Are there communication issues between providers and arrivals?

26. How many staff members work directly with arrivals?

27. How many arrivals do you serve in a year?

28. What kinds of help would be useful to get arrivals in for domestic health assessments and enrolled in Medicaid?

29. In an ideal world, how would the processes for domestic health assessments and Medicaid enrollment work?