A Private-Sector Preferred Provider Network Model for Public Health Screening of Newly Resettled Refugees

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US law and regulations stipulate a process for the health screening of refugees. The responsibility of caring for refugees resettled in the United States rests, in part, with public health or welfare departments. Massachusetts has met its screening responsibilities through the innovative creation of a network of private preferred providers.

We explore the Massachusetts model of public–private collaboration within the context of federal refugee health priorities and current state fiscal restraints affecting public health programs, and demonstrate the model's accomplishments. (*Am J Public Health*. 2005;95:196–199. doi: 10.2105/AJPH.2004.040311)

Over the past decade, approximately 70 000 refugees have resettled in the United States each year. US federal regulations stipulate a process for the health screening of refugees shortly after they arrive in the country. Responsibility for this screening rests in part with public health or welfare departments. This screening is usually the first contact of newly arrived refugees with the US health care system and provides an important opportunity for promptly addressing the unmet health needs of refugees, educating refugees about the US health care system, and facilitating a transition into primary care.

In most states, refugee health screening is performed at state or county public health clinics. By contrast, Massachusetts has met its screening responsibilities by creating a network of private preferred providers. We discuss the Massachusetts model for refugee health screening within the context of federal refugee health priorities and current state fiscal restraints affecting public health programs, and we demonstrate the model's accomplishments.

A refugee is a person who has crossed an international border owing to a well-founded fear of persecution.[1] In this report, "refugees" will be defined as those eligible for federally funded refugee health screening, including refugees, recipients of political asylum, and Cuban and Haitian entrants. During state fiscal years 1999 through 2001, over 7000 refugees resettled in Massachusetts from over 40 different countries (Table 1).

OVERVIEW OF CURRENT REFUGEE HEALTH SCREENING PRACTICES

Refugees are required to undergo an overseas health screening. Because refugees often have unmet health needs and come from situations of poor hygienic conditions with endemic infectious diseases, US regulations permit and fund a second, domestic screening to eliminate health-related barriers to successful resettlement while protecting the health of the public. Departments of health or public health usually run these screenings; however, the breadth of clinical services and laboratory testing that are provided varies considerably among states.

FUNDING OF REFUGEE HEALTH SCREENING SERVICES

The organization of and payment for refugee health screening services may influence their content and delivery. Funding

KEY FINDINGS

- Public health authorities can successfully implement public–private partnerships using a preferred provider network model for conducting refugee health screening.
- Health screening using this model can integrate federal funding streams to reduce barriers to care for refugees.
- Consolidation of clinical screening into selected sites enhances caregivers' knowledge of refugee health issues and promotes better quality and consistency of care.
- The use of a limited network of preferred providers facilitates program evaluation and monitoring for the changing health needs of refugees.

TABLE 1—Demographics of Refugees Resettled in Massachusetts July 1998–June 2001 Eligible for the Refugee Health Assessment Program

Region and Country of Origin[a]	n	% Male	% Aged < 18 y
Africa			
Burundi	15	40	60
Congo/Zaire	49	51	55
Ethiopia	44	55	43
Liberia	232	54	55
Nigeria	10	70	30
Rwanda	11	55	64
Sierra Leone	105	46	45
Somalia	456	52	41
Sudan	268	75	39
Americas			
Cuba	134	54	26
El Salvador	11	36	73
Haiti	156	47	30
East Asia			
Cambodia	62	48	58
China	54	52	56
Myanmar (Burma)	15	67	20
Vietnam	614	52	28
Europe and Central Asia			
Former USSR	2682	48	33
Former Yugoslavia (including Kosovo)	1703	53	38
Near East and South Asia			
Afghanistan	166	43	56
Iran	59	61	17
Iraq (including Kurds)	103	53	45
Total	7008	51	37

[a]Countries with fewer than 10 refugees resettled in Massachusetts include the following: Africa Region—Algeria, Burkina Faso, Ghana, Mauritania, Senegal, Togo; Americas Region—Brazil, Colombia, Guatemala, Honduras; Europe and Central Asia Region—Albania, Romania; Near East and South Asia Region—Bangladesh, India, Pakistan.

may come from several sources: Refugee Medical Assistance (RMA, via the US Office of Refugee Resettlement [ORR]), Medicaid, preventive health grants from ORR, and state or local government funds. RMA is normally used as a funding stream to provide Medicaid coverage for refugees who are not eligible for Medicaid under typical criteria used by states. ORR regulations allow states with an approved screening plan to use RMA funds to pay for refugee health screening for all refugees provided that the screening is initiated within 90 days after arrival. Otherwise, states must rely on Medicaid reimbursement (with funding streams from either Medicaid or RMA) directly to medical providers who perform refugee health screening services. In such cases, the scope of refugee health screening services depends on the state's Medicaid plan, and entry to care depends on the refugee's receipt of Medicaid coverage.

Most states use county and local public health clinics to provide refugee health screening services. Others fund private health clinics in areas where refugees are concentrated, or they rely on private physicians who accept Medicaid to perform screenings without guidance or standard requirements. Reflecting the economic recession, state and federal budget cuts in recent years have had a negative impact on states' ability to maintain public health program infrastructures for clinical programs such as refugee health screening.

THE MASSACHUSETTS EXPERIENCE

The Massachusetts experience demonstrates how a state can creatively combine various health priorities and funding streams into a coordinated program tailored to the state's infrastructure. In 1987, the Refugee and Immigrant Health Program of the Massachusetts Department of Public Health developed formal recommendations for refugee screenings. Unlike most other states, Massachusetts does not have county or local public health clinics. Therefore, screening depended on the cooperation of private practitioners, health centers, and other clinics and their willingness to screen refugees with Medicaid coverage still pending. As a result, public health authorities could not control timeliness, consistency, physician knowledge of refugees, or the quality of the screening. Lag times between the refugee's arrival and receipt of Medicaid coverage often resulted in delays of several weeks or months before screening was implemented, if it was at all.

In 1995, with approval by ORR, the Massachusetts Department of Public Health established a unique competitive procurement process to develop a network of private clinics, mostly federally qualified community health centers, specially qualified for screening refugees—a "preferred provider network" called the Refugee Health Assessment Program (RHAP). No other state with significant resettlement has relied exclusively on such a contract-based network. RMA-funded payment to RHAP providers is determined by state Medicaid rates for each Current Procedural Terminology code for the various components of the clinical encounters (billing codes for the evaluation and management complexity level of the office visit, visual acuity testing, laboratory tests, etc.). Because it is bundled per capita, the reimbursement rate paid to the clinics conveys the requirement of complete implementation of RHAP protocols.

Recent refugees come from an increasingly diverse array of countries (Table 1). The RHAP network has ensured delivery of culturally and linguistically appropriate care and facilitated the development of specialized programs to meet changing refugee health needs. Examples include a refugee oral health project and coordinated services for HIV-positive refugees. An example of multilingual/multicultural patient information in Bosnian is shown in Figure 1.

DISCUSSION AND EVALUATION

The Massachusetts model facilitates prompt screening with standardization and improved quality of care. In addition to basic screening, the program allows rapid implementation of

specialized protocols to meet specific refugee health needs. By concentrating refugee health screening in contracted clinics, providers and staff develop clinical expertise in refugee health issues and adapt more easily to increasingly diverse refugee populations and their language needs. The RHAP has also promoted the dissemination of this knowledge to other medical practitioners and the public through the publication of clinical research and program screening data (box page 198).

The contractual preferred provider system has improved completion of screening and, most importantly, facilitated transition to primary care. In Massachusetts fiscal year 1995, 31% of eligible refugees completed screening; the rate increased to 83% in fiscal year 1997. Since fiscal year 1998, 90% overall have completed screening. In fiscal year 2003, 91% of eligible refugees had screening, including 94% of those identified overseas as needing medical follow-up after arrival in the United States. On average, the screening for all eligible refugees was initiated within 19 days after arrival. In addition, over 99% of those completing the screening did so within the federally mandated 90 days after arrival in the United States. These rates compare favorably with those of other states during the same period.[8–10]

Initiating primary care is a critical component of RHAP; however, comparative data are limited. It is likely that few refugees promptly initiated primary care before the implementation of RHAP. While a number of factors influence the transition to primary care and other medical follow-up health screening,[11,12] RHAP's efforts to train their contracted clinicians as primary care providers for refugees have played a significant role. Continuing medical education activities for RHAP clinicians, and contract monitoring with clinical feedback by RHAP, have helped heighten awareness of refugee health issues among contracted primary care providers. Similarly, the combined clinical experiences of specific providers performing refugee health screenings have increased their ability to diagnose and manage refugees' health problems. The result is that most refugees have opted to continue with RHAP providers. By using likely primary care clinics for refuge health screening, RHAP provides a seamless transition into primary care for most refugees.

ENHANCING KNOWLEDGE OF REFUGEE HEALTH

The following published research by RHAP clinicians has increased knowledge of the health status of more recently arrived refugee populations:

- Pilot screening of Vietnamese refugees to understand psychosocial risk factors.[2] The study highlighted the importance of issues like depression and substance abuse that fall beyond the traditional focus on infectious diseases.
- Investigation of the extent of exposure to war violence and psychological trauma among Bosnian children.[3] The study also demonstrated that although RHAP offered an opportunity to identify psychosocial problems, it was not an opportune time to intervene.
- Study of seroprevalences of protective antibody titers against measles, rubella, and varicella among refugees.[4] Using this evidence, RHAP phased in serological testing to reduce costs associated with unnecessary vaccinations and visits necessary for meeting school and immigration immunization requirements.
- Description of growth status and related medical conditions among newly arrived refugee children.[5]
- Description of the extent of lead poisoning among recently arrived refugee children.[6] The study also highlighted the increased risk of refugee children acquiring lead poisoning in the United States.
- Description of prevalences of intestinal parasites among African refugees, both adult and child.[7] The study also evaluated the impact of a an overseas predeparture, antiparasitic treatment program for African refugees implemented by the Centers for Disease Control and Prevention.

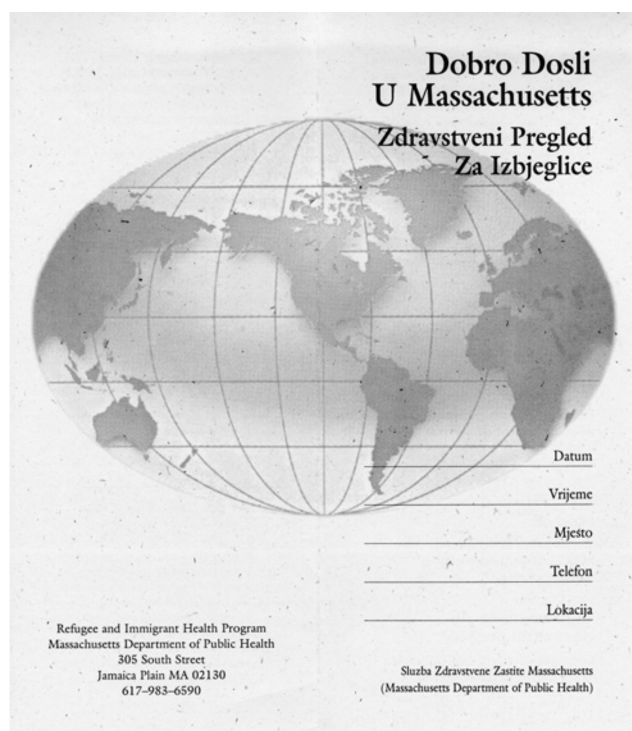

FIGURE 1—Bosnian version of the patient information brochure *Welcome to Massachusetts: Your Refugee Health Assessment*.

NEXT STEPS

As refugee backgrounds and needs change, health screening programs must adapt and adopt positive elements of managed care such as provider networks. Since September 11, 2001, after which the numbers of overseas refugees declined, refugee health programs have been screening larger numbers of political asylum recipients and other special visa holders who have very different origins from refugee popu-

lations that have been well-studied. Programs must actively assess the health needs of newer or emerging populations that previously were not represented sizably among refugees entering the United States. In doing so, programs must compare these needs to those of past refugee populations on which refugee health screening guidelines often were based. The use of a limited provider network facilitates program evaluation and monitoring for changing needs.

In the context of the increasingly complex structure of health care delivery combined with government budgetary restraints imposed by the poor economy in recent years, use of public–private models can help streamline and standardize health screening services. Preferred provider networks would allow rapid implementation of health screening with smooth transition into primary care. Lastly, use of RMA funding through a stable and well-developed reimbursement mechanism reduces delays in implementing screening due to reimbursement uncertainty, thus facilitating a healthier start to refugees' new lives in the United States. ■

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Contributors

Both authors jointly conceived of, drafted, and edited this report.

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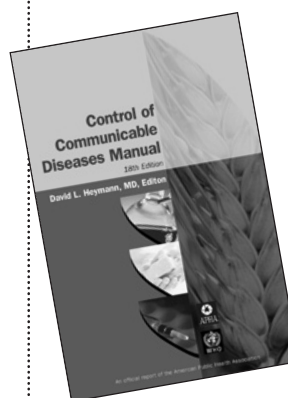

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