Executive Summary:

- Since 2000, Canada has resettled approximately 11,000 refugees per year, representing 10 to 15 percent of all foreign-born people entering the country each year (McKeary & Newbold, 2010).

- Despite a higher number of diagnoses, refugees in Canada have been shown to have fewer medical consultations than host populations in a number of countries studied (O’Donnell et al., 2010).

- Refugee clients may experience challenges booking appointments, attending appointments on time, following management and referral advice, all of which create challenges accessing care in community family practices (Cheng & Smith, 2012).

- The fee-for-service system creates financial disincentives for family physicians in community practices for accepting refugee clients into their practices. This can reinforce diminished access to health care for refugees (Russell, Harris, Cheng, et al., 2013).

- The Primary Care Amplification Model offers to enhance the delivery of refugee health care in the primary care setting by working to amplify the strengths of primary care practices to enhance capacity to meet the specific health needs of refugee clients in primary care (Kay, Jackson & Nicholson, 2010).

Overview

This literature review and jurisdictional scan provides a summary of the limited research literature on processes for refugee clinics in Canada and internationally to transition clients into family practices in the community, to support development of the transitional model for the Refugee Health Clinic, Central Zone, Nova Scotia Health Authority.

This literature review highlights:

- Specific health needs of refugees
- Challenges to transitioning refugees into community-based primary care practices
- Challenges to working with refugees in community-based primary care practices
- Primary Care Amplification Model
- Enablers of transitioning refugee clients into community family practices
- Working with interpretation services in refugee clinics and community family practices

This review includes peer-reviewed articles, systematic reviews and grey literature. A literature search was performed using the following databases: Pubmed, CINAHL, Google Scholar, and Google. A combination of the following key terms was used: refugee health, refugee clinic, primary care, transition processes, family physician, Primary Care Amplification Model.
Background

The United Nations defines a refugee as a 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 unable or, owing to such fear, is unwilling to avail himself of the protection of that country (Heerman & Wills, 2011). The United Nations High Commission for Refugees (UNHCR) reports that over 40 million people worldwide have been displaced as a result of violence and persecution, of which many have sought refuge and resettled in foreign countries, including Canada (Sheikh & MacIntyre, 2009). Many refugees come from areas of political unrest and armed conflict and have thus experienced war, trauma, torture, and uncertainty about their family and friends (O’Donnell, Higgins, Chauhan, & Mullen, 2007).

Since 2000, Canada has resettled approximately 11,000 refugees per year, representing 10 to 15 percent of all foreign-born people entering the country each year. Canada has broadened its protection to include people who face returning to torture or risk to life, and has recognized that individuals can be persecuted on the basis of gender and sexual orientation (McKeary & Newbold, 2010).

In 2011, 27,872 refugees arrived in Canada; a quarter of them were government-assisted refugees. With the enactment into law of the Immigration and Refugee Protection Act (IRPA) in 2002, priority is given to refugees whose vulnerability and need for protection is greatest, therefore government-assisted refugees arrive in Canada with less social capital. It is generally acknowledged that refugees have greater health needs than most immigrant arrivals, with needs that are partly shaped by the refugee experience and the resettlement process (McKeary & Newbold, 2010). Government-assisted refugees resettling in Canada are thus expected to experience integration challenges due to complex physical and mental health care needs (McKeary & Newbold, 2010). Health care providers are challenged significantly by the lack of continuity of care in refugees’ health experiences (O’Donnell et al., 2007).

In Canada and other Commonwealth countries, people of refugee background are recognized as one of the most disadvantaged population groups. Refugees tend to be a vulnerable population, since they have not voluntarily chosen to leave their country of origin, often arriving in their resettlement country at short notice, via other countries or from refugee camps (McKeary & Newbold, 2010). Refugees may also be separated from family members at the time of resettlement, have experienced torture, and have lost material possessions, wealth, and status. Refugees therefore, tend to have poorer health status than other groups of immigrants (for example, economic immigrants). A significantly greater proportion of refugees studied in Canada and internationally report physical, emotional, or dental problems than the overall population, including higher rates of TB infection, undiagnosed psychiatric problems and higher proportions of psychological illness, diabetes, maternal child health concerns, and infectious diseases (Bhatia & Wallace, 2007; Heerman & Renzaho, 2014; McKeary & Newbold, 2010). Lawrence and Kears (2005) reported that challenges for the refugee population include not only access to care, but also that many refugees encounter challenges understanding the local health care system, feel uncomfortable with the lack of culturally competent care, and feel unable to navigate the system in order to meet their needs.

It is well established that Canada’s refugee population experiences significant health disparities, both relative to other immigrant groups, as well as to the native-born
population, however refugees remain an under-researched population (McKeary & Newbold, 2010). Despite the significance of Canada’s refugee program, detailed information on the refugee experience within the Canadian health care system is notably missing in the literature (McKeary & Newbold, 2010).

**Specific Health Needs of Refugees**

Refugees have a number of complex physical and mental health problems related to experiences, including persecution, trauma, deprivation, environmental conditions, and poor access to health care. Studies utilizing both patient- and physician-reported data consistently demonstrate that refugees and have a high prevalence of one or more medical conditions, and where a comparison group is available, this is significantly greater than local general populations in countries of resettlement (Cheng, Drillich, & Schattner, 2015). Some specific health needs of refugees arriving in Canada include, but are not limited to:

- a higher prevalence of mental health conditions, specifically anxiety, depression, and post-traumatic stress
- infectious diseases including hepatitis B and C, intestinal parasites, malaria, syphilis, varicella
- nutritional deficiencies
- under-immunization
- obstetric complications
- musculoskeletal conditions
- poor dental and optical health
- poorly managed chronic disease
- delayed growth and development in children
- immunization needs including measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, and Hib disease
- physical consequences of torture
- disability

(Swenkels, Pottie, Tugwell, et al., 2011; Spike, Smith, & Harris, 2011; Harris et al., 2013; Cheng & Smith, 2012).

Some refugee women have significant gynecological health needs and may have undergone genital mutilation or experienced sexual assault (Cheng & Smith, 2012). Although infectious disease continues to be a significant issue for refugees, mental health and chronic diseases have emerged as areas of concern in the care of recently arriving immigrants and refugees (Swinkels et al., 2011). Cross-sectional studies correlating demographic risk factors, albeit limited, indicate that female gender, history of experiencing violent conflict or pre-migration trauma, and a lengthy asylum process are associated with poorer health outcomes (Cheng, Drillich, & Schattner, 2015).

Refugees are more likely to have increased morbidity, poor health habits, and a decreased life expectancy than the general population and compared to other immigrant populations (Joshi et al., 2013). Many refugees come from regions where access to health care is limited, and thus may have multiple complex health care needs attributed to inequities in the social determinants of health, experiences of persecution, torture, unhealthy environmental conditions, and disrupted access to health care (Harris et al., 2013; Swinkels et al., 2011). Refugees require care to address unique health needs on arrival as well as ongoing comprehensive, continuous primary health care. For example, refugees who have experienced torture not only need health care for the sequelae (psychological and physical) of the torture, they also require access to comprehensive medical care to address infectious diseases, medical problems that may have never been addressed or have been neglected during their time in flight, and preventive medicine (Tamblyn, Calderon, Combs, & O’Brien, 2010).
The process of settlement in a foreign country can be a source of ongoing hardship (Cheng & Smith, 2012). In addition to concerns related to accessing health care, refugees may also require access to employment services, shelter, and specialized health services including mental health services, which makes refugees a more vulnerable population facing multiple health risks (McKeary & Newbold, 2010). Health status may be impacted by acculturative stress, and may be further impacted by prioritizing other settlement needs, such as settling children into school and earning an income, ahead of health needs, which can exacerbate health problems (Kay, Jackson, & Nicholson, 2010; Victoria State Government, 2012; Cheng & Smith, 2012). Limited local language proficiency can have a significant impact on health status, and on the quality and accessibility of care. It also influences access to the resources required for health, such as education, employment, and social support (Joshi et al., 2013).

Recently resettled refugees may find themselves without any established community of people from their culture in resettlement communities, which can lead to fear, discomfort, and isolation. Some refugees, including women and ethnic groups without communities of other people from their culture in their resettlement communities, are particularly vulnerable. Social isolation and access to health care facilities is frequently complicated by transportation challenges. Research indicates that refugees who experience social isolation in their resettlement communities experience higher morbidity and mortality compared to refugees who have stronger social connections in resettlement communities (Cheng, Drillich, & Schattner, 2015). Established communities within resettlement communities can assist recently arrived refugees by sharing knowledge of available services, facilities, and processes, as well as advocating and explaining complex access or eligibility rules (McKeary & Newbold, 2010). While there are many successful programs that encourage social interaction through religious groups, settlement agencies, and community centres, isolation can be compounded by transportation availability, gender, and age. Bhatia and Wallace (2007) found that refugees without support from friends, family, and refugee agencies may have the most difficulty accessing primary care because of language difficulties and lack of knowledge regarding documentation required.

Studies have shown that active outreach, education, and health promotion can increase utilization of healthcare services by refugees. However, there is little data in the literature on the effectiveness of health promotion in improving access to care (Cheng, Drillich, & Schattner, 2015; Sheikh & MacIntyre, 2009).

The healthcare needs of refugees in countries of resettlement have been found to be greatest within six months of settlement, with the biggest challenges being in the primary care setting (Gould, Viney, Greenwood, et al., 2010). On arrival in Canada, refugees face long waits to get connected to a family practice, and significant barriers to accessing health services, which can compound their situation, and exacerbate health issues and contribute to marginalization (Swinkels et al., 2011).

Timely access to comprehensive, continuous primary health care is an essential foundation for successful integration and settlement for refugees (Russell, Harris, Cheng, et al., 2013). Good physical and mental health is essential for refugees to deal effectively with the challenges of resettling in a new country and participating fully in the economic, social, and cultural life in their new communities, and provides a stronger basis for refugees to adapt and thrive in their country of resettlement (Joshi et al., 2013; Russell, Harris, Cheng, et al., 2013).
Research has identified significant gaps in transitioning of clients and their health information between health services and also between health and non-health services (Russell, Harris, Cheng, et al., 2013). Primary care is considered a gateway to the healthcare system in many countries, yet in Canada the sector has experienced a persistent shortage of providers in certain geographies. This has resulted in a growing number of unattached or “orphaned patients” who are unable to find a primary care practitioner to coordinate their care. Many cities in Canada experience shortages of providers are considered “under-serviced,” and it is into this milieu that newly arrived refugees are resettled (Fowler, 1998). Work is required to plan processes for integrating refugees into existing mainstream services with the same rights to high-quality care as all other Canadians (Feldman, 2006).

Challenges to transitioning refugees into primary care

Refugees resettling in Canada typically receive written information about the local health system and how to register with a local family practice on arrival (Joshi et al., 2013). Refugees typically also meet with a refugee health professional for a health status check and review of immunizations. Research has reported variation in services provided by health professionals on entry to Canada for resettlement (O’Donnell et al., 2007). After arrival in a resettlement country, even if there is an early intervention service to provide a health assessment, most routine health care for refugees continues to be delivered in the primary health care setting. Research has shown that written materials on health and the health system given to refugees on arrival were not used as a source of information when required later (Joshi et al., 2013).

The time-sensitive health needs of refugees require an integrated community-based primary health care intervention that includes support for navigating the local health system, culturally appropriate care and successful integration (Nicholson, 2013). To support connecting refugees with longer-term primary care, transitional refugee health clinics have been established. Research has shown that refugee clinics have a significant impact on refugee health. By enabling longer visits with health professionals who are trained to work with refugees, and providing interpreter services, refugee health clinics can eliminate barriers and challenges refugees commonly face accessing health services in their resettlement communities. Refugee health clinics help ensure that refugee patients and families understand health information and the local health system, and can engage in full partnership in decision making in their health care (Balachandra et al., 2009). Referrals to non-physician health care providers were shown to nearly double following availability of a refugee clinic (Russell, Harris, Cheng, et al., 2013). Wait times to see a health provider were shown to decrease by 30% with the introduction of a dedicated refugee health clinic (Russell, Harris, Cheng, et al., 2013). The likelihood of refugees being referred to physician specialists decreased by 45%, but those referred to specialists were shown to be the patients who were more likely to require multiple referrals due to complex medical needs (Kay, 2011).

Challenges to transitioning refugees into primary care: Physician-centered challenges

Bischoff et al. (2003) found that despite a higher number of diagnoses, refugees had fewer medical consultations, shorter duration of care, and lower costs than the host population in resettlement communities, suggesting that they face significant barriers to accessing care in their new communities. These findings conflict with research reported by O’Donnell et al. (2010), which concluded that refugees had more frequent consultations and higher costs.
The contradictory findings may be a result of different study methodologies and costing models, but nevertheless highlight differences in examining healthcare consumption of refugees (O’Donnell et al., 2010).

Refugee clients may experience challenges booking appointments, attending appointments on time, and following management and referral advice, all of which create further challenges in accessing ongoing care in community family practices (Cheng & Smith, 2012). Lack of family physicians in community practices willing to accept new clients means that refugee clients may visit a number of providers including community health centres, emergency departments, or walk-in clinics, requiring each provider to individually reconstruct health histories in the short consultation window and resulting in disjointed care and duplication of service (McKeary & Newbold, 2010). These issues, combined with the language barriers, time constraints, and lack of cultural competency from providers, can result in a reluctance to “share” one’s personal history for fear of the impact on a refugee claim (McKeary & Newbold, 2010).

The fee-for-service system creates financial disincentives for family physicians in community practices for accepting refugee clients into their practices, for example, longer appointment times needed by refugees. This can reinforce diminished access to health care for refugees (Russell, Harris, Cheng, et al., 2013). Staff in community family practices face significant challenges providing quality care for refugees when there is limited support available to inform care delivery (Gould et al., 2010). Re-location of refugees away from points of arrival has been associated with increased rates of temporary registration in community family practices, which can remove some financial incentives for family physicians accepting refugee patients, such as incentives for performing longer-term interventions, immunization and cervical smear tests with this population (Bhatia & Wallace, 2007). Other barriers to follow-up in community family practices were identified by Alarcon (2014), including health literacy, accessibility, transportation, lack of culturally competent providers, and issues with healthcare insurance coverage.

Clinical appointments with refugee patients who have limited local language proficiency may require additional time to accommodate interpretation services, and to ensure information provided is accessible and understandable (McKeary & Newbold, 2010). Interim Federal Health Program (IFH) coverage for interpretation services is limited in Canada. Interpretation requirements beyond the amount provided by IFH is not covered by the provincial health system, and the responsibility for paying for the service is placed on the individual or family practice. Although the need for interpretation is great, McKeary and Newbold (2010) reported that most community family practices do not consider it their responsibility to provide interpretation services to make their practices accessible to refugee patients who cannot afford interpreter services. Language barriers prevent community family physicians from understanding patients’ needs, which can lead to decreased symptom reporting, and fewer appropriate referrals for specialized care (Bjatie & Wallace, 2007).

Harris (2015) reported that some private clinics considered refugees “bad for business”, particularly in view of the additional time resources required to address their unique health needs within the fee-for-service structure. Lack of consistent professional interpreter services that follow a client through the system may mean refugees need to re-tell their story via multiple interpreters, using valuable clinical time, and increasing the potential for compromising confidentiality (McKeary & Newbold, 2010). Practitioners also reported greater administrative requirements for refugee patients in community
practices, such as appointment reminders, follow-ups, and translation support, especially for patients who are new to the country and new to the practice. Community family physicians report increased pressure of work resulting from patients who are not proficient in the local language and who have multiple complex health problems, with health representing only one part of their social needs. Community family physicians and other health professionals in the community are often unsure about refugees’ coverage for health services, how to deal with refugees’ mental health problems, and where to make appropriate referrals for refugee patients (Harris, 2015).

Few health care providers are formally trained to identify and work with the specific health needs of refugees. Refugees are perceived by some community family physicians to have multiple complex health needs that are beyond the scope of family practice, and consequently some refuse refugees registration (Bhatia & Wallace, 2007; Gould et al., 2010). McKeary and Newbold (2010) also reported that some doctors, pharmacies, and dentists were not willing to accept clients who had IFH health coverage. McKeary and Newbold (2010) reported that many community family physicians do not wish to deal with the bureaucracy, payment delays, pre-approval process for some services, and lower financial compensation, and therefore do not accept refugee clients into their practices.

Lack of medical history was reported by community family physicians as problematic (Priebe et al., 2011). Other challenges include cultural barriers, refugees’ understanding of next of kin, and providers’ lack of familiarity and comfort working with interpretation services (Gould et al., 2010). Health literacy, transportation, local language proficiency, and health literacy were identified by Alarcon (2014) as challenges which also impact follow-up completion rates among refugee patients at community family practices. Some refugee patients reported feeling afraid to go to the doctor because they felt unwanted or a burden on resources (Cheng, Drillich, & Schattner, 2015). Initial refugee health visits are often met with ambivalence on the part of refugees. Refugees may have minimal trust of the medical system and limited experience with Western concepts of disease and disease management (Cheng, Drillich, & Schattner, 2015).

Other challenges in community family practices

Tamblyn et al. (2010), reported that language barriers do not exist only during interactions between providers and patients, but at every level of the health system, from making an appointment to filling a prescription. Language was discussed by refugee respondents as a significant barrier to care, particularly in situations where there was no interpreter, such as phoning a practice to arrange an appointment (O’Donnell et al., 2008). Over half of health providers interviewed by Tamblyn et al. (2010) reported that they perceived that language barriers led to refugees utilizing health services only when they are very sick, or not sick at all.

Access to medication was reported as another significant barrier in access to care. Refugee patient respondents reported experiences of being expected to pay for painkillers such as Tylenol over the counter rather than receiving a prescription, which incurred significant costs for families. This was found to be especially challenging when the family had received information about their health coverage and expected to be exempt from paying (O’Donnell et al., 2008).

Challenges transferring clients into community family practices

Bridge Clinic in Vancouver reported significant challenges transitioning clients into community
family practices. It has been an ongoing challenge to discharge clients from Bridge Clinic and stabilize their health needs closer to their new communities. Bridge Clinic has reported clients continuing to come back for service after they have been accepted into community family practices. Bridge Clinic reported it has evolved into a family practice rather than maintaining its original intention as a bridge for transitioning clients into community family practices due to lack of culturally relevant health services in the community (Bridge Clinic, 2014).

Refugee clients at Bridge Clinic have reported strong feelings of connectedness to the clinic due to the high quality of care, and specifically to the mental health support they receive. Quality care and mental health support for refugee clients was reported to be a common barrier to registering with a primary care provider outside of the refugee health clinic (Vancouver Coastal Health, 2015). Clients who understood the need to move on to a community family practice cited the high quality of care and relationships they had built with clinicians, lack of knowledge about how to access primary care outside of Bridge Clinic, and fear of losing access to medication coverage as key reasons for not wanting to leave the refugee health clinic (Vancouver Coastal Health, 2015).

Language and availability of interpreters

Many refugee patients voiced a desire to stay with Bridge Clinic because of availability of interpreters, and the desire to not need to re-explain their history and build new relationships with other providers. This has led clients to want to stay attached to the clinic even when they live significant distances from the clinic (Vancouver Coastal Health, 2015). Bridge Clinic identified the lack of translation/interpretation services at other clinics as a key challenge in exiting clients, and stated that language barriers are one of the biggest challenges of refugee patients, and the primary reason for continuing to come from far out communities to get care at Bridge Clinic (Vancouver Coastal Health, 2015).

Orientation to the health system

Challenges understanding the local health system – health system literacy – pose a significant barrier for refugee patients accessing primary care. This is a particular concern for refugees disconnected from settlement support (Russell, Harris, Cheng, et al., 2013). Cheng, Drillich, and Schattner (2015) identified knowledge gaps in refugee patients’ understanding of the role of the family physician, how to find a family practice, how to make an appointment, and how to access care outside regular business hours. It is critical to empower refugees and communities to successfully engage with the local health system: Harris (2015) reported that interventions which orient refugees to the health system are likely to improve accessibility in primary care for refugees. Joshi et al. (2013) reported that written materials on health and the local health systems given to refugees on arrival for resettlement in Canada were not used as a source of information when required later. This suggests the need to develop strategies to support newly arrived refugees to understand the local health system (Joshi et al., 2013). Health and health systems education provided immediately before or after arrival in Canada needs to be reinforced by further education once the refugee is more settled (Russell, Harris, Cheng, et al., 2013). Teaching refugee patients how to navigate the health system through bilingual and culturally appropriate information in written and video form was found to significantly enhance health system literacy and utilization of health services (Joshi et al., 2013). Priebe et al. (2011) interviewed refugees who had been patients in the local health system for several years and reported that refugees felt they would...
have benefitted from instructive programs and multi-language information materials about the local health system to support them in accessing appropriate services and seeking effective treatment.

Tamblyn et al. (2010) interviewed resettled refugees who had been using their local health system for several years, and reported refugees’ significant difficulties and dissatisfaction getting timely appointments at their family practices. Respondents often considered symptoms such as flu or stomach pain as emergencies requiring immediate attention (O’Donnell et al., 2007). Refugees reported frustration when they had to wait several days for an appointment, particularly when the concern was about a child or when symptoms improved before the consultation. Refugees often proceeded directly to the hospital emergency department for issues they perceived as emergencies or requiring a specialist consultation, which could have been adequately and appropriately dealt with in a community family practice. Refugees also reported perceiving that their family physician was not specialized enough to deal with their problems, such as when physicians developed care plans collaboratively with patients, or asked the patient’s opinion. This led some refugee patients to seek second opinions or not follow self-management plans (O’Donnell et al., 2007).

Seeing the same physician each time they attended the community family practice and feeling respected during the consultation were both reported to increase refugees’ confidence in their family physician (O’Donnell et al., 2007). Refugees reported that seeing the same physician at each appointment was important because the doctor knew their, often complex, histories (O’Donnell et al., 2008). Refugees appreciated physicians who spent extended amounts of time with them in history taking, physical examination, and explanation. Continuity with the same physician was reported to be important for building mutual familiarity and trust, and highly valued by refugee patients (O’Donnell et al., 2008). Cheng, Drillich, and Schattner (2015) reported that patient expressed dissatisfaction with seeing a different physician or interpreter at each visit.

**Health literacy**

Low health literacy presents barriers to primary care for refugees. Refugees’ health literacy challenges can be compounded by limited local language proficiency and dramatic changes in culture (Heerman & Wills, 2011). In preparation for transition into a community family practice, refugees require health literacy education, especially refugees who are disconnected from settlement support (Russell, Harris, Cheng, et al., 2013). Provision of appropriate health information in community family practices was found to be a gap in service for refugee patients, for example, lack of appropriately translated patient education materials (O’Donnell et al., 2007). Bilingual and culturally appropriate information provision in written and video form has been reported to significantly enhance health literacy and improve access to care (Geltman, 2005; Harris et al., 2008).

Health literacy support is also needed to help refugees understand the tasks of management of ongoing or chronic health issues. For example, Heerman and Wills (2011) reported that many refugees experience challenges understanding that diabetes requires lifelong therapy: refugee clients often did not return to the clinic when a prescription ran out of refills, thinking that they had completed treatment for diabetes. Tamblyn et al., (2010) reported that refugees were commonly not accustomed to the idea of preventive care such as annual medical, vision, and dental exams, and refugees delayed seeking care until conditions were severe.
Many participants in Tamblyn et al.’s (2010) research indicated that dramatic differences between economic and health systems in their previous countries and previous health care experiences contributed to refugees’ expectations of medical care in countries of resettlement. Expectations reported by Tamblyn et al. (2010) included curing chronic diseases instead of managing them, and fast care by clinics. A refugee participant shared, “when I go to the doctor, I want him to touch me, to look in my eye, hit me with the little hammer…” (Tamblyn et al., 2010). Some participants expressed frustration and disappointment when their health did not immediately improve upon arrival in their resettlement country (Tamblyn et al., 2010). Disappointment was reported to make many refugees reluctant to seek care because their expectations were not met (Tamblyn et al., 2010).

**Primary Care Amplification Model**

The Primary Care Amplification Model is an internationally recognized model of health service for refugees that offers to enhance the delivery of refugee health care in the primary health care setting (Kay, Jackson, & Nicholson, 2010). It recognizes the collective strengths of the established local primary care providers and works to amplify strengths to enhance capacity to meet the specific health needs of refugee patients in primary care. The model identifies a central beacon practice with clinicians who have specific skills in delivering refugee health care and close ties to the community and partner organizations (Kay, Jackson, & Nicholson, 2010; Heerman & Wills, 2011).

Beacon clinics are outcomes-focused, providing initial health assessments for refugees with onsite interpreter services and patient education materials available in multiple languages. Beacon practices provide initial, transitional primary health care for refugees during the first six months from acceptance as a refugee, as a gateway service to full registration in the local health system (Russell, Harris, Cheng, et al., 2013; Kay, 2011). Patients receive a patient-owned medical record (POMR), and the beacon practice subsequently links patients with local providers for ongoing primary care and provides information about other health services in the community (Feldman, 2006).

Roles of beacon clinics include planning and providing best practice care in a primary care environment, sharing best practice knowledge with providers in the community, and supporting research to improve primary care for refugees (Heerman & Wills, 2007; Nicholson, 2015). Beacon practices provide information and resources about infectious diseases, immunization needs, and practice policies, which help to up-skill practices in the community in their capacity to deliver care to refugees locally. As the beacon practice helps practices in the community to confidently provide quality care to the refugee community, it also helps to build trust between the local refugee community and community practices. When the beacon practice refers patients to community family practices, a practice visit from the beacon staff is offered to the community practice. During a practice visit, specific issues (medical and administrative) are discussed to support the practice in addressing common challenges. Relevant information is provided to administrative staff about booking interpreters for appointments.

Concerns from community primary care providers, and members of the refugee community, can be directed to the Beacon practice, and effective strategies to address these concerns can be shared by the beacon practice (Kay, Jackson, & Nicholson, 2010). Telephone advice is also available from the beacon practice to community family practices (Kay, Jackson, & Nicholson, 2010). Support from beacon practices helps to reduce concerns...
for many local providers. Teaching about cultural sensitivity and management of refugee patient’s health issues have been areas of expertise for which *beacon* practices are widely recognized (Kay, Jackson, & Nicholson, 2010). *Beacon* practices maintain two-way communication with family practices in the community. Community family practices can report emerging issues within specific communities, or difficulties with specific health services to the *beacon* clinic and enable the *beacon* to help address these issues within the broader sector.

*Beacon* practices provide a wide range of services to patients, beginning with full registration, comprehensive health assessments, and other services such as tuberculosis screening and vaccination (Feldman, 2006). They also provide support for clients to obtain and understand basic health information, particularly around medication management and navigating the health system (Victoria State Government, 2012). *Beacon* practices establish processes for consistent client information transfer between immigration and settlement services, schools, primary care, and specialist services to improve continuity of care, and reduce duplication of service and inadequate immunization and testing (Kay, 2015).

Although the usual fee-for-service funding model can fund the health service delivery component of a *beacon* practice, additional funding is likely to be needed for a *beacon* to develop the expertise required, and extra funding is needed to enable the development of resources for best practice in the community (Kay, 2011).

A *beacon* practice’s ongoing healthcare delivery, concurrent with its development and dissemination of best practices, maintains its perceived legitimacy when training other primary care providers in the community (Kay, 2011). The model is strongly supported in the literature as a best practice in refugee health, and successful implementation of this model has recently been reported for enhancing care in the community for refugee patients with diabetes (Heerman & Wills, 2007; Kay, Jackson, & Nicholson, 2010).

An example of *beacon* practice is the New South Wales Refugee Health Service. It was established by the NSW Department of Health in 1999 in response to health needs of refugees in New South Wales and difficulties accessing health services. The service employs salaried part-time family physicians who conduct health assessments. Refugee health nurses provide advice and follow-up for clients to ensure referrals are followed up and treatment advice is followed. Interpreters are used when required, either onsite or via telephone. After initial assessment and treatment, clients are referred to family physicians in the community for ongoing care (Cheng & Smith, 2012). The service provides policy and practice advice to government, health services, education for students, health staff, general practice trainees, and family physicians, and supports health promotion projects (Cheng & Smith, 2012).

### Enablers of transitioning

Patients who transitioned from Bridge Clinic in Vancouver into community family practices referenced finding a family physician close to their home community who speaks their native language as one of the most significant reasons for transitioning into the community (Vancouver Coastal Health Authority, 2015). In consultations conducted by Bridge Clinic, it was identified that community family practices and community partners want more information about available services to help clients transition into community family practices. Some opportunities and recommendations for supporting clients to transition into community family practices from the literature are listed below, grouped by the themes: communication,
language accessibility, starting the transition process early, refugee health clinics operations, impact to community family physicians, and advocacy.

**Communication**

- Consistently and clearly communicate to clients the time-limitations of transitional refugee health clinic services (the clinic works with clients for a limited amount of time to establish medical history, address immediate health needs, and prepare clients for transitioning into community family practices) (Vancouver Coastal Health Authority, 2015).

- Consistently and clearly communicate to clients the time-limitations of transitional refugee health clinic services (Vancouver Coastal Health Authority, 2015)

- Develop a communication platform through which partner agencies can be updated on staffing and program changes at the refugee clinic (Vancouver Coastal Health Authority, 2015)

- Work to address gaps in translated and local language primary care services in the communities in which refugees are most likely to settle (Vancouver Coastal Health Authority, 2015)

- Increase awareness within the health provider community about the Interim Federal Health Program (IFH). (McKeary & Newbold, 2010). Provide a thorough overview of the IFH and other health insurance coverage typically used by refugees so providers in the community understand services covered, medications covered, how providers are paid, and typical wait-times for payment (McKeary & Newbold, 2010). Vancouver Coastal Health Authority (2015) recommended that a health provider connect directly with community family practices to explain IFH coverage, for when clients are able to be transitioned into community family practices when they still have IFH coverage.

- Consistently communicate to refugee patients the importance of bringing their IFH documentation to appointments at their family practice in the community (McKeary & Newbold, 2010)

- Ensure refugees understand their IFH or other health insurance coverage, particularly what they need to pay for, and what they do not need to pay for (McKeary & Newbold, 2010)

- Assemble a list of health service providers in the community who accept IFH (Vancouver Coastal Health Authority, 2015)

- Assemble a list of family physicians in communities where clients live, and a list of providers who speak different languages (Vancouver Coastal Health Authority, 2015)

- Educate family physicians and other health professionals in the community about potential health needs of refugees (McKeary & Newbold, 2010)

- Provide information to community family physicians and other health professionals in the community about the health systems that refugees are used to in their countries of origin, and ways in which the health systems refugees are accustomed to can influence their expectations of healthcare here, such as previous direct
access to specialists in the hospital, direct access to antibiotics, and lack of appointment systems (O’Donnell et al., 2008)

- Communicate the importance of considering affordability of medications, such as recommending over-the-counter medications to refugee patients rather than prescribing them (O’Donnell et al., 2008)

- General information packages may be distributed to community family practices to support practices in providing care for refugees in a way that is relevant to the local community. For example, this can include guidelines for conditions more commonly found within the refugee community, information on making referrals to local services, or mental health supports available for refugee patients (Kay, Jackson, & Nicholson, 2010).

Language accessibility

- Support clients in building networks of family, friends, and community members who are proficient in the local language for support with making appointments, and accompanying them to appointments for the purpose of registering with the receptionist. Bhatie and Wallace (2007) reported that only patients who were accompanied by a friend, relative, or refugee agency staff member experienced a trouble-free registration process at community family practices (Vancouver Coastal Health Authority, 2015)

- Explore the potential of a multilingual phone-based electronic booking system, promote to community family practices (Vancouver Coastal Health Authority, 2015)

Partnerships in the community

- Work with partner organizations to collect resources to support the transition process (Vancouver Coastal Health Authority, 2015)

- Work with pharmacists in the community to identify when and how medication instructions can be translated for patients (Vancouver Coastal Health Authority, 2015)

- Work closely with agencies providing mental health services to refugees to establish consistent referral pathways and triaging procedures (Vancouver Coastal Health Authority, 2015)

- Create or support a partner collaboration meeting to bring together service provision agencies for refugees (Vancouver Coastal Health Authority, 2015)

- Support cooperation and coordination of care for refugee patients between clinics, and establish clear procedures for transferring client health information between clinics (Harris, 2015). Effective procedures for transfer of client health information between services was identified as the most important requirement for successful
coordination of transition between services (Harris, 2015)

- There is a high level of consensus in the literature that complete health records or summaries need to be transferred directly between health services and generally not transferred via settlement services or refugee clients. Direct transfer mitigates concerns about privacy breaches and loss of health records in transit (Harris, 2015)

- Coordinate networks of services (often facilitated by a refugee health nurse) to improve access to a range of services and transportation to services (Joshi, Russell, & Cheng, 2013)

Starting the transition process early

- Begin planning the transition with patients in a systematic way as soon as possible (Vancouver Coastal Health, 2015), such as by supporting clients in calling community family practices requesting to be accepted as a patient, or supporting clients in accessing community resources to improve their language proficiency in preparation for transitioning to community family practices.

Refugee clinic operations

- Develop a policy for when transportation fare is provided to patients, clearly communicate the policy, and implement it consistently (Vancouver Coastal Health, 2015)

Supporting community family practices

- Increase service provision and staff training in refugee health clinics and community family practices to meet the mental health needs of refugees (Vancouver Coastal Health, 2015)

- Encourage referrals to community family practices to come from physicians at the refugee health clinic when clients are ready to transition: referral to a family doctor can be more impactful when it comes from a physician colleague (Vancouver Coastal Health, 2015)

- Support community family practices in learning processes for pre-booking interpreters before patient visits, especially for preliminary health assessments (Cheng & Smith, 2012)

Advocacy

- Advocate for accredited continuing medical education opportunities focused on refugee health that can be hosted by the refugee health clinic. Clinical and cultural information should be provided, and community family practices should be invited to co-design the learning opportunities to help meet their needs. Such meetings also provide an important opportunity for networking (Kay, Johnson, & Nicholson, 2010).

- Case management was identified as the most effective strategy for successfully transitioning clients into community family practices (Harris, 2015). Case
management is strongly endorsed by the literature as being associated with improved communication between service providers, as well as improved access to preventive health services for refugee patients. Case management support for refugees may include:

- making appointments
- ensuring appropriate interpreter services are arranged
- providing appointment reminders
- assistance with transportation, ensuring clients can afford travel costs to appointments
- overseeing clinical handovers
- ensuring follow-up on health issues
- facilitating transfer of health information between services
- supporting clients in learning to use the health system independently (Harris, 2015).

A case management model effectively used in Canada involved medical students providing refugee patients with information on the health system and preventive services, and assisting in completing a cumulative patient profile to help ease their transition into community family practice (Harris, Russell, Cheng, et al., 2013).

Establish or improve systems for collecting numbers and demographic characteristics of refugees in local communities, and involve local refugee community members in planning and delivery of services (Feldman, 2006).

### Jurisdictional Scan

#### Ottawa Newcomer Clinic: Siffan Rahman, Program Coordinator

The Ottawa Newcomer Clinic is operated by fee-for-service physicians and a nurse practitioner from a local community health centre. The partnership of independent and community health centre providers aims to increase access for clients who are uninsured, and helps to create connections with other community health centres. The clinic provides a comprehensive medical assessment, builds a medical history with clients, and orders appropriate laboratory tests. Within one month of the first encounter, clients are seen for follow-up, with immunizations and well women’s clinics. Further follow-up is determined individually by providers.

Generally, patients are seen at the clinic for less than one year before they are transitioned into community family practices: the clinic strives to transition all clients within one year. The clinic reported that they have been successful in connecting clients with community-based providers within the first year of being seen at the clinic.

The Ottawa Newcomer Clinic maintains a list of providers in the community who are accepting new patients, categorized by languages in which the provider can practice. When staff at the clinic become aware of a new provider in the community, they reach out to introduce the clinic, explain the types of health coverage refugee clients have, and ask if the provider would be willing to accept clients from the Ottawa Newcomer Clinic into their practice. The clinic reported that most often community providers willingly accept their patients when they reach out to them. The clinic also reported that they have been successful in connecting clients with providers who speak their native language, since in Ottawa there are many providers who speak other languages.
The clinic has not noted specific barriers to connecting patients to community family practices: providers in the community do not appear to be less willing to accept refugee patients. The clinic reported that the only time community providers tend to not accept their clients is when they have full practices and are not accepting any new patients.

The Ottawa Newcomer Clinic acquired funding for a Health Navigator program, coordinated by community health workers who work with clients from the 4 primary language communities seen at the clinic: Arabic, Nepali, Somali, and French. Health navigators are paired with clients with lower levels of English proficiency. Health navigators help clients call community family practices to ask to be accepted as a patient. Navigators also provide case management for clients who have complex medical needs, and provide education on the local health system, teach clients how to arrange and reschedule appointments, and help clients attend appointments on time. For patients with multiple complex health issues, the process of finding a community family practice is started earlier, with more regular follow-up care provided by the clinic.

For clients with functional proficiency in English, the clinic provides a list of providers accepting new patients, and encourages clients to connect with providers to arrange a meet-and-greet appointment. Follow-up support for connecting to a family practice is provided as needed.

The clinic reported that significant challenges have arisen for patients who have transitioned into community family practices, because community providers are often unaware of patients’ health coverage, and how their coverage works. The clinic reported patients transitioning into family practices and subsequently returning to the Newcomer Clinic or their community practice because community providers prescribed medications that were not covered by their health coverage. To address these challenges and duplication of services, the clinic provides an overview of patients’ health coverage to community health providers as part of their chart transfer process.

The Clinic reported that community family practices are typically unwilling to book interpreters for clients, so the clinic provides information to clients and community family practices on how to book in-person and phone interpretation services. For clients whose English skills are limited, the clinic encourages taking a family member or support person to appointments for support registering and signing in. When clients transition to community practices, the clinic provides a letter the community providers encouraging them to book specialist consultations for clients, as needed, at the hospital because the hospital has a budget for interpretation.

When clients are transitioned to community practices, the client’s full chart is provided. A letter from the clinic is also provided to thank community providers for accepting the client. The clinic has reported that community providers have found their chart transfer process and information letters useful. Some community providers have indicated that providing the entire chart is too much information and would not be used. The clinic is currently exploring options for creating a one-page summary with its EMR for the client information transfer process. Short summaries have been prepared individually by clinic staff for providers have been found to be useful and appreciated by community providers.

The Ottawa Newcomer Clinic provides 2 hours of interpretation services, the maximum amount covered by IFH. For clients who require interpretation services beyond 2 hours, a small amount of additional funding for interpretation services is available from a co-located settlement agency. Though the clinic has not implemented the practice in a
systematic way, the clinic considers it a promising practice to encourage clients to use their English skills at appointments to strengthen the language skills they will need to use in the community, by providing interpretation services at follow-up appointments on an as-needed basis. The clinic has noted that clients from some of the main language communities have appeared to learn English faster than others, which may be attributed to larger communities of people who speak those languages living in Ottawa. For example, the clinic has noted that people who speak Nepali have appeared to learn English at a slower rate than other communities, which may be attributed to a smaller community of Nepali speakers in Ottawa. Additional interpretation support is thus provided to clients from the Nepali language community.

From the first appointment at Ottawa Newcomer Clinic, clients are informed that the clinic is time-limited and transitional in nature. The Clinic has found that finding a provider close to where the clients live is the element that makes clients most interested and willing to transition into a community practice. This is because the Clinic is located downtown and there are significant challenges for clients to access it. When refugee clients initially arrive in Ottawa, they stay in a downtown shelter called Reception House located close the clinic, but within one month they are transitioned into their home which are typically outside the city, which creates challenges accessing the downtown Newcomer Clinic. The Clinic has encountered some rare challenges with clients being unwilling to transition into community practices, attributed to the expanded services, length of appointments, availability of interpreters, and staff going out of their way to support clients (such as printing out maps and other resources) in the Ottawa Newcomer Clinic. The clinic provides education on the value and importance of having a long-term family physician to oversee and coordinate their health services.

The Ottawa Newcomer Clinic does not use formal assessment tools to assess readiness for transitioning into community family practices. The clinic has reported challenges with maintaining or reducing the length of appointments, mostly attributed to providers taking longer times than planned to get to know the clients, however this has created challenges with scheduling of both patients and interpreters.

Crossroads Clinic, Toronto
Dr. Meb Rashid, Medical Director

Crossroads Clinic has been operational for 4 years. The clinic is presently staffed by two physicians, 0.8 and 0.4 FTE, and one full time nurse practitioner who practices to her full scope of practice. Clients are triaged through an informal process by the clinic receptionist: patients who appear to be healthier see the nurse practitioner. The clinic reported that process has generally worked well.

Services are provided over a two year period for clients at Crossroads Clinic in preparation for transitioning into community family practices. The clinic chose to offer care over two years because many preventative interventions take longer, for example, getting clients fully up to date on immunizations, developing relationships with clients such that, for example, a pap test can be provided for a person who may have experienced sexual violence, or treatment for latent tuberculosis which can take nine months. Since the clinic sees a large number of refugee claimants who can wait as long as 18 months for their first refugee hearing, the two year window provides adequate opportunity to provide comprehensive care for both government-assisted refugees and refugee claimants. For patients who are dealing with significant mental health issues or are awaiting their refugee hearing, they can stay with the clinic past 2 years.
Prior to opening the clinic, a significant amount of time was spent developing networks for transitioning clients into community practices. The clinic has worked to build strong relationships with community health centres and academic family health teams to support transitioning patients into community practices. The clinic continues to develop and maintain these networks. In building networks of community providers willing to accept patients of the Crossroads Clinic, the clinic reported that they did not encounter any providers who weren’t receptive. The clinic recommends that the networking be led by physicians to promote credibility and trust. Relationships established with practices in the community are not formalized, but an agreement to accept refugee patients is formed and ongoing communication is maintained. The clinic recommended working to build formalized relationships with community practices and academic family practices. The clinic reported that often resident teaching practices are more open to accepting more complex patients, and may be more willing to accept refugee patients; working with refugee patients can be a valuable learning opportunity for residents: they’re interesting patients. The clinic has transferred some very complex patients into the community. For patients with complex health needs, the clinic relies on its relationships with more specialized services, such as community health centres and academic family medicine clinics which may be more equipped to work with complex refugee patients than family physicians in solo practice.

The clinic noted that Toronto is a diverse city, and encountering someone who doesn’t speak English is common: physicians in Toronto may therefore be more sympathetic to language diversity and be more willing to accept patients who don’t speak English. The clinic indicated that the issues that tend to cause reticence among community family physicians are infectious disease issues. To address this, the clinic provides a summary of all testing and treatments provided, so that when a patient is referred to a community practice, community providers can be informed that the patient does not have infectious diseases and should fit into the practice like any other patient, language issues aside.

Crossroads Clinic has explored developing a standard package of forms and patient medical history for transferring patient medical information, but has heard from community practices that it is not needed. The clinic stated its EMR system can prepare a cumulative patient profile in a way that is succinct and easy to use.

Crossroads Clinic reported that as patients become more proficient in English, or are well supported by family members or community members who speak English, they tend to leave the clinic on their own. This may be attributed to the clinic’s downtown location, which can be difficult to access. The clinic noted that most refugee clients live on the periphery of the city, and it takes at least an hour to get to the clinic with a $3 fare each way via public transit, which is a significant cost in time and money.

In the early days of the clinic it was realized that resources would need to be used to actively help transition patients into community practices. Staff at the Crossroads clinic devote approximately 1 ½ - 2 days per week to reviewing charts of patients who have been receiving service at the clinic for 2 years or more, and contacting either the community health centre or practices they have a relationship with in their community to provide referrals. The clinic has found this process to be effective.

The clinic has found that patients from some language communities appear to navigate the health system more easily than others: this may be because some groups of refugees come to Canada with higher levels of education. In some cases, there are many physicians who
speak the language of the refugee clients, so clients are able to find a practitioner who speaks their language. These clients typically are able to transition into community family practices more quickly and require less time at Crossroads Clinic.

The clinic strongly discourages reducing interpreter services use for the purpose of strengthening clients’ language skills within the health setting. The clinic stated that it’s OK to force clients to use the local language in some settings in the community, but in health settings without effective communication, clients face significant risks. The clinic does actively encourage clients to use English when they’re out in the community.

The clinic reported challenges establishing expectations and clients’ understanding of the two year limited time window for services at Crossroads Clinic. The clinic is actively working to include the time limitations of the clinic in initial conversations with patients from their very first encounter at the clinic. Some patients have been surprised after two years of accessing service at Crossroads clinic. The clinic noted that if patients are aware of the time limitations of the service at Crossroads, they may be more engaged in seeking services independently.

No formalized tools are used at Crossroads Clinic to assess language proficiency or other aspects of readiness for transitioning to a community practice. The clinic stated that providers are effective in using their judgment: within five or ten minutes of conversation in an appointment, a provider will know whether a client has adequate language proficiency. The clinic noted that language proficiency in the health setting requires different skills than language proficiency for other tasks in the community: some patients are able to have a clear conversation in English about a sore throat, but are not proficient enough to talk about more complex issues such as post-traumatic stress disorder. The clinic indicated that the most risky interactions with patients are with patients who speak some English and perceive that the provider is understanding. Some clients speak English in a limited way, but are enthusiastic about learning English and motivated to practice, and therefore do not want to use an interpreter. These are considered the most risky clients to hold an appointment in English with, and sometimes the provider overrides the patient’s request to conduct the appointment in English and orders an interpreter to ensure that the communication is clear. The clinic noted that some refugees learn English readily, and some do not. Many government-assisted refugees learn English less readily: it could take 5 or 10 years, especially for people over 35.

The Crossroads clinic uses almost exclusively phone interpretation, and encourages use of telephone interpretation for other refugee clinics to promote anonymity. For example, when an interpreter comes into the clinic to translate in a less common language, there is a high probability that the interpreter will be regularly encountered and strongly integrated into the community that the clients are joining. This can increase the risk of problems with confidentiality or of clients underreporting health or social issues in the office.

In Ontario the College of Physicians and Surgeons keeps a database of secondary languages spoken by physicians: this has been a useful resource for the Crossroads clinic in connecting clients to providers who speak their languages.

Bridge Clinic

Dr. Mei-ling Wiedmeyer, Family Physician

Bridge Clinic provides a transitional service to refugee clients for one year. Previously, the clinic had been seeing refugee clients on an
ongoing basis, and had not developed processes for transitioning clients into the community. Bridge Clinic has experienced significant challenges discharging patients over time. Bridge Clinic is currently in the process of establishing its model for transitioning clients into the community.

Bridge Clinic actively reaches out to local providers and practices in communities where refugees are settling, and works to incentivize them to accept refugee clients from the clinic. The clinic has established relationships with clinics in the Vancouver Metro area, suburban areas, and outer communities where refugees tend to settle, however most of these clinics have low capacity for accepting refugee patients. The clinic actively seeks opportunities for networking in the community. When Bridge Clinic staff host presentations in the community on refugee health, they routinely ask if anyone is potentially interested in taking on a refugee patient, obtain contact information, and follow up.

The clinic provides letters to community family practices detailing billing codes for complex patients and unattached patients. Many providers have been unaware of these billing codes, so raising awareness of financial incentives for accepting refugee patients has been helpful increasing providers’ willingness to accept refugee patients. Bridge Clinic is also working to become certified as a training site for international medical graduates (IMG’s). In British Columbia, IMG’s are required to complete a return to service work rotation, which can be completed in a high-need area. Many international medical graduates (IMG’s) speak languages common to the refugee clients seen at Bridge Clinic, so the clinic is collaborating with other clinical training sites to enable IMG physicians to do shifts at the refugee clinic. Ultimately this could enable IMG physicians to accept refugee clients from Bridge Clinic into their practice upon completion of return to service requirements.

Bridge Clinic is developing a triage system that can be initiated on the first clinic encounter, using indicators related to literacy, English proficiency, and health needs that can be used as an indicator of when patients can be discharged. Some refugee clients seen in the clinic require only an orientation to the local health system, some need to work with Bridge Clinic over a longer period to address health needs, connect with other community resources, and strengthen language ability. No other assessment tools are used for assessing readiness for transitioning. Bridge Clinic reported that providers at the clinic tend to go with their gut judgement, but are searching for tools for assessing readiness.

Bridge Clinic works to establish expectations with clients regarding the time-limited nature of the service by explaining at the first appointment that the service is available for one year to address immediate needs and help transition to a community family practice.

To strengthen skills using English in a clinical appointment, the clinic recommends reducing the use of interpretation services after medical history and a relationship with the client are established: this has not been implemented systematically but is used in practice. As clients appear to be developing proficiency in English, they are gradually transitioned to telephone, rather than in-person, interpreter services. Then clients begin appointments in English with the physician one-on-one, and can use telephone interpretation services if required. In-person interpreter services are then reserved for specific clinical needs like pap tests. The clinic is interested in formalizing these processes, and integrating indicators which specify the level of English required for patients to function effectively in a
clinical appointment. Bridge Clinic offers a walk-in clinic in the afternoons, and when refugee clients who seem to be developing proficiency in English attend a walk-in appointment, the clinic encourages them to go to the walk-in clinic down the hall which is open to the general public which is down the hall, and come back if needed.

The clinic considers it a promising practice to decrease the length of appointments over time to model a typical appointment in a community family practice, but this has not been implemented in practice: 30 minute appointments are used. The clinic does speak with clients to set expectations about appointment times in community family practices.

The clinic encounters a significant number of patients who do not want to transition into community practices. Some patients connect themselves independently to family practices as their English skills develop; there are also a limited number of local physicians who speak Arabic or Farci who accept refugee patients. Bridge Clinic reported that most refugee clients ultimately resettle far outside the city so it becomes expensive and inconvenient to travel to the clinic for appointments. This has helped to build interest and willingness to transition to a family practice closer to where refugees live.

For some clients who are unwilling to leave Bridge Clinic, a nurse arranges an appointment with them before their appointment with the physician to review a list of local family physicians accepting new patients. The nurse and patient select physicians from the list and make a plan for the patient to call those practices to get connected with the practice. At subsequent physician appointments, the nurse meets with the patient first to check-in, explore challenges and barriers, and select more practices with the patient to try.

Fraser Health Authority: New Canadian Clinics (Burnaby, Surrey), and Global Family Care Clinic
Rita Hayre, Project Leader

It is estimated that over 80 percent of refugees in British Columbia move into Fraser Health Authority because housing is more affordable further east from Vancouver. BC Housing helps move most refugees into the Fraser Health region. With the high proportion of refugees moving into Fraser Health, the 3 existing refugee health clinics have not been able to keep up with the demand for refugee health services.

Fraser Health reported that the initial triage of refugee clients is conducted by Bridge Clinic in Vancouver. Given limited resources, Bridge Clinic supports refugee clients who have some English proficiency or are medically stable to independently connect with community family practices. Fraser Health reported that refugees who are referred to the 3 refugee clinics in Fraser Health are the refugee clients who have the highest medical and language needs, which has contributed to significant wait lists at the Fraser refugee clinics, which has limited capacity for accepting new clients. Thus far there have not been formalized processes for transitioning clients into the community, and some clients at Fraser clinics have been there for 6 years.

Fraser Health reported that, from a patient perspective, it is not surprising that patients have been unable and/or unwilling to transition into community family practices. Whereas at community family practices, appointments are short, often only one concern can be addressed, patients cannot bring their entire family to the appointment, and if patients miss their appointment they are charged a missed-appointment fee, at Fraser refugee health clinics, clients have hour-long appointments with nurse practitioners, with interpretation services, families can attend appointments together, and missed-appointment fees are not
charged. Fraser has noted that it cannot sustain the current system or accept new patients, and needs to develop processes for effectively transitioning patients out into community practices, in collaboration with Divisions of Family Practice.

Fraser Health reported that initially many community physicians were hesitant about accepting refugee patients into their practices; many physicians in the community perceived refugee patients to be complex, high-needs patients, requiring significant amounts of office time. Part of developing the transition processes at Fraser Health has been working with community physicians to understand and address their needs.

5 criteria were developed for the transitional process, which evaluate factors that could interfere with patients working effectively with a community family physician in a typical family practice appointment: medically stable, administratively organized, health literacy, language proficiency, supports in place. Within each criterion are several levels of readiness. There are multiple primary care clinics in Fraser Health which provide care to clients who do not have a family physician. Criteria developed for the refugee clinics to indicate readiness to transition to family practice are applicable across the entire patient population. These criteria will be applied to all patients in Fraser Health to help transition them to community family practices.

A modified Government of Canada proficiency rating scale will be used to assess language proficiency. The scale has 5 categories: no proficiency, memorized proficiency, elementary proficiency, limited working proficiency, general professional proficiency. A 6th category enables clients to meet proficiency requirements by having a support person or translator to provide interpretation services. Clients can be discharged from the clinic when they have limited working proficiency: able to satisfy routine social demands, limited work requirements, can handle complicated tasks with confidence but not accuracy, speaks with ease when discussing concrete topics, using general vocabulary, linking sentences together smoothly.

Health literacy is assessed based on understanding of the Canadian health care system, and awareness of personal health. Health literacy categories are no or very little understanding of health, healthcare, and health promotion; understands healthcare; knowledge of own health and how to use the health care system; ability to advocate for health care.

The health literacy criterion also assesses clients’ understanding of the concept of time, which can be a foreign concept for many refugee clients and create problems with missed appointment in family practices. Fraser refugee clinics have experienced significant no-show rates on rainy days. This is attributed to refugees’ experiences with health systems in their countries of origin. Fraser Health reported that many refugees are not accustomed to making appointments, but rather going directly to the physician; on rainy days, for example, many refugees in countries of origin may have decided not to go to appointments. Refugee clients may experience a shift in culture in Canada where appointments are arranged and maintained regardless of the weather. At Fraser refugee clinics, the medical office assistant works with clients to help them understand that appointments are times set aside for the client. The clinics will be consistent in seeing clients only at the pre-booked appointment time. When a client is late, or shows up early or late, the medical office assistant holds the client accountable and explores reasons for missing the appointment or showing up at a different time.

The goal of the health literacy criteria is to help clients reach the point of being able to adequately prepare for appointments. Health
Literacy criteria also support clients in learning to work collaboratively with family physicians.

Medical care stability is assessed using 4 criteria: chronic disease management pathways in place, up to date, screenings up to date; mental health screenings and treatment plan in place; prescription and non-prescription treatment stable; and specialist services accessed and stable. Each area is assessed using yes, no, or non-applicable, and if a no is in any category, the client is not considered ready to transition.

Criteria to assess whether clients are administratively organized include determining whether they have MSP coverage, are signed up for Fair Pharmacare, and have medical records. Fraser Health reported that refugee clients require many application forms to be completed, which can be completed by the refugee clinic nurse practitioner at no cost to the client. Fraser Health reported that community family physicians have been hesitant to complete forms for newly accepted patients that they do not know well enough, and for most forms, there is no billing code for a physician to complete them.

Supports in place are assessed by determining what additional services a client needs in order to ensure their health is stable, such as:

- home health services
- mental health services
- ministry of child and family development
- physiotherapy/rehabilitation
- public health services and immunizations
- housing services
- education and language services
- employment services
- community support systems.

Similarly, each category is scored using a yes, no, or non-applicable score. If any categories are scored as no then the client is not considered ready to transition.

In addition to assessing indicators of readiness to transition, Fraser refugee clinics will work with clients to gradually reduce the length of appointments, so that at the end of the transition process they are modeling a typical family physician appointment. When clients are ready to transition they will be receiving 10 minute appointments at the refugee clinic where they can discuss only one or two issues, cannot bring their entire families, and must attend the appointment on time. When clients reach this point of the transition process, they will not experience a shock when they start seeing a fee-for-service physician in the community. Milestones indicating when a client is ready to reduce the length of their appointment time at the refugee clinic are under development.

Considering all assessment criteria, a weighting scale is being developed, which will allow the clinic to reinforce decisions regarding changes to appointments to clients – when patients ask why they can’t have a longer appointment, the weighting scale will enable the clinic to explain to the client that they are ready for a shorter appointment based on the indicators, and they are working toward being able to effectively use the same type of appointment that all the other Canadians use.

Fraser refugee clinics are also working to embed indicators for the transition process and the weighting scale into their EMR systems that will create a discharge summary that shows all the indicators of readiness to transition in addition to the medical history and discharge summary that will be provided when clients are transitioned into community family practices. This transition process summary will provide a quick summary to community family physicians of how the clinic has determined that a client is ready to transition into family practice care, and the physician will see
everything that has been done to prepare the client for transitioning into the family practice.

Once a transition process summary, medical history, and discharge summary are prepared, community physicians can see that patients are not transitioned out until they have met in-depth criteria. It shows that the clinic has eliminated the barriers for community physicians to accept refugee clients. Fraser refugee clinics consider the transition readiness assessment process as tools for a marketing process. Using the criteria as a marketing tool, patients are shown to be stable, lower need, the clinic has modeled a typical family practice appointment and rehearsed scheduling appointments, attending on time, and preparing for the appointment. The clinic also provides community physicians information on billing codes which provide financial incentives for accepting complex and unattached clients.

Interpreter services are offered for all appointments at Fraser refugee clinics, and for when refugee clients attend specialist appointments off-site. Fraser refugee clinics consider it a promising practice to reduce provision of interpreter services over time. When clients’ language proficiency does not meet the criteria for transitioning, at every appointment the nurse practitioner asks about their plan for increasing their proficiency and explains that an interpreter is provided for a limited amount of time. The need for clients to strengthen language proficiency is reinforced at every appointment, and charted in the client’s EMR.

Fraser Health refugee clinics reported that over 90% of refugee clients have post-traumatic stress disorder (PTSD), and their mental health needs are expected to be the component that most prevents refugees from being ready to transition. It can be difficult to meet the mental health needs of refugees dealing with PTSD given limitations of the scope of practice of family physicians and nurse practitioners in the refugee clinics and limitations of IFH coverage for mental health services. With the current system, IFH approves mental health services on a case-by-case basis and approves only registered psychologists. Availability of registered psychologists and language barriers are highly limited, so the Fraser refugee clinics are advocating for expanding the approved mental health clinicians eligible to bill IFH to include clinical social workers, and is exploring options for group mental health services.

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