Podcast: Preparing for the Arrival of High-Risk Medical Cases

January 2, 2025

Transcript

Introduction

Sarah Clarke: Welcome to the Switchboard podcast. Switchboard is a one-stop resource hub for refugee service providers in the United States, funded by the Office of Refugee Resettlement. Today's podcast is made possible through a partnership between Switchboard and the Society of Refugee Healthcare Providers. The Society of Refugee Healthcare Providers is a nonprofit organization dedicated to improving the health care of refugees and asylum seekers, as well as addressing equity in health care. My name is Sarah Clarke, Executive Director for the Society, and I am your host today.

Today's Speaker

SC: Hi, everyone. Welcome to our session on preparing for the arrival of high-risk medical cases, tips for resettlement case managers. I'm thrilled to introduce you all to Janet Kurczaba. Janet has a wealth of experience that she's going to be sharing with us today. Janet has a Bachelor of Science in Nursing. She's specialized in high-risk neonatal care in the Neonatal Intensive Care Unit at a Level 3 trauma hospital on the East Coast. She was also a director of nursing for a national home health agency, serving vulnerable multi-ethnic populations. Janet also served as a national resource for a home health agency, regarding and implementing cultural literacy for staff. She's currently the Intensive Case Manager Supervisor overseeing the ICM team in Phoenix. Her role is reviewing high-risk medical cases.

SC: Thank you, Janet, for joining us today, and I'll turn it over to you to introduce yourself.

Janet Kurczaba: As Sarah stated, I have my bachelor's in nursing. I did my stint in the NICU for quite a long time, which is where I really got into health care disparities and the effect that it places on families.
I then went into community health, maternal/infant. More disparities this time. I was seeing them in the home, a lot of newborns with HIV, a glaring example of health care disparities for the most part. Then I moved out here to the Southwest and started with Lutheran Social Services of the Southwest Refugee and Immigration Services. I've always been with the PC Intensive Care team. I work with two other colleagues. We have generally about 60 clients during the fiscal year. Many of them are very high risk. That is our specialty.

Q&A

SC: Janet,

What are some best practices that resettlement agencies could use to help them initially identify high-risk medical cases?

JK: That's a very good question and foundation of our program and delivering services. What we do is monitor our EDN [electronic disease notification] database. We refer to it as IRIS. Our national agency is Global Refuge, which used to be Lutheran Immigrant, LIRS. Two to three times a week, sometimes daily, look through the non-assured—because I figure they're going to be assured—and the assured cases. I keep a running list and determine if there's any medical needs. I try to look at every case, but basically the case looks good. It looks like there's not any issues. I just mark it as okay and go on to the next thing. Then when I find a case that has issues, but based on the biodata, I delve into all their medical documents, most importantly, the medical exam form, the MEF.

JK: Once it looks like that's a case that we will need to work with, you know, typical case for all of us, I'm sure, is filed with cerebral palsy and seizures. I will then discuss it with my team at a team meeting. We meet weekly, and we'll make the determination at that point. Is this something that we need to enroll this client right away in addition to being in Reception and Placement? Can it wait a while while they finish Reception and Placement? ORR does get concerned about concurrent service.

JK: If it's something like the case I just described, we're going to enroll them right away. If it's questionable, we might leave it alone for a while, check in with the case manager periodically, see how they're doing. After that, if it's a case we've accepted, I will notify the R&P supervisor and say, "We're going to enroll as soon as possible." Once the client arrives, we go to that particular R&P case manager. We often have to explain exactly what we're doing and what they're doing.

JK: In this whole process, we look to see if there's instructions regarding when their first medical appointment is going to be. If there is, then we follow through with that, whether it's 24 hours, 48 hours, or one week. If they are also arriving with anticonvulsants because they have seizures, we don't believe that they're going to have enough meds, even though they will tell us they're going to have 12 weeks. So we will make that first appointment anyway. I do know that every resettlement agency doesn't have the staff to look at all your assured arrivals, but our theory is as long as we can do that, we don't want any surprises at the airport.

What do you recommend resettlement providers look for when the arrival doesn't have a significant medical condition or SMC form?

JK: Actually, we have had the opposite experience. I feel like a lot of these docs who are doing the evals are using the SMCs all the time. Sometimes they'll have an SMC and the client is independent with everything. It doesn't need any help. Then at the bottom, it might say, "HIV, compliant with meds." Well, to me, we didn't need that SMC. I go to the medical exam form and look to see what type of history this client has and what the provider is saying about the client.

SC: I think this is where having a partnership with the health care clinic can be useful, where you have a relationship with the health care provider and you can say, "Hey, what is this condition? What does this condition mean?"

JK: Yeah, because I get questions from some of our R&P case managers like, "Why does this kid have oxygen? Do they need oxygen?" "No, they really don't. It's prophylactic. They have sickle cell. They need to travel with oxygen. They probably won't use it. That's just part of the disease." Or, "Why is this client coming in a wheelchair? Do we need a wheelchair?" "No, IOM is ensuring that the client is safe because she's 97. So they don't want her walking through the terminal, but no indication that she is going to be using a wheelchair when she's here."

What role does the State Refugee Health Coordinator play in this process when you're receiving complex medical cases?

JK: Our state health care person is very helpful. If we need assistance, we contact her. We generally do let her know when we are getting a case that is going to need to be transported via ambulance to the hospital. It's the procedure we follow here. She is also very good at expediting Medicaid for us. Once the client has landed, she's aware of it. She has to wait until the client lands. Once they land and they sign that magic little piece of paper, then she can get the Medicaid number for us very quickly.

SC: And then do you work with her at all? I know people have issues such as maybe they can't get into a specialist for months, but the client needs urgent care, or they can't find someone who would work with an interpreter.

Are there other ways that you engage with your State Refugee Health Coordinator, or is it mostly at arrival?

JK: It's mostly at arrival. She is more than willing to assist us with any issues where we might need some help. It's interesting that you mentioned specialists, because I'm sure everybody has the same problem. A lot of our specialists do not provide interpretation. This has been going on forever. It doesn't seem to change, but it is something that our State Refugee Health Coordinator has focused on and has worked with insurance plans that take Medicaid.

Going back to when you were talking about getting a first appointment with a primary care provider in a timely manner, how do you make sure you can get that first appointment in a timely way? Some service providers have talked about having difficulties with delays with that first appointment.

JK: We work with one main hospital… that is still the public hospital. They have cultural health navigators, a refugee pediatric clinic, and internal medicine for refugees. We have a very good partnership with that. We also make sure to thank them a lot. And then if we goof up, we make sure to apologize profusely.

JK: That has taken years to develop, really from prior to when I was there. I will promise that it's something you need to be aware of because everyone, including refugees, has the right to choose their own health care provider. Ninety-nine point nine percent of the time, the client is willing to say, "Okay, you have good experience with these people. They have people who will interpret for me. I'm good with this."

JK: We do not have an MOU with this hospital. And we recently have a case where the client said, "I want to go elsewhere." This was based on information that he got from the community. We didn't agree with it. But after explaining the pros and cons to him, he said, "Nope, I still want to switch to this other group." So, yes, we said,

“Fine, we will continue to work with you.” And he switched to this other group. It’s something to be careful of just to make sure that patients, clients are being able to choose when they’re able to choose.

SC: That’s a great point. And I know sometimes with our clients, we’ve ended up finding new health care providers to work with through clients branching out. So sometimes it can be very positive. But other times it can be difficult when you know that that provider doesn’t work as well as they could with refugee patients.

JK: I would suggest things like working with the providers that you feel good about and doing the Refugee 101 presentations, contacting the social work department, doing a presentation for them, just reaching out to them and trying to build something.

SC: I agree. Probably if you can pick the most promising health care provider that you’ve worked with and try to build a relationship with their medical director. We also found it best to work with federally qualified health centers since their mission is serving vulnerable and low-income populations and they seem to be more flexible and understanding with these nuances with insurance. So a lot of it is about education, especially when you’re calling, you’re talking to the front desk staff, where they have to follow their script: “If you don’t have insurance, we can’t see you.” You really need to go to someone with more decision-making power who can help you create an alternative channel for scheduling appointments.

JK: I will say that our clients get their Medicaid really quickly. So that has not been a terrible problem for us. But I know historically we would focus on one person doing the Medicaid paperwork that seemed the most receptive and try and build a relationship with that person.

SC: Service providers have also asked,

How do you suggest alerting hospitals that they will be receiving a high-risk case?

SC: For example, if you know an arrival will need to be transported to the hospital right away or ends up needing to go shortly after arrival to the emergency room. Providers are interested in tips for encouraging hospitals to work with resettlement agencies as the experts in the community on refugee and immigrant populations rather than disregarding them.

JK: I really believe it’s about developing a partnership. There was another question about ER admissions which ties in. What we do is when we have that situation occurring where we’re being told client has to go through the ER, we contact one of our cultural health navigators. Even though they’ve never seen the client, they help as much as they can. They have no power over the ER, and the ER is the worst place in the world to start somebody off on their journey into the health care system, but sometimes it is what it is.

JK: And if you have a contact in one of the clinics, this is what happened with our client. What they did was they created a chart for the client so that when the ER doc pulled up the client’s name, there actually was a chart there. All it had was the documents that we had sent, but that seemed to help a little bit.

JK: And again, just sort of going to these different clinics and doing a Refugee 101 presentation is basically the best way to go about it. And I also think being really cooperative—we identify partners so that they know they can count on you. So if there’s ever a change, for example, if someone goes to the trouble to give us an appointment within 48 hours, then their arrival date changed, the number one person we’re going to notify is the person who set up this appointment because we want to demonstrate our partnership.

SC: Thank you.

As you mentioned before, a lot of specialists, especially for dental and eye care, while legally required to do so, do not provide interpretation. Do you have any ideas to tackle this?

JK: Seems to be a problem around the country. We start by trying to [explain] to them that when they sign that contract with Medicaid, they agreed to interpretation. And then they will often tell us, "Well, we speak Spanish." Well, it doesn't really help us a whole lot. So again, we try education with the entire staff. Generally not dealing with a medical center, you're dealing with a smaller staff. So we offer to do a presentation. We'll do Refugee 101, we'll speak with them individually and see if we can move them along. We end up building a list of places that are receptive and will provide interpretation.

JK: We explain to them about telephonic interpretation, if that's the best they feel they can do. Our state Medicaid insurer has a number they can call. We try and make sure they have that number. In some cases, we'll go with that client to make sure it all happens. But we will insist that they provide the interpretation and not our staff member.

SC: Yes, we've spoken with health care providers and do try to gently introduce that concept. Janet, you said that providing interpretation is legally required. Many clinics aren't particularly receptive to immediately talking about legal obligations as the way to enter that conversation because they can feel like you're threatening them, and that may make them feel defensive. We have found that, like Janet said, it's helpful to evaluate how receptive the clinic is to using interpretation, and are they just unaware of what their responsibilities are or how to obtain interpretation?

SC: Just as clients have barriers to accessing health care, clinics can have different levels of barriers to interpretation use. I used to work at a resettlement agency where the agency provided training for community interpreters to become medical interpreters. We then partnered with the federally qualified health center, where the center contracted our agency's medical interpreters because they were more cost-effective than the language line and could also go to appointments in person. And so that clinic really enjoyed that partnership. Sometimes you might be able to talk with a specialist about a partnership such as that, but I acknowledge that that's really rare that a specialist is able to do that.

SC: Janet, service providers are asking,

What's the best practice when creating a plan with the client who has high health needs along with their support system to ensure that everyone works well together and has clear roles? They particularly want to know this in relation to applying for expedited Supplemental Security Income, or SSI.

JK: If you look into SSI carefully, there are some conditions where they can do a temporary approval immediately. Generally it's our R&P case manager who's taken them to Social Security, and they do have to take everybody. We have been advising them when they have somebody who would technically be approved immediately that if that is not offered to them by the Social Security representative for the case manager to point that out. "Look, I think this is a case that can get immediate approval while we're getting all the paperwork in."

JK: One little tip: I'm not really seeing much in the way of expedited SSI. Generally speaking, the clients we are working with, a lot of them do have cognitive disabilities. So what we do is we focus on the person who is going to be the one caring for the client. Generally, it is the mom, and it doesn't matter whether it's a mom of a minor or a mom of an adult. And we sit down with that person. If the person with the disabilities is able to understand that, of course, we include that person also. And we basically lay out what our plan is going to be, which is to get the best possible care on an ongoing basis for the person with disabilities and to make sure that in the end, whoever the caregiver is, is able to advocate for herself or himself.

JK: We're very lucky because we work with cultural health navigators at our local hospital. So once they have their first appointment, it is the health navigators employed by the hospital who also maintain contact with the clients. And we'll call and remind them of appointments or call to make an appointment. They'll even go to the house to deliver medications.

JK: The plan is in conjunction with the identified family member and the rest of the family and the client, if they are able to understand. We have a lot of kids. So, lots of times we're talking about a six-year-old with cognitive disabilities. So we are dealing mostly with the identified caregiver.

JK: We have a pretty good success rate with people being independent at the end of the 12 month. We've dealt with a lot of kids with seizures, and medication can be an issue. Over the years, I've learned to take myself out of my Western medical brain and listen to what people are saying to me. We do a lot of education around seizures, further neurological damage, but we have to really listen to these parents. I've learned to be respectful of that and try to just be a partner.

JK: There are also times when a plan for me or my team members would be, "Okay, this kid can't eat. You've been feeding this child pureed food." Of course, the first thing that I think of is aspiration. But I've learned to respect and remember that this caregiver has been feeding this child, say, for seven or 10 years. Maybe they had an aspiration, we don't know, but the child is still here and the mom is still feeding the child. So that automatic jump by the medical establishment to a feeding tube can't be automatic. Most of our clients will not agree to feeding tubes. So our plan has to jive in a totally sensitive way while still meeting the child's health care needs.

SC: Agreed. Listening to clients and working in partnership with them is really important.

SC: A quick note about the SSI. There can be a bit of tension in the health care world of wanting to wait and have clients go to medical appointments first. Primary care providers may want clients to establish some U.S. medical records first and really determine whether they need SSI versus the strategy of applying as soon as possible because the process takes so long. And if they get approved, they'll be able to receive the back payments. For service providers, it might involve talking with whomever the primary care provider is going to be for that client and explaining why you're applying for SSI early and also sharing what kind of support they can give you with getting the documentation completed in a timely manner.

SC: Service providers are also wondering how to support clients who are hospitalized for a health issue and need to apply for SSI. For example, one service provider has a client currently in the hospital due to surgery for a chronic leg infection. This client has never applied for SSI.

The service provider is wondering, how do they get SSI for their client while he's in the hospital and can't go in person?

JK: My suggestion would be to speak to the hospital social worker. They can sometimes work miracles and sometimes you have to, you know, call them multiple times. They do have a lot of patients, but they would be your best source as to how to go about that.

Another SSI complication service providers are facing is having scheduled an SSI appointment for a client, and Social Security says they will provide interpretation, but on the day of the appointment, the office says they don't have an interpreter.

JK: Yes, it has happened to us, but the wrong language. We would have to reschedule the appointment. So it does delay the process. If they put the wrong language on the phone and the client says, "I can't understand this person," then it has to be rescheduled.

SC: I think that's one of the key aspects when applying for SSI with clients is setting expectations by alerting them, "This will be a very long process." Hopefully that way service providers can try to lessen a little bit of the frustration that clients will inevitably feel when delays like that happen.

Service providers have also voiced issues with insurance, denying clients necessary medical equipment, for example, wheelchairs. Do you have any tips?

JK: We had a similar issue about five years ago with a Syrian client who was a quadriplegic. When the evaluation for his wheelchair was put in, the insurance company denied it and just expected us to walk away. But between the client and my team, we weren't walking away and kept appealing. Then they were like, "Well, okay, then you're going to have to go to court." We were like, "Fine, we'll go to court." So it was maybe about six months. But then right before we got to the court date, the insurer stepped forward and said, "Okay, we're going to okay this." The attorney from the company was not difficult. I think they feel like they're far enough removed that they don't get insulted. It's just their job.

Intensive case managers are wondering, what are some ways they can set clear boundaries with family members?

JK: Yes, we often get sucked in. We try from the get-go to explain that we are focusing on the person with the most complex medical needs. But in the end, we do end up being a lot with the family under primary risk domains in our ICM paperwork. We put that under family policy.

JK: We haven't had too many difficulties because I would say, in general, the family really is focusing on that one person. They really do want the best for that one person. If they say to us, "Oh, I don't know how to make an appointment for myself," then we're going to help with that.

For some medical conditions, the family has an opinion as to how fast that individual should be seen and how bad their health situation is. But the significant medical condition form might say they don't need to be seen for a month or two. Thoughts?

JK: Well, I generally feel comfortable making a decision. Let's say in hypertension, the client has his medications, they're taking the medications. Then I will educate that family and say, "Oh, your family member's blood pressure is controlled. They have their medications. They know how to take it." So we can make an appointment and the client will be seen in two weeks or whenever is available.

JK: We do have clients that need to be seen right away for life-threatening conditions. So that's where we have to focus our main work when we have clients. They certainly will have opinions as to how fast their loved one should be seen. And yeah, education about the American health care system is paramount.

SC: I agree. I think that's one of the most important topics we can cover. And a first meeting with clients is setting expectations about the U.S. health care system. Also, this is where the primary care provider can be a valuable resource. If a family thinks their loved one needs to be seeing a specialist sooner, you can help them arrange an appointment with the primary care provider. The family can discuss their concerns with their PCP and work with the PCP to determine how quickly they should be getting in to see a specialist.

Conclusion

SC: Thank you, Janet, very much for your time today sharing how service providers can prepare for high-risk medical arrivals. We appreciate all that you do to advocate for clients.

SC: If you are a resettlement service provider and are looking for more materials on refugee health, you can check out the latest resources available on the Switchboard and Society websites. Don't forget to listen to the other episodes in the Newcomer Health series. Thank you for tuning in.

The IRC received competitive funding through the U.S. Department of Health and Human Services, Administration for Children and Families. For fiscal year 2024, funding came from Grants #90RB0052 and #90RB0053. Fiscal year 2025 is supported by Grant #90RB0053. The project is 100% financed by federal funds. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services, Administration for Children and Families.