FAIRNESS FACTOR WITH HUGH LYTLE

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Did You Know That Asthma Incidence Among Refugees Increases After They Settle In The US — Is The Crisis Fixable?

20% of the ~600,900 refugees admitted to the US from 2010 to 2020 were from Myanmar/Burma and nearly **70% of these households reportedly have multiple members with undiagnosed, undertreated or mismanaged asthma,** typically developed after arrival –their story is a lesson on challenges managing subsets of the Medicaid population.

Surprisingly, in nearly 3 of 4 refugee families, the defacto head of household is a teenage boy or girl, as young as 13 in some situations.

They often bring young siblings or neighbors from their "community" to the hospital and in the oft chance they go to a medical center, instructions on diagnosing or treating something like asthma are confusing, misunderstood, or rarely followed…

- Two thirds of refugees were under 40 when they came to the US and 45% of youth left school
- 9 in 10 think of the hospital as their doctor
- 49% in a national study by The Behavioral Health Hour have at least one confirmed child with asthma, more than half hospitalized multiple times
- 63% of the adults from one community reported some form of substance use- which in turn eats into what little funds they had. Several turn to gambling to put food on table, so some teens say they resort to "capturing crickets with empty water bottles" like they did back in the refugee camps

In situations when these families do find a primary medical provider, it can be taxing to be consistent with check-ups — a majority lack a car and the doctors or APRNs often don't look like them, speak their native language, or understand their culture…

Primary care groups feel unfairly burdened - they lack a true picture of the family's health and situation, and have limited resources to keep patients from using hospitals as their main source of care.

– Medical Director, MCO

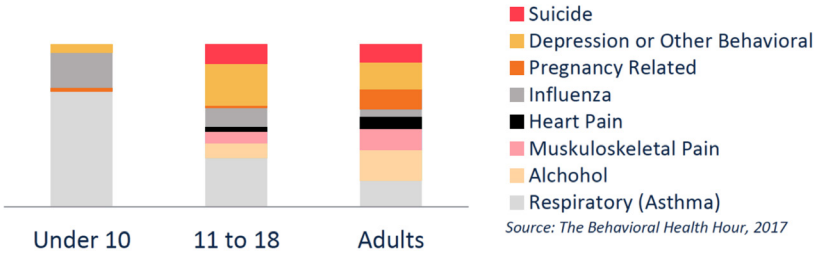
State policy efforts to encourage Medicaid MCOs to pay providers to screen for social risk factors have been well intended, but complicated

In Texas, the plans asked the state in early 2021 for flexibility around implementing SDOH, VBC and disease management requirements rather than hold them to separate rules. Some Medicaid insurers have also tried to use Z-codes to pay primary care doctors for screening, but the doctors say they lack the funding to train and hire culturally competent staff and interpreters, say screening misses what is really happening at home, and lack care management support to help families with preventive, such as with asthma.

One Medicaid patient—a 15 y/o—complained of severe headaches and after MRIs and 2 hospitalizations it was eventually deemed to be PTSD, linked to the war in Myanmar.

4 Medicaid managed care plans from states with some of the most prevalent populations – Delaware, Texas, and Minnesota report a crisis in figuring out how to manage care for this population, but feel hamstrung.

ER Diagnosis, Sampling of 4 Medicaid MCOs



Source: The Behavioral Health Hour, 2017

The primary care community often reports that it takes 5 to 6 times more visits to diagnose the refugee population, with a lower certainty of a positive outcome.

More funding and flexibility is needed for primary care to hire, invest in, or partner with local organizations. These organizations serve as health advocates for things such as check-ups, immunizations, medication adherence, nutrition and also with more complex situations.

In Connecticut, one of the few U.S. states without managed Medicaid, a non-profit representing one community has partnered with schools, a health center and local arts and sports organizations to support the teenagers who have to help manage medical care in their homes and in their community.

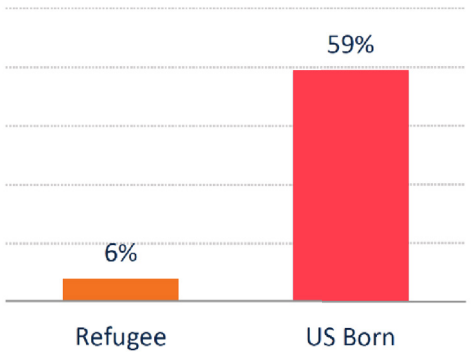
The non-profit leverages ~300 volunteer advocates, with a 1:1 advocate to family ratio, allowing for more successful care plans, fewer hospital visits, support care plans, fewer hospital visits and support for the teens.

Volunteers work with community health centers to encourage adherence to treatment plans and to provide information. They may help families communicate symptoms in real-time, sharing logs with nurses, noting dietary factors that may be influencing anxiety, and supplying severe asthma patients with spirometers.

One of the challenges of primary care groups is initiating treatment and identifying the appropriate outreach in order to impact the health of the community. For example, for asthmatics ages 9-19, the incidence of co-occurring depression is high. However, when attempting to schedule a psych referral, or a virtual therapy visit, practices are challenged by language, communication, and internet barriers. Appointments often go unscheduled due to an inability to connect.

Additional funding is likely necessary in order to help primary care practices stay connected to their asthma patients and to monitor risk factors such as BP, A1C, and lung function. Asthma ER visits were cut in half in the second year of the non-profit program in Connecticut. However, sustaining and scaling models such as this one will be difficult given their reliance of the goodwill of volunteers and physicians.

Success in Setting Up Treatment/ Medical Home



Fairness Factor is a special report from
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