DEVELOPING PROMISING CULTURALLY APPROPRIATE TOOLS AND INSTRUMENTS TO BETTER SERVE AANHPI PATIENT POPULATION

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Practitioners' Essay

Opening Access for Burmese and Karen Immigrant and Refugee Populations in California:

A Blueprint for Integrated Health Service Expansion to Emerging Asian Communities

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Abstract

This article describes: 1) internal and external factors enabling the expansion of health care access to Burmese and Karen refugees, 2) operational processes required to expand integrated primary health care services to this emerging community, 3) the importance of culturally and linguistically competent services that incorporate prior experiences of forced immigration, and 4) lessons learned and what to expect when expanding health care access to new populations within a federally qualified health center (FQHC). This case study may provide a blueprint for other FQHCs seeking to respond to emerging immigrant and refugee populations. Such expansion gains relevance as the nation grows more diverse and continues to rely on FQHCs to respond to the health needs of medically underserved populations.

Introduction

In the last decade, an average of 350,000 to 450,000 Asian immigrants (lawful permanent residents) arrived annually in the United States (U.S. Department of Homeland Security, 2012), while the number of Asian refugees totaled over 50,000 in 2010 (U.S. Department of Homeland Security, 2012). Of Asian refugees, a large number were from Burma, with an increase from 128 refugees in 2002 to nearly 17,000 in 2011 (Administration on Children

and Families (ACF)/Office of Refugee Resettlement (ORR), 2011). In 2010 and 2011, Burmese refugees constituted the largest single refugee group resettled in the United States. Fleeing political oppression and regional conflict, Burmese refugees began arriving in the San Francisco Bay area in 2007. An estimated 500 have resettled in this area, particularly in the city of Oakland in Alameda County, California (Jeung et al., 2011). California remains one of the primary states into which refugees are resettled.

Burma's complex political history spawned three waves of immigration to the U.S., with the most recent wave resulting from ethnic minority refugees fleeing civil war with the central military government (see Figure 1). Burmese refugees are extremely diverse, with eight main ethnic groups with distinct languages and over 130 distinct subgroups (Barron et al., 2007).

The influx of non-English-speaking refugees from vastly different cultural backgrounds resulted in an increased demand on service providers and a moral imperative for communities to meet the basic needs of the new arrivals. The policy guidance issued by the Office for Civil Rights suggests that health care providers have a special obligation to ensure language access for their patients, given the importance of health care services. Once a health care provider accepts any federal funds, the provider is responsible for providing language access to all the provider's patients (Chen et al., 2007). Since federally qualified health centers (FQHCs) receive funding to provide health care services to the medically underserved and vulnerable, it is essential that FQHCs establish a method by which to absorb new language groups into their practices in an organized, sustainable way.

While federal civil rights mandate language access in the health care sector, California in particular passed SB 853 in 2003, which requires all privately managed care plans as well as individual and group health insurers to provide members with appropriate access to translated materials and language assistance when seeking care (Chen et al., 2007; Health Care Language Assistance Act, 2003). Despite these federal and state mandates, the community's capacity to accommodate new refugee cultures and languages is lacking. As described below, FQHCs can proactively embrace emerging communities to provide comprehensive primary health care. While systematic and coordinated efforts to provide services on the federal, statewide, and local levels must also occur, FQHCs can act individu-

ally to integrate new communities into care. Key internal and external factors, as well as operational processes that enabled expansion at Asian Health Services (AHS), are highlighted below.

Internal Factors

AHS is an FQHC in Alameda County, California, that provides health care to the medically underserved, a majority of whom are Asian immigrants and refugees (Asian Health Services, 2014). AHS provides services in eleven different Asian languages, most recently adding language access in Burmese and Karen (a distinct language for a separate ethnic group of Burmese refugees) in 2010.

Several internal factors were instrumental in expanding access to a new language group, priming AHS for service expansion. The first was the creation of open capacity to provide care to new patients. At AHS, the Frank Kiang Medical Center (FKMC) was a new clinical access point that opened in Oakland in 2010. Partially funded by the American Recovery and Reinvestment Act, the site had an estimated new capacity to care for 5,000 additional patients (Chang, 2010). This new capacity created an environment fertile for expansion of clinical services to the Burmese refugee population.

Second, AHS' mission incorporates the dual tenets of "service and advocacy" (Asian Health Services, 2014). AHS seeks to not only deliver high quality clinical services, but also to advocate, organize, and address emerging issues in its diverse communities. A guiding mission that integrates service and advocacy was critical to expanding access to the new Burmese refugee population in a coordinated fashion; without these principles, decisions about service provision could have become centered on an individual patient basis only, rather than taking a population-based, public health perspective that includes a responsibility to the entire community.

Third, leadership played a pivotal role at AHS to expand services to the Burmese population. A physician who volunteered in the refugee communities served as an internal champion within AHS. She advocated for the needs of the Burmese refugees and was critical in initiating and leading the effort. In addition, a vertical alignment within the agency (Site Director, Chief Medical Officer, Chief Dental Officer, and Chief Executive Officer) supported expansion efforts to the Burmese and Karen refugee group and paved the way for successful problem solving, resource allocation, and operational processes.

Fourth, AHS' FKMC site offered a comprehensive scope of clinical services: prenatal care, pediatrics, adult medicine, geriatrics, minor procedures, behavioral health care, and nutrition services, among others. Although dental service is not on-site, the agency does have a dental department, which provided dental screening for targeted Burmese patients at health fairs, and churches. From these screenings, many Burmese patients were found to have severe dental needs including caries, periodontal disease and missing teeth. The dental department trained a Burmese dental assisting student who was later hired to serve this patient population. Furthermore, when dental issues were identified by the medical providers at the clinic, dental services were quickly brought into the integrated care system. The site became a one-stop, comprehensive health care facility for these patients. Because expanding access to new languages entails additional staffing and costs to provide interpretation, intensive health education for patients unfamiliar with the Western and allopathic health care system, case management, and other enabling services, it was crucial to locate as many services as possible at one site to maximize usage of additional staffing. Comprehensive services allowed Burmese and Karen refugees to concentrate their care at one medical home, as a one-stop shop.

Finally, it was critical to hire culturally competent staff members to provide interpretation, service navigation, and outreach. This meant hiring from within the Burmese community as well as identifying staff with a high level of linguistic fluency, strong leadership skills, and a service ethic toward this community.

The clear delineation of these internal factors—service capacity, commitment to advocacy, leadership, and staff drawn from the community—facilitated the process for including the Burmese refugee population into care at AHS in a culturally competent way.

External Factors

Several external factors helped ensure a critical mass of Burmese patients enrolled into AHS to maximize the costs of hiring linguistically and culturally concordant personnel. First, data demonstrating the growing size and demographics of emerging immigrant and refugee groups helped to establish the need for expansion. This data was accessible through the local department of public health and the federal Office of Refugee Resettlement. In Alameda County, and Oakland in particular, the San Francisco

State University and AHS' physician champion conducted a local health assessment, which greatly assisted efforts to understand the Burmese community's needs (Jeung et al., 2011). Understanding the demographics and determining whether there were enough residents to balance out the costs of a full-time hire were essential before reaching out to the Burmese community and promising in-person interpretation and comprehensive primary care services on par with English services.

Second, support and allegiance from other community-based organizations (CBOs) and stakeholders, signifying a horizontal alignment across the community, were necessary. By working with organized community groups and social services providers who assisted immigrant and refugee resettlement, AHS had greater reach into the Burmese community. This helped to develop a critical mass of patients. These partnerships created a movement for community improvement and care, provided a vehicle for sharing resources and information, strengthened the referral base of patients into the clinic, and helped the clinic provide comprehensive services and advocacy for patients both within and outside clinic walls. AHS' physician champion also participated in the refugee health care access task force.

Third, in parallel to AHS' physician champion, an influential public health nurse acted as an external champion, agitating for refugee inclusion by bringing together the initial needs assessment team. She advocated directly to AHS to provide services to Burmese and Karen refugees. Her efforts helped to align AHS with community needs.

Fourth, the external process of conducting a needs assessment and organizing health fairs helped to establish community partnerships. The health fairs helped to create partnerships with other CBOs, such as the Burmese church, and introduced community members to AHS' medical and dental providers, giving them a glimpse of AHS before ever setting foot inside the clinic. Joint efforts to conduct the needs assessment also built trust in other agencies working with refugees.

Finally, media advocacy efforts helped to spur inclusion of emerging communities into AHS' services. After the needs assessment was published, there was widespread media attention, with coverage in local print and ethnic media. AHS's Burmese/Karen community health worker (CHW) was instrumental in finding

community members for the media to interview, and also interpreting for them. The publicity pressured the county into funding an adjustment/employment counselor for the Burmese/Karen community and generated momentum for inclusion of emerging refugee communities into AHS' services.

AHS encountered multiple barriers as it began serving the Burmese/Karen community. The small size of the community (estimated at less than 500) created initial reluctance from the executive leadership to invest in establishing full-time equivalent positions to provide language access for the community. Rather than starting with regular staff, AHS began by funding a Burmese- and Karen-fluent student intern during her summer break and only hired a full-time staff after the student intern succeeded in enrolling nearly 100 new Burmese- and Karen-speaking patients. The intern achieved this goal in less than two months. Grants also helped offset the cost of full-time staff serving this community. In addition to financial risk, there occurred occasional conflicts with other agencies caring for the Burmese and Karen community, in the form of perceived catchment area of service conflicts, or "turf battles." Staff (interpreters, for example) from these agencies erroneously perceived a threat of losing clients and possibly their jobs if AHS provided additional services to the community. While managers from the different agencies could agree to collaborate, front-line staff sometimes perceived competition and rivalry that, at times, impeded efforts to share information and smoothly transfer care. Service navigation was also lacking for newcomers, leading to fragmentation and interruptions in care. This occurred when patients lost Medicaid access and were not successfully linked to regular primary care after an initial, legally mandated immigration health screening. Advocates from multiple organizations, including AHS, had to approach leaders within the county public health system to address these gaps in care transition and issues with staff oversight and accountability.

Operational Processes

The operational processes leading to full language/cultural access at AHS for the Burmese/Karen community can be divided into four overlapping, yet distinct, phases. The first phase focused on outreach and data gathering; the second phase on internal FQHC infrastructure development; the third phase on developing, maintaining, and refining clinical programming and operations;

Figure 1. History of Burmese/Karen Immigration to U.S.[1] and History of Asian Health Services

1948	Burma gains independence from U.K. Civil war begins soon after.
1962–2011	Burmese military regime takes over former territories controlled by ethnic groups. Burma is under military rule.
1960–70	First wave of Burmese migration into U.S. after Burmese military takes control of the government.
1965	U.S. Immigration and Nationality Act (INA) passes, lifting the quota on Asian immigrants.
1967	The start of anti-Chinese riots in Burma. The first wave of Burmese migration to U.S. is of people with predominantly Chinese descent.[2]
1974	Asian Health Services is founded in Oakland, California.
1980–90	Second wave of Burmese migration into U.S.
1988	Burmese national democratic uprising on August 8, 1988, known as the "8888 Uprising."[3] Many refugees from camps along Thai-Burmese border provide assistance to U.S.-backed democratic forces.
2001	9/11 tragedy occurs in U.S.
2001	U.S. Patriot Act passes, effectively denying entry to persons involved with or providing support to terrorist or rebel groups, even if support was coerced or if the aims of the group matched American foreign policy. Legislation effectively renders Burmese and other ethnic minority refugee groups in political limbo as stateless people.
2005	U.S. Real ID Act passes, effectively denying entry to persons involved with or providing support to terrorist or rebel groups, even if support was coerced or if the aims of the group matched American foreign policy. Legislation effectively renders Burmese and other ethnic minority refugee groups in political limbo as stateless people.
2006	U.S. Secretary of State, Secretary of Homeland Security, and Attorney General issue the very first waiver, via INA discretionary authority, specifically designated for refugees from Burma at the Tham Hin Camp in Thailand, allowing resettlement in the U.S. even if they may have "provided material support" to the Karen National Union. The exercise of this authority determined that the material support bar was inapplicable and allowed the approval of otherwise eligible Karen refugees by the Department of Homeland Security, the agency responsible for adjudicating refugee applications for the U.S. Refugee Admissions Program.[4] Third wave of Burmese migration begins.
2006–7	12,800 Karen refugees resettle in the U.S.
2010	Frank Kiang Medical Center opens in Oakland, California, increasing health care access for Burmese and Karen immigrants and refugees.
2010–11	Burmese refugees, and the Karen in particular, constituted the largest refugee group resettled into the U.S.

[1] Cheah, Joseph (2008). Huping Ling, ed. *Emerging voices: experiences of underrepresented Asian Americans*. Rutgers University Press. pp. 199–217. ISBN 978-0-8135-4342-0

[2] Cheah, Joseph (2008). Huping Ling, ed. *Emerging voices: experiences of underrepresented Asian Americans*. Rutgers University Press. pp. 201. ISBN 978-0-8135-4342-0

[3] Cheah, Joseph (2008). Huping Ling, ed. *Emerging voices: experiences of underrepresented Asian Americans*. Rutgers University Press. pp. 202. ISBN 978-0-8135-4342-0

[4] U.S. Department of State, Office of the Spokesman, Fact Sheet, Secretary Decides "Material Support" Bar Inapplicable to Ethnic Karen Refugees in Tham Hin Camp, Thailand, May 5, 2006

the fourth phase on evaluation and continued quality improvement. Development of a culture of diversity and inclusion, with shared respect and understanding as common values, was an important outcome of these operational processes (see Figure 2).

There were two components to Phase I: community outreach and hiring/funding staff. When conducting outreach, collaboration with other refugee social services providers was essential to building awareness about AHS. Community health fairs proved to be an effective outreach and organizing tool, bringing together medical, nursing, dental, and community services staff from AHS with staff and volunteers from various community partners. In addition, yearly participation in local World Refugee Day events and cultural events like Karen New Year helped outreach and built the patient base to a level that could sustain full-time Burmese- and Karen-speaking staff.

In Phase I, AHS started with a college intern, who initially assisted with the needs assessment, then became a grant-funded CHW, and finally learned the clinical skills to become a Health Navigator (medical assistant with interpretation and referral duties). The CHW did not need health education or technical clinical skills; it was more important that the CHW served as a community organizer who gained the community's trust and had the language skills to communicate effectively in a health care setting. Because it is often difficult to find previously trained technical workers from a newly emerging community, it was beneficial to train an existing community member as additional skills were needed when the patient base grew.

Phase II consisted of internal infrastructure development. Operationally, this was divided into three components: structure of roles and responsibilities, personnel and staffing, and training needs. First, in defining roles and responsibilities, it was essential to incorporate interpretation duties into every job description. For the newly emerging Burmese and Karen populations, the intern/CHW role in Phase I shifted into a clinical role that also included outreach, health education, and minor eligibility duties. The multifunctional role lent flexibility and ensured continuity of patient care, information exchange, and community buy-in from the community outreach setting into the clinical setting.

When designing the structure of roles and responsibilities, it was also important to ensure that new patients were distributed across a number of clinical providers throughout the site. This

Figure 2. Opening Primary Care Access for Emerging Communities
Phase I
Outreach & Data Analysis
Phase II
Internal Infrastructure Development
Phase III
Development of Clinical Operations
Phase IV
Evaluation and Quality Improvement
Outreach: needs assessment, health fairs, coalition building
Staffing: intern, community health worker
Structure: staff roles and responsibilities, multifunctional health navigator, distribution of patients across clinicians
Training: technical training, history of new community, build culture of inclusion
Staffing: add new support staff positions, hire and promote from community, hire language concordant clinician
Eligibility: patient navigator to community events, civil surgeons at FQHC, waive I-693 fees
Programming: programming specific to emerging community needs, grant-funded health education, patient navigation and empowerment programs (Healthy Tomorrows, Office of Refugee Resettlement grants), dental and behavioral/mental health care integration
Training: continued cultural awareness training
Staffing: celebration and recognition
Evaluating: practice improvement team

would encourage buy-in from the staff that the entire clinic was responsible for caring for the community, as opposed to a single person bearing individual responsibility. By engaging various providers with direct care for patients from the emerging community, a cadre of internal advocates following the leadership of the internal champion was developed to ensure operational inclusion.

Second, personnel and staffing was increased as the clinic patient population increased; creation of new full-time equivalents (FTE) of support staff enabled language-concordant hires from the community. The increase in staff served as a "face" to the community and also ensured that care for the emerging community was internalized and operationalized at AHS. Because a new site was opened, AHS had the ability to hire additional staff to represent and serve the Burmese and Karen community. Furthermore, consideration and priority were given to hiring a physician fluent in Burmese to assist with institutionalizing the community as a core constituency of AHS.

The third component of Phase II consisted of staff training. At baseline, AHS ensured proper levels of the hard skills of technical training for the job duties and tasks, such as medical assisting or eligibility enrollment. The technical training may be more critical and more intensive for new community groups because there is a smaller hiring pool of candidates who have the educational level and skills, in addition to bilingual language fluency, appropriate for specific jobs. Furthermore, for the purposes of expanding access to a new immigrant or refugee population, it was essential to include training for all staff on the migration histories and culture for the new group. This helped to build understanding and awareness of health practices, beliefs, and health literacy levels. For example, it was noted that Karen patients did not know what a prescription was or how to use an elevator. At AHS, staff were trained on migration histories, trauma-informed care, and the differences between ethnicities and languages. Training sessions also created the space for all staff to share their own respective experiences and backgrounds and to learn from other groups. This created a culture of inclusion and shared collectivity for all other groups. The site became a clinic for all groups and cultures, with shared respect as a common value.

Phase III consisted of developing clinical operations at the health center. A first priority was determining patient eligibility for

different insurance options and assisting with immigration status so they could become eligible. A second and ongoing priority is developing, maintaining, and refining programming to reflect the needs of emerging communities.

In part one of Phase III, patient navigators collaborated with the CHWs and external CBOs to ensure that patients were counseled on their insurance eligibility. Furthermore, four AHS physicians were credentialed as civil surgeons so they could perform immigration examinations at the health center with low costs for patients. AHS also began a pilot program using discretionary community care funds to waive fees for emerging refugee patients in need of an immigration examination.

In part two, AHS designed and developed special programs to enable care coordination, service navigation, and health education for new arrivals, who had almost no appropriate interpretation in any service sector and very limited knowledge of the Western health care system. Several funding processes contributed to this phase, with grants from foundations as well as large federal grants from the Maternal Child Health Bureau and the Office of Refugee Resettlement.

Finally in Phase IV, there is ongoing evaluation and continuous quality improvement of services. The Health Navigators continue to learn from each other about cultural practices and customs. AHS celebrated milestones in terms of number of Burmese/Karen patients served, and management recognized those who were key contributors in enabling access to our clinic and those who went beyond the call of duty to assist our emerging community patients. There is ongoing Practice Improvement Team (PIT) work to identify areas for improvement and to develop solutions as a team. An example of a PIT project was attempting different solutions when our sole Burmese interpreter was needed to assist more than one provider concurrently. One solution was to "book a parallel appointment" (resource scheduling) with the interpreter at the same time Burmese patients are scheduled for their next visit. This ensured the interpreter only had to be in one place at a time and, as a resource, could not be overbooked. This was a temporizing measure until we were able to secure additional positions. Today, AHS has three full-time Burmese- and Karen-speaking staff members and a Burmese-speaking physician. With nearly 500 Burmese and Karen patients, who comprise nearly eight percent of

patient visits at FKMC, funding for these positions will continue long after the grants are over.

Lessons Learned

Expanding access to emerging immigrant and refugee populations with distinct linguistic and cultural needs can be sustainable. While an initial investment in personnel time and funding for additional staff to provide enabling services is required, there is a high return in the community's engagement and trust with the FQHC, external coalition capacity building, and the fulfillment of FQHC mission-driven values and moral obligations. Financial sustainability can be achieved once a critical mass of patients is enrolled, especially with the Affordable Care Act Medicaid expansion in California and a majority of patients from the Burmese and Karen community meeting high poverty levels for Medicaid eligibility, thus yielding reimbursable visits for care. (In other states, however, the federal bar against legal residents accessing entitlements prior to five years of residency poses a significant hurdle for emerging immigrant and refugee groups seeking access to care and will act as a large barrier to reimbursed care.) There are funding opportunities from foundations to support the initial unmet needs of emerging communities. Furthermore, as many refugees are resettled in the U.S., the patient base continues to grow with the addition of neonates as prenatal and family care services are provided to existing patients. Proactive planning of service expansion created a vertical alignment throughout the FQHC, as well as a horizontal alignment across other community-based organizations to meet the needs of the emerging Burmese and Karen population. Expansion is possible in FQHCs, and it can be done well and with significant community input and financial sustainability.

What to Expect

While AHS was able to integrate this new community successfully, it continues to face ongoing challenges inherent in reaching out to smaller, emerging language groups. The recent immigration history and small community size limit the available pool of bilingual community members with the interest and readiness to assume a health care role, which requires a certain level of education, literacy, and commitment to the community. Enabling services, or service navigation, continues to require heavy investments

of time and effort to complete specialty referrals, get prescriptions filled, or get diagnostic tests completed. Lack of language capability in other parts of the service system (subspecialty services, social services, school districts, etc.) makes the work of care coordination much harder (see Table 1).

Also, notably, AHS' success in incorporating Karen- and Burmese-speaking refugees spurred significant interest from other populations; however, it has not been replicated for other needy emerging communities, such as Bhutanese, Nepali, Karenni, Sri-Lankan, or other local refugee groups. With such demand for services from the community, the FQHC will be challenged to decide to which populations it will expand. While phone interpretation in these languages is available, phone interpretation alone cannot replace the deeper communication, trust building, and service navigation that in-person interpretation by staff can provide. Because it took a heavy up-front investment of time and funding before the clinic could reach a sustainable number of patients to justify bilingual staff, AHS ultimately lacked the internal capacity to expand in-person interpretation services to these other emerging groups, despite community demand and requests from partnering agencies to help serve a broader community of refugees. In reality, turf battles between service providers can impede collaboration at a local level. Competition for grants and limited resources may contribute to such conflicts, along with an unofficial competition between staff from different agencies for a greater share of clients. Interpreters within smaller communities wield out-sized influence since access to health care and other vital services passes through them. Care must be taken to provide appropriate training and accountability to ensure that the needs and wishes of patients, as well as the concerns and plans of health care providers, are communicated with fidelity.

Recommendations

When considering expanding primary care access to additional populations which have distinct language and cultural needs, it is important to carefully craft a phased plan. Each phase of the operations has separate staffing, structural, and operational needs. Phase I consists of community outreach and demographic analysis; Phase II consists of internal infrastructure development; Phase III consists of development of clinical operations; and Phase

Table 1. Examples of Burmese and/or Karen Refugee/Immigrant Cultural Conflicts with Federally Qualified Health Center (FQHC) Healthcare

Issues	Examples	Solutions	Recommendations
Community Capacity	Lack of Burmese/Karen applicants for clinic nursing positions	Recruit within the community where word-of-mouth is still a powerful tool Network among local churches, health fairs Tailor jobs so staff can continue to serve his/her community while advancing his/her education and career	Develop community coalition Mentorship of community members Consider collaborating with education institutions for workforce development programs
Sense of Time	Patients are late for appointments Agrarian and refugee camp life does not revolve by the hour and minute	Practice Improvement Team tasked with solutions to encourage punctuality Interpreter personally calls to remind each patient two days prior to appointment	Continued staff education about cultural competency and sensitivity Work with refugee groups on education about Western culture
Transportation	Patients are late because they do not read English or drive; they rely on others for transportation	AHS staff assists in transportation for the patient Friends, volunteers, or church-members assist in transportation	Reimbursement for enabling services: transportation Consider policy advocacy for (improved) transit lines to neighborhoods
Employment Rights	Patient with shoulder injury was terminated from his receiving dock job Patient lost her waitress job for being pregnant	Providers intercede on patient's behalf	Coalition building with social service agencies. Legal advocacy regarding employment rights Consider medical-legal partnerships
Language Barrier	A patient with a large abscess leaves the ER twice and returns to the clinic because he does not understand the ER treatment plan, despite suffering severe pain Patient took 30 pills instead of 30 mg of his meds and ended up in ER	AHS provider speaks directly with the ER provider to discuss patient's condition and plan. This is then interpreted and explained to the patient. Patient agrees to return to the ER a third time to be treated. Additional iteration and education about taking Western vs. herbal medicines	Horizontal Integration: outreach to downstream services such as specialists, ER, mental hospitals, and hospice to build capacity with appropriate staff or contracted services Working with other CBOs to educate the community regarding Western medications
Beliefs about Death and Dying	Patients do not want to discuss hospice or die at home (that would bring bad luck to the household). One patient went to the ER four times in three weeks until he expired in the hospital.	Many of our patients do not have Advanced Directives because the topic is taboo and very difficult via an interpreter Sometimes the topic can be addressed with the adult children of these patients. Develop trainings for staff on hospice care	Enabling services: health education

IV consists of evaluation and quality improvement (see Figure 2). These distinct phases do overlap and are often revisited as the evaluation and quality improvement phase mandates rethinking and revamping programs, roles, staffing, and structure.

Policy recommendations on several levels include the following:

1. Development of federal, state, and local funding streams and resources for new refugees should occur and be coordinated to support the needs of these emerging communities at levels similar to those provided to Vietnamese and Cambodian refugees. These funding streams should reimburse for enabling services from the FQHC (interpretation, care coordination, case management, health education, eligibility counseling, and transportation). These enabling services reduce some of the social determinants of poor health and can improve future health outcomes.
2. The five-year bar against lawful permanent residents accessing entitlements, such as Medicaid or Medicare, should be eliminated. Currently, refugee assistance expires after eight months of arrival to the U.S., but it takes much longer to assess and address the medical, dental, and behavioral health care needs of these highly marginalized and vulnerable populations.
3. Smaller community groups face particularly thorny challenges in getting any in-person, language-concordant services since they may never reach a critical numerical mass to justify, in the eyes of clinics and other service providers, the costs of bilingual staff. These smaller language groups may be served by collaboration between multiple agencies to fund a pool of interpreters who can interpret in multiple settings while also helping patients to navigate the service system. While the need for such collaboration has long been recognized, it has been difficult to come to concrete agreement on who should fund, hire, supervise, and support such interpreter/navigators.

At the community level, FQHCs considering service expansion to emerging immigrant and refugee populations should consider the following:

1. Developing and fostering relationships with community organizations representative of these emerging popula-

tions to share resources and information in order to establish a stable, sustainable community network;

2. Hiring CHWs from the emerging community with the skills not only to speak the community's language, but also to organize and build trust within the community;
3. Dedicating current personnel time to lead the expansion; and
4. Identifying both internal and external community champions who can work closely with FQHC leadership.

Integrated health care service expansion at FQHCs to new refugee communities is a daunting task. While there are immense challenges (funding gaps, capacity building, and creation of operational workflows), AHS demonstrates that it is possible to expand services to new communities and language groups through proactive planning and committed leadership from the FQHC and the community. FQHCs have a moral obligation and mandate for the underserved, and service expansion to emerging immigrant and refugee populations contributes to securing health equity for marginalized populations.

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Phyllis Pei, RN, MBA, is the Nurse Manager at the Frank Kiang Medical Center of Asian Health Services. She manages the daily clinical operations of FKMC and has extensive experience in quality improvement.

Kwee Say, BS, is a Health Navigator at the Frank Kiang Medical Center of Asian Health Services. She is fluent in Burmese and Karen and has also served as a community health worker and medical assistant. She plans on becoming a physician.

Julia Liou, MPH, is the Director of Program Planning and Development at Asian Health Services. She was instrumental in guiding the development of agency goals and evaluation measures for the clinical programming for the Burmese and Karen refugees, as well as securing funding for the programs.

Huong Le, DDS, MA, is the Chief Dental Officer at Asian Health Services. She developed the dental operations at the agency as well as the oral health community engagement programs for the Burmese and Karen refugees.

George Lee, MD, is the Senior Medical Officer and the immediate past Chief Medical Officer and Medical Director at Asian Health Services. He provided guidance and leadership to the outreach and development of programming to include the Burmese and Karen populations into care at Asian Health Services.