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William Arscott
Brian Costello
Kathryn DiPalma
Alex Folkl
Megan Malgeri

See next page for additional authors

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Authors
William Arscott, Brian Costello, Kathryn DiPalma, Alex Folkl, Megan Malgeri, Amanda Miller, Rebecca Purtell, Jon Bourgo, and Rodger Kessler

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Identifying barriers to care in the Burmese and Bhutanese refugee populations of Burlington, Vermont
Arscott T1, Costello B1, DiPalma K1, Folk A1, Malgeri M1, Miller A1, Purtell R1, Bourgo J2, and Kessler R1
1 University of Vermont College of Medicine, 2 Community Health Center of Burlington, Vermont

Introduction
Many refugees who escape persecution in their own country have trouble navigating and accessing the American health care system. Language barriers often impair effective communication, while financial challenges can be prohibitive after the eight-month government insurance subsidy for new refugees expires. In addition, many refugees do not understand the concept of chronic disease, which is a concern considering the overall rise in hypertension (HTN) and type-two diabetes mellitus (T2DM) in the US population. Understanding how refugees access health care, and how well they understand chronic disease, is essential for organizations providing medical care for these populations. Little is known about how the Burmese and Bhutanese refugees experience the Vermont health care system, nor how well they understand chronic diseases such as HTN and T2DM. To address these limitations, we conducted focus groups with these two Vermont refugee populations at the Community Health Center of Burlington, Vermont (CHCB).

Background on Study Population
• Of the 2.6 million refugees that have resettled in the US since 1975 more than 5,000 have resettled in Vermont
• Included in this population are 42 Burmese and 131 Bhutanese who began to arrive in 2006 and 2007 respectively1,2 (Fig. 1).

Results
Transportation barriers
• The expiration of the bus pass at 8 months frustrated and confused both populations.
• Difficulty finding appointments and language barriers made asking for directions difficult.

Appointment barriers
• Lack of translation services made scheduling appointments difficult and resulted in some missed appointments.
• Lack of patient support at Fletcher Allen Health Care (FAHC) made referrals difficult to navigate.

Prescription medications
• Burmese refugees had problems understanding prescription instructions, while Bhutanese did not.

The US health care system
• Some had lost insurance after the 8 month period and many feared losing insurance (getting a job without insurance and losing Medicaid).
• Both populations expressed difficulty understanding insurance coverage, paying bills (including copays), and did not understand the transition process from their initial insurance program.
• Many Bhutanese were unaware of Vermont’s low-income medical insurance (VHAMAP).
• Most were unaware of insurance-assistance programs offered by the CHCB and FAHC.

Patient/provider relationship
• Communication barrier limited understanding of medical information.
• Many Burmese would not tell their doctor if they used traditional medicine.
• Most trusted their doctor.

Chronic disease
• Most did not understand chronic diseases, or the causes, consequences, and treatment of HTN and T2DM.

Discussion/Recommendations
• Lengthening the time of the free bus pass would help to ease transportation for the refugees.
• Educational programs should begin during the refugees’ first 8 months. These programs would cover:
   • Options for insurance after the loss of Medicaid
   • Information about the US health care system
   • Chronic disease education
• Lack of translation services hinders care at all levels.
• For patients with limited English, it is essential to have translators onsite at all possible healthcare appointments for the provision of adequate care.
• Providers should be encouraged to provide translated and pictorial instructions when giving out prescription medications.

Conclusions
The respondents appear to struggle with lack of understanding of the health care system due to inadequate education, inadequate translation services, and fear of or loss of Medicaid. These recommendations may be beneficial to existing and future refugee populations studied.

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