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Recommended Citation
Arscott, William; Costello, Brian; DiPalma, Kathryn; Folkl, Alex; Malgeri, Megan; Miller, Amanda; Purtell, Rebecca; Bourgo, Jon; and Kessler, Rodger, "Identifying barriers to care in the Burmese and Bhutanese refugee populations of Burlington, Vermont" (2010). *Public Health Projects, 2008-present*. 36.
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The UNIVERSITY of VERMONT
COLLEGE OF MEDICINE
In alliance with Fletcher Allen Health Care

Identifying barriers to care in the Burmese and Bhutanese refugee populations of Burlington, Vermont

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Introduction

Many refugees who escape persecution in their own country have trouble navigating and accessing the American health care system[1]. Language barriers often impair effective communication, while financial challenges can be prohibitive after the eight-month government insurance subsidy for new refugees expires[2]. 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[3].

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 respectively[4,5,6] (fig. 1)

Figure 1. Location of Burma (red) and Bhutan (blue)

Figure 2. Htang, a Burmese immigrant and graduate student, translates for the Burmese.

> ***"Everything is better here, but the language is a problem."***
>
> -Bhutanese community member
> (referring to the US healthcare system)

Methods

- Focus groups were organized by community members who provided translation. They were conducted at the CHCB, lasted two hours, and were transcribed and moderated by members of our group.
- Demographic information was collected from Burmese and Bhutanese participants (Fig. 3).
- Questions were standardized between the two groups and previously reviewed by translators.
- The questions assessed 1) transportation barriers to accessing healthcare; understanding of 2) appointments/referrals, 3) prescription medication, 4) the US healthcare system, 5) the patient/provider relationship; and knowledge of 6) HTN and 7) T2DM.
- Research was conducted with approval of the UVM Committees on Human Research and with informed consent and photograph permission of all participants.
- Transcriptions of the focus groups were used to develop recommendations for the CHCB.

	Burmese	Bhutanese
Focus group size (% of Vermont population)	7 (6)	9 (3)
Age (range)	34.7 (17-65)	46.9 (29-59)
Chronic disease (%)	14.3	33.3
Hypertension (%)	0	0
Type-two diabetes mellitus (%)	14.3	11.1
Health insurance (%)	100	100
Employed (%)	14.3	0

Figure 3.
Focus Group Demographics.

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 (VHAP).
- 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.

Figure 4.
Burmese and Bhutanese community members during the focus group session.

Figure 5.
Second year medical student Rebecca facilitating the Burmese focus group.

Limitations

- Focus groups were small and not randomly assigned; thus, may not be representative of population.
- Additionally, with the use of interpreters some information may have been lost.

Discussion/Recommendations

- Lengthening the time of the free bus pass would help to ease transition 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/or pictorial instructions when giving out prescription medications.
- These recommendations may be beneficial to existing and future refugee populations studied .

Conclusion

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.

Acknowledgements
A sincere thank you to the Community Health Center of Burlington, especially Jon Bourgo, Htang Lay and Leela Neupane; Dr. Rodger Kessler, Dr. Jan Carney, Aaron Hurowitz, and Raj Chawla of the UVM COM.

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