



# Webinar: Children with Significant Medical Conditions Across the Migration Continuum

February 26, 2024, 12:00 – 1:30 PM ET

Transcript

## Introduction

**Sarah Clarke:** Hello, everyone, and welcome to today's training. I'm going to give people a few seconds to sign on, and we'll get started shortly.

[pause]

**SC:** Hi, everyone. I see that people are still signing on, so we're just giving everyone a few more seconds, and then we will get started.

[pause]

**SC:** Hello, everyone, and welcome. Thank you for joining today's training on Children with Significant Medical Conditions Across the Migration Continuum. My name is Sarah Clarke. I'm the executive director for the Society of Refugee Healthcare Providers. This training is presented to you by Switchboard. Switchboard is a one-stop resource hub for refugee service providers in the United States, and we're delighted to have you all joining us today.

## Zoom Orientation

**SC:** I know we're all very familiar with Zoom by now, but we just want to do a quick overview of your settings. We're in a webinar mode, so you're in listen-only mode. Due to the large number of learners on today's webinar, we've disabled the chat box. However, you do have the option to send messages to the speakers and facilitators through the Q&A. Keep an eye on the chat for messages from Switchboard and links to various resources. Today's webinar will run for about 90 minutes. We are being recorded. You'll receive an email with the recording, slides, and recommended resources within 24 hours. The webinar transcript along with the recording will also be posted on the Switchboard website within the following days.

**SC:** Then, lastly, we kindly ask that at the end of the session, when we share the survey, that you complete it. It's very short, only three questions, and it will help Switchboard know what you liked about the session today and what they can think about for the future. Now I'm delighted to turn it over to the wonderful Dr. Beth Dawson-Hahn and our excellent panelists to introduce themselves. Thank you, Dr. Dawson-Hahn and panelists, for being here today.



## Today's Facilitator and Speakers

**Beth Dawson-Hahn:** Good morning. It's great to be in conversation with everyone today. I'm Dr. Beth Dawson-Hahn. I'm a pediatrician at Harborview Medical Center and the University of Washington, and I serve as a medical advisor to IOM focused on maternal child health. There are few things I like talking more about than talking about the continuum of care across the migration spectrum, particularly for children, and I'm delighted to be with a series of colleagues today to share our perspective and to be in conversation with all of you. With that, I'm going to pass it over to my colleagues to introduce themselves. We'll start with Dr. Harith.

**Harith Mayali:** Thanks, Dr. Beth. My name is Dr. Harith Mayali. I'm a physician by training, and I'm the medical movement operations officer for IOM based in Washington, DC. I'll pass to Diane. Thank you.

**Diane Reichert:** Hi, I'm Diane, and I am a nurse, the lead nurse with the Refugee Health Promotion Program at the Harborview Pediatric Clinic. This is a primary care clinic that serves as a medical home to newcomer children with medical complex needs.

**Mary Fabio:** Hi, my name is Dr. Mary Fabio. I am a general pediatrician and the director of the Children's Hospital of Philadelphia Refugee Health Program.

**Lubna Almaroof:** Hi, everyone. My name is Lubna Almaroof. I'm the resettlement program manager at Jewish Family Service of Seattle, one of five resettlement agencies in Washington State.

**Jasmine Matheson:** Hi, I'm Jasmine Matheson. I use she/her pronouns. I'm the State Refugee Health Coordinator in Washington State.

## Learning Objectives

**BDH:** Great, now that you've met our speakers, we're going to share what our learning objectives are today. Our hope is that by the end of this session, you'll be able to describe the overseas medical examination and ongoing monitoring of children with significant medical conditions before resettlement, including transport to the U.S., and also to be able to recognize ways resettlement agencies and public health organizations serve children with significant medical conditions.

**BDH:** You're going to be hearing a little bit from us, and then we're going to be having an interactive case discussion, and then we'll look forward at the end—we've planned a significant amount of time for us to do question and answers with all of you.

## Poll Questions

**BDH:** In order to make sure that we're all on the same page, we'd love to ask you where you work, so please respond to this poll:

Where do you work?

[pause]



**BDH:** Great, thank you so much for responding. It looks like about two-thirds of us today are at resettlement agencies, and there are almost equal proportions of people coming to us from other contexts, community-based organizations, public health centers, and others. Thank you for being here. I think it'll be a really rich conversation.

**BDH:** We have one more poll question for you, which is,

[Do you ever accompany refugee families to medical appointments, or coordinate staff or volunteers who accompany families to appointments?](#)

[pause]

**BDH:** Great, so it looks like about two-thirds of us accompany families to appointments or coordinate staff or volunteers who do. We're looking forward to everyone on the group having a sense of what this might be like. With that, I'm going to transition us to hearing from my colleague, Dr. Harith.

## 1. Significant Medical Conditions

**HM:** Thank you, Dr. Beth. Thank you for having me today. I think it will be very helpful for colleagues to understand the whole process from the start overseas with IOM and then until they receive them on the domestic side. In today's presentation, we will talk more about significant medical condition cases or what we call them... or what is known as SMC cases.

**HM:** In the beginning, who falls under these categories? In these categories, in general, we have all pregnant refugees will be flagged as significant medical SMC cases. Refugees have travel requirements like medical escort or they need mobility assistance, wheelchairs, stretcher, or other travel requirements. Refugees require urgent medical follow-up within one week or earlier, and usually, cases require warm handoff to the domestic health professional. Cases requiring extensive surgery or treatment at the final destination. Refugees who have special schooling accommodation or employment needs. Refugees require assistance in their daily living.

**HM:** The idea of flagging them as SMC cases is to pay more attention to them and their needs either during health assessment or during travel or after arrival. We have created the SMC form, which has been created to communicate all the needs to non-medical staff and the resettlement agencies.

### [What criteria are used to identify significant medical conditions?](#)

**HM:** Next slide. [What does] it mean if the case [is] flagged as SMC case? When the case is flagged as SMC case, panel physicians or migration health physicians from IOM will start completing additional forms for these cases. For example. SMC form, activities of daily living forms, ADL forms. They initiate the medical expedite process if needed, so they can... if the case cannot receive the treatment, the required treatment or care, where the process is going on, we will initiate the expedite process so they can travel to the U.S. to continue their treatment.

**HM:** Also, it requires creating a follow-up management plan and refer them for care over the next period and prepare them for travel, and stabilize them to make sure they are fit to travel by the time of their departure. Of course, assigning a medical escort if needed. We always receive question about who's eligible to travel with the medical escort from the SMC category. If the case has a significant medical condition requiring monitoring or



possibly some treatment while in transit or have a risk of deterioration during travel, we will assign a medical escort.

**HM:** Other categories need medical escort if refugee traveling with a medical device, for example, oxygen, and to a urinary catheter or suction machine, and the family, they can help them with these needs, like we assign a medical escort. It varies, according to the needs. Sometimes we assign a doctor medical escort. Sometimes we assign a nurse medical escort. It varies by the needs. If the case requires mobility assistance, for example, carry-on cases and/or stretcher cases, and usually these cases, family will not be able to take care of them during travel, so we assign also medical escorts.

**HM:** We also assign medical escorts for cases with behavioral, cognitive, or intellectual impairment requiring supervision and ADL assistance, activities of daily living assistance. We always assign medical escorts for frail elderly cases with no family support. We also assign medical escorts for stabilized major psychiatric illness cases.

## Poll Questions

**HM:** For the next slide, this is a poll:

What percentage of refugee children have significant medical conditions?

**HM:** Just guessing.

[pause]

**HM:** I see different answers. Actually, the correct answer is it's between 15% and 20%. Refugees with SMC conditions, the percentage moves between 15% and 20%, especially in the recent years where such cases have been prioritized so they can continue their treatment at the final destination. Great.

**HM:** We have, also, a second poll question:

Coming into today's webinar, how comfortable are you with serving clients who are children with significant medical conditions?

[pause]

**HM:** It seems like 25% they're comfortable with serving SMC cases. We hope by the end of this webinar, you will feel more comfortable serving SMC cases.

## 2. Health Care Across the Migration Continuum

### Refugee Health Timeline

**HM:** For the next slide, in this slide, we will talk about the refugee health timeline, or the process in general, for the health assessment for refugees. This diagram reflects the timeline for the refugee health assessment



process. In general, the complexity of health assessment has increased over the last few years following the demand of improving the health of refugees and facilitate their integration at the final destination.

**HM:** Usually, the overall process takes place within approximately a six-month period prior to travel. All the time, the final details can change up to the last minute before departure, if medically necessary. At the right end of the slide, we have the final steps of the refugee health assessments. At this stage, we have a pre-departure evaluation to medically evaluate and prepare a specific group for refugees with known health conditions or movement should occur within approximately two to three weeks.

**HM:** Also, we have a pre-embarkation check that is usually done three days before departure. All refugees will fall under the category of having the pre-embarkation check. Lastly, we have the point of departure observation performed by operations staff. The whole process is usually six months. During the out-processing time, in the middle, usually, we have all the investigations [are] done like for TB, giving vaccinations for children, finalizing their vaccinations, and making sure that they meet the CDC recommendations for all the investigations. Usually, all the changes happen during the pre-embarkation check.

**HM:** Sometimes, you see travel requirements assigned during the health assessment or the initial medical examination. You always sometimes find that the travel requirements changed or maybe you see in the beginning that a medical escort is assigned, but by the time they are ready for departure, they are stable, and they do not need medical escort, so medical escort will be moved. We always receive questions about these changes. You should expect that all the changes can happen at any time during the process. We encourage the resettlement agencies and the receiving side to always be ready for any changes during this time. I think that's it from my side. I'll hand it over to Dr. Beth.

### Care Across the Migration Continuum: Collaboration Between Resettlement and Health Care Providers

**BDH:** Thank you, Dr. Harith. Today, our goal is really to talk to you about care across the migration continuum. If you look at these boxes, starting with box number one, this isn't an area we're going to focus on a lot today, but we just want to acknowledge that the prior medical care that families have received in their country or countries of origin before they have the opportunity to be in the resettlement process, of course, is going to impact their child's health. It likely also impacts their trust in the health care system and really sets the foundation of their interaction with the health care system to come.

**BDH:** Bearing that in mind, we're going to be focusing on numbers two through five as we discuss two cases with you of children with significant medical conditions. We'll walk through each component: the overseas resettlement process, medical movement for the case, U.S. resettlement, and then ongoing medical care in the U.S. We'll do this for two different cases with our multidisciplinary colleagues we have together. We know we're not going to cover everything that we likely anticipate you hope to hear about because we have a finite amount of time, but please put questions in the question and answer.

**BDH:** Please know that we've saved time at the end to really be able to talk more between ourselves about your questions. We welcome that as we go forward. The other thing we want to remind everyone of is that we know that this process ideally looks linear, those five boxes that were all in a row. All of us in this process know that it's never linear. It looks more like this wavy line. We thought having a multidisciplinary discussion today about these cases would help all of us remember the intersecting pieces that we play in working together to ensure the health of children who are in the process of migration.



**BDH:** With that, we're going to transition to the cases.

### Case Scenario #1

A family is being resettled to the U.S. with their two-year-old child. She has had a serious heart condition since she was four months old. It may be possible to fix the heart condition surgically, but she has not yet had surgery. The family is hoping she can once she is in the U.S.

**BDH:** Dr. Harith, can I ask you to start from the overseas perspective?

[silence]

**HM:** Yes, sorry, I had some technical issues.

[pause]

**HM:** From the overseas perspective, we usually send for the cardiology consult and identification. For this case, we identify that the case has pulmonary hypertension and wanted to highlight here that usually the availability of a specialist depends on the location where the health assessment is done. If there is a need for a specialty and there is no specialist available in the remote cities, we usually refer them to the capital city to receive the care. In some locations, if it is not feasible, we arrange tele-consultations with the specialists in the region. I just wanted to highlight this important point that the availability of specialists is not feasible in all locations.

**HM:** We did also a general pediatric referral as the cases as malnutrition. We have our own SOPs to implement, refer to a nutrition clinic and follow up with them. As I mentioned, for all SMC cases, follow up with them monthly and sooner if needed. We always keep following up with them until the time of departure. Thank you.

**BDH:** Lubna, do you want to share what it's like to be on the receiving side of welcoming a child and a family with this type of condition?

**LA:** Absolutely. Oh, go ahead, Harith.

**HM:** Sorry. I just wanted also to talk about, I forgot to mention the medical movement part because from our side also, from the U.S. side, we have a team to review the medical cases before departure. We make sure that the case is fit to travel and they meet all the SOPs. For this case, since the child [has] low O2 saturations, we assigned a medical escort and we request an oxygen for the international flight and for the domestic flight. Usually, all airlines or carriers, they do not provide oxygen. We have an agreement with a medical service provider to prepare a portable oxygen concentrator to have it ready at the port of entry.

**HM:** When they arrive, the medical escort would pick up the portable oxygen concentrator to be used for the domestic flight. Usually also, for similar cases, we request a wheelchair to minimize exertion and also coordinate with the resettlement agencies. For this case, I remember we had a next-day medical handover. The RA will work with the receiving provider to arrange a next-day medical handover, and the medical escort will accompany the family to the medical appointment to hand over the case to the receiving physician. Over. Thank you.



**LA:** Thank you, Dr. Harith. Moving on to the resettlement agency perspective. Just quickly before this case or before we receive the travel date for this case, we would have access to all of the medical records. That'll give us a couple of months, a couple of weeks of preparing for this family's arrival. In that stage, we plan capacity within the agency. Make sure the resettlement case manager has capacity to serve this case. We also make sure that intensive case management internally has capacity to serve this case.

**LA:** We prefer to keep things internal. We have a smooth handover when resettlement is done, which is basically just 90 days. Moving on to when we receive the travel information—at that point, we send the medical records to our great partners in Washington State, to Harborview Medical Center. They'll review the information that we have and they'll know what day and time the family is arriving. Based on that, they will schedule an appointment for the family. At that point, at the arrival time, we make sure the medical escort form is filled out, IOM and the nurse or the doctor that's traveling with the family knows who's the staff member that's meeting the family at the airport.

**LA:** They'll do a handover there, or if there is a next-day handover, then we have the appointment set up. We will be present at the appointment with the doctor the next day. We know these appointments can be very extensive. There will be a lot of information shared and obviously very stressful for the family as well. We always make sure we're present at those appointments to make sure we also have that information and we help the family follow up on the care plan as well.

**LA:** In addition to that, there's a lot of other aspects that we have to cover—medical insurance, housing, all of that. Those are most of the time considered pre-arrival. The hospitals in Seattle are closer to downtown and prices don't make sense. Instead, we consider proximity to local urgent cares, hospitals, family, friends. If it's a non-USDI case, no family or friends in the area, we try to keep them as close as possible to their community so at least they have that support. We also help introduce them to the community so they feel welcomed. That's pretty much it from... there's much more, but I'll hand it over to the next stage. Thank you.

**BDH:** Thank you, Lubna. I just wanted to say we're getting some great questions in the question and answer. Please keep them coming. Wanted to frame that we're focused today on the U.S. Refugee Assistance Program. A lot of what we're going to be sharing is really specific to programming that's been built in that context, but we'll do our best to answer any other questions that come up as well. Mary, I'll pass it to you.

**MF:** Great. I think from a medical provider standpoint, what I'm first looking at is I have a great partnership with the resettlement agency typically. As soon as they know about a medically complex child that's coming to the Philadelphia area, they will reach out to me and let me know what the condition is. I really look for those forms that Dr. Harith was talking about, the significant medical condition forms. Those are incredibly valuable as a provider. I take a look at that form, I see what the medical condition is, I see what it says in terms of how quickly the child needs to be seen, and I partner with the specialist.

**MF:** I know this child has a cardiac problem, so I'll immediately reach out to someone in cardiology at Children's Hospital and figure out how quickly they think this child needs to be seen by cardiology. Not just me, we will see that child immediately, but we also need to talk to the specialist and see how quickly they think that child needs to be seen. I also try to make sure that if the kid is coming on a Friday, how best are we going to make that medical appointment happen so that the family is not super stressed out about getting to an emergency room to be seen?



**MF:** Can we possibly see them in the primary care clinic? What is the best venue for that? I really try to work hard with the resettlement agency to see what the best option is for the family. One of the things that's very important on that form is how quickly does the child need to be seen? Is it like an immediate? Is it next day or one week, one month? I think that's very important to take a look at that and see how quickly.

**MF:** Now, this child, obviously, because they had the congenital heart disease and pulmonary hypertension and then an oxygen requirement for travel, they really should be seen immediately. That child that's marked on that form, and we work really hard with the resettlement agency to see them as soon as they're there. We work to make sure that we can communicate even right after the child lands, someone from the resettlement agency is there to greet them. How does that child look? Can we go with our plan that we had? Can they come to the clinic, or do they need to go to the emergency room because they look terrible? Those are the things that we can talk about with the resettlement agency to make sure that this child gets the best care and right away if they need it right away.

**MF:** We do partner with them to say, "Look, this kid is going to need surgery and then this kid is probably going to need surgery, is going to need a lot of follow-up appointments. It would be best if they live closer to an area that they can get to the hospital easily because it's going to be a lot of back and forth." We really work hard on doing that also. Then the other really important thing is when I'm talking to the specialist, is there any blood work or evaluation that they would like immediately before I get them in to see the specialist so we can sort of coordinate that at that initial visit? Is there something that's critical to them? I will make sure that we try to get that done at that initial visit with us.

**MF:** Other things that are really important is when the family comes in and they've been told, "Your child has congenital heart disease and they're going to need to have that fixed." I cannot promise anything. I do not know what that congenital heart disease is. Really important when they're asking me questions at that initial visit to talk to them and say, "Look, I don't know what you're going to need. Your child may need heart surgery. We need to get you to a specialist."

**MF:** Sometimes the heart disease is so complex that it is not amenable to surgery. That's something, and I know many refugees that come to the United States are under the impression that the medical system in the United States can fix everything. We all know that that is not necessarily true. I try not to make any promises at that initial visit and tell them, "We're going to get you exactly where you need to be seen. We're going to do a full evaluation and then you and the specialist will make the best choice for your child." I think that's also very important.

**MF:** The other thing that I always find for a kid that has heart disease in particular or is going to require surgery, usually for me, a rate-limiting factor for them getting cardiac surgery is their dental issues. If they have a large number of cavities and oral decay, they can't have heart surgery. I speak to the resettlement agency right away. When I see the kid, I say, "This kid has a ton of cavities. They're not going to be able to get their heart surgery, if they can get heart surgery, until they have their teeth fixed. So let's work as quickly as possible to get them into a dentist and get those caries taken care of."

**MF:** The other thing is—and we have had this with a number of complex patients that come to the United States—is that there's some vaccine hesitancy. Many of them have not even had the vaccinations that are recommended in the country that they're coming from, or they declined vaccinations for travel because their provider in their home country or somewhere else has told them that because the child has such medical complexity, they should not get vaccinated. That's something that we often need to work through once we





develop some trust and rapport, but that is a common issue that I have with children with medical complexity. That is definitely something to consider and to bring up with the family, although maybe not at the very first visit. [laughs] Thank you.

**BDH:** Wonderful. Thank you, Dr. Fabio. When now colleagues having heard each other share about each step of the journey, is there anything you want to add before we go on to the case? We're getting a lot of great questions that I anticipate we can answer in the question and answer, but they may have triggered something that you want to bring up now. I want to create the space to do that.

**JM:** I can jump in and add a little bit because I see some of the questions are really locality-specific. I guess I want to just note the fact that our programs and resources as states and localities are different in different areas. This is collective work. As you heard in all the different case studies, that communication pre-arrival, the more coordination that is feasible, the better our ability to support a newly arriving child is within our really complicated medical systems. The relationship and that reach out ahead of time to ask questions, to try and put in place a care plan is really important within your local context.

**JM:** I noticed that in our poll, we have a lot of resettlement agency partners on the line. I think in terms of considering assurances, that relationship is also really important to understand what your local community has in terms of the access points. Since not every community has the same opportunity for direct access or close access to specialty care, particularly for children, it can be really important in terms of considering whether or not to assure a case and how successful that family can be locally.

**JM:** The other thing I'll drop in the chat here is a list of our State Refugee Health Coordinators and State Refugee Coordinators' contacts by state. We are here to be a resource for you all. If you are struggling to connect with local resources or to understand who some of your partners might be, your state refugee health programs can be a great resource in that area as well.

**BDH:** Wonderful. Thank you, Jasmine. Does anyone else, and do any of the other panelists have something they'd like to add at this point? I'm going to transition us to our next case because a lot of the questions I see coming in are also applicable to this case. I think it will create foundation for more questions and understanding.

## Case Scenario #2

A six-year-old child has cerebral palsy and seizure disorder. He drinks formula for meals. He takes two anti-epileptic medications and had his last seizure last week. His family carries him or he uses a wheelchair.

**BDH:** We're going to follow the same approach and walk you through the overseas exam, medical movement, resettlement, and ongoing care. I'll pass it first to Dr. Harith.

**HM:** Thank you, Dr. Beth. For this child overseas, after the health assessment, the panel of physicians will start the referral process. For this case, the panel of physicians sent the child for a neurology consultation to make sure that if there is any steps that IOM need to be done before departure to make sure that the child will be fit to travel by the time of departure. Since the child has been identified to have severe acute malnutrition, we follow IOM SOPs for malnutrition. We do all the needed investigations and refer them to a pediatrician to follow



up on their condition and also refer them to a nutrition clinic also to make sure to improve their nutritional status before departure.

**HM:** For this child also, before departure, we need to make sure that the child has enough medications before departure. As per IOM SOPs for refugees traveling with medications, they need to have at least eight weeks of medications, eight weeks of supply of medications. Because we know the time after arrival, it will take time for them to be—sometimes there is a delay to see a primary care provider and until the insurance is issued. We need to make sure that they have enough medications until they receive a renewal of their medications.

**HM:** Also, since this case will be for sure identified as SMC case, we will plan to have a regular follow-up, monthly follow-up by a nurse until their departure to make sure they are stable and by the time of departure, they have all the required referrals and their fitness to travel letter from the specialist.

**HM:** Next, I will talk about the medical movement part. From our side, for this case, since the child has cerebral palsy and probably a problem with neck support, we ensure that he has good neck support. And whether the child can sit in the upright position for takeoff and landing... If the child cannot sit in the upright position, we usually arrange for a stretcher to move him as a stretcher, or we book a business class seat. It depends on the needs and the availability. If the child can sit with a car seat, we arrange a car seat with the proper neck support so they can travel safely to the final destination.

**HM:** By the time also of the departure, the medical movement team will make sure that the child has enough medications. Medical escort needs to make sure that they split the medications in their carry-on luggage and the rest... and the checked-in luggage so they do not lose all the medications in case [something] happens.

**HM:** Feeding supplies for this child: we need to make sure that the child has enough bottled formula for travel. If needed, suction device if the child needs regular suction. Of course, we will have a medical escort for this case. If the decision [is made] that the case will be traveling as a stretcher case, we make sure that the handover will be done at the residence. Usually, for the medically escorted cases, the handover will be done at the airport to the resettlement agency. For similar cases with significant mobility issues and they need to travel in a stretcher, we arrange an ambulance to pick them [up] from the airport at the final destination. We always ensure that the handover will be done at the residence. Even the medical escort will make sure that the residence is safe for the child and the resettlement agency case manager is fully aware of the child's condition. Thank you.

**BDH:** Thank you, Dr. Harith.

## Q&A Panel

**BDH:** There was a question in the chat that might be easiest to answer now, which was a curiosity about:

[How much formula travels with people when they are dependent on formula for their caloric needs?](#)

**HM:** Usually like for the formula, I don't think that the airline will allow them to travel with a lot of formula. We ensure they have enough formula only for travel.

**BDH:** Great, thank you. Lubna, can I pass it to you to talk about the resettlement perspective?



**LA:** Absolutely. Similarly to the previous case, we knew about this condition pre-arrival at the assurance stage, which is when we decide we can serve the case or not. We've considered ICM capacity, intensive case management capacity, resettlement capacity, language, cultural backgrounds of case managers as well. We get the travel information, immediately send it to Harborview Medical Center, try and get appointments as soon as possible, complete the medical escort handover form.

**LA:** At the airport pickup, we'll make sure we have a low-ground clearance vehicle to make sure the kid doesn't struggle when going in and out of the car. We don't drive, unfortunately. We don't have the capacity to have ADA-accessible vehicles, so we work with what we have. Then if an ADA unit isn't ready by the time of arrival, which we have actually in the area, ADA hotel rooms, which is great. In that room, we try to consider what are safety risks in the room. We try to remove that if we can. We will escort the family. I saw that in the questions, we will escort the family to the first appointment. It's a big hospital. They will not be able to navigate that on their own. We'll escort them to their first appointments, all of their first appointments with the first-time providers. If they're not comfortable going with medical taxis to future appointments, we'll make sure we repeat those one-on-one orientations to those bigger hospitals to make sure they're comfortable taking the taxis in the future.

**LA:** As far as the formula, we try to talk to the family if they have any family or friends here, to get us information or get in touch with the family itself about what type of formula they're using and try to prepare as much as we can on our end because they don't always arrive with enough formula with them. That's pretty much it from our end. Thank you.

**BDH:** Thank you, Lubna. Lubna, do you mind, there are a couple of questions about how people connect to primary care after arrival. I know you touched on this a little bit. Do you mind expanding on that?

### How do people connect to primary care after arrival?

**LA:** Connecting to family—?

**BDH:** To primary care, like to medical care.

**LA:** We have a referral line with the major hospitals, so Harborview Medical Center, which we use for complex medical cases. Most of the time, those with SMCs go through the Harborview Medical Center pipeline. We have the peds department, Diane, who's great here, helps us with appointments. Then we also have an adult nurse scheduler as well. Then for cases that are—sometimes SMC is for hypertension and it's in control, and the case arrives and there's no major concerns. We use a smaller community clinic pipeline and we have a direct access. There is a refugee program there. We send them the MEFs and the SMCs as well, same process. Usually, those appointments are two weeks to three weeks. Obviously, we can get a sooner appointment if we think the case needs one.

**LA:** In addition to that, obviously, a lot of things can change between assuring the case to getting the travel information and then to landing. A lot of things can happen in the flight or even before flying to Seattle. It's really important for us to be at the airport to get that information firsthand, make sure the case is fine and nothing has changed from the information that we have already. In short, if it's a severe complex medical case, that's Harborview Seattle Children's. If it's controlled, they have enough medications, they arrived with no immediate medical concerns, they're stable, then we go to a community clinic that's closer to either their temp housing or their permanent housing.



**LA:** Then in the meantime, as soon as they land, we submit the health care or medical insurance application, and we make sure we know it's in the subject that this is urgent because there's a medical condition here that needs to be taken or treated as soon as possible. Our state partners have been great in expediting those applications and making sure clients have insurance for those payments. I hope that covered the question.

**BDH:** That was fantastic. Thank you, Lubna. Diane, can I pass it to you now?

**DR:** Yes, and I think that's a good standing point too, just to start the conversation before I roll into the next steps from a care perspective. The state of Washington does have a very unique model for supporting the high medical needs of newcomers. We do this in a multidisciplinary approach, and that involves us at Harborview in which we see and serve as a home for medically complex children. Along with, we do have a partner who serves the adult side, but again, for this particular conversation, we'll just speak particularly to pediatrics.

**DR:** That partnership includes our five resettlement agencies, for which Lubna and Jewish Family Services is one of them. It also involves public health as well as our state DSHS and ORIA. What Lubna is speaking to is when she does receive that complex case, they do reach out to myself at Harborview. We have yet another specific model within our clinic. I act as the lead and I will review those medical records to see and assess what those medical needs are of that child in relationship to when they're arriving. If we're missing any information, then I'll reach out to Harith and our other partners and IOM to make sure we have enough information as possible to create a very safe arrival for that child.

**DR:** In this particular case, this child is going to arrive with a medical escort. We know that beforehand as well. That is part of what I will do is work with the resettlement agency and my physicians within the clinic to make sure that we have a warm handoff at the time of the arrival, meaning that the resettlement agency will meet them at the airport when that child arrives. We'll have a phone call conversation from physician to physician to ensure that that child did have safe travels and that we don't need to make a change of plan and send that child to a local emergency room, whether that be something super close to the airport or our partnering hospital would be the Children's Hospital of Seattle.

**DR:** At that time, if the warm handoff goes as planned, then as I've reviewed those pre-overseas records, we have a plan in place to see that child in our clinic soon after the arrival. In a case like this, speaking specifically to a child with CP and seizure disorder, this can actually vary. I would anticipate a child like this to be seen in our clinic anywhere from one to three to four days, again, depending on how stable that child is, and especially focusing on the seizure disorder, which is probably going to be the deciding factor as to how soon we need to get them seen.

**DR:** It's been my experience that we will see these families arrive on Thursday night. [chuckles] Sometimes even though they seem somewhat stable, we will work them in to get them seen prior to the weekend just to make sure lay eyes on them, make sure everything is okay, make sure that they do have all their appropriate medications and/or start any specialty for referrals. In most cases, again, just making sure that child is safe to make it through the weekend.

**DR:** In all of this, there's that ongoing conversation with the resettlement agency, and I think that that's really back to that partnership to help make this whole situation super successful, is that I am always communicating with them as to what to anticipate. Again, the first thing is making sure that this family knows how to call 911 in case of an emergency once they are here as well, and again, especially on those weekend arrivals. If the



child is stable enough and in that ideal situation that we may not have to see that child in our clinic for several days out, say day three or four, then I call the family prior to that appointment.

**DR:** The purpose of that is to not only gather more information—although those overseas medical records have a ton of information—it's really usually most beneficial to have that one-on-one conversation with the family to really get to understand how they've been caring for this child. It really sets the stage for the provider in the clinic at the upcoming visit to focus more on the needs of what's going on then and there and focusing on those next steps with referrals when they have a little bit of history involved.

**DR:** It also allows me to set the stage for the family welcoming them to the States, welcome them to Washington, and preparing them as to what this is going to look for their child and that they are about to enter a very strange and confusing medical environment where they will be having multiple specialists see their child where perhaps they've only seen perhaps one doctor from whatever country they're originating from.

**DR:** Our clinic is a primary care clinic, so we do not have specialty care services in our clinic or at the institution in which we live in. We partner with Seattle Children's Hospital, and for a child with CP and seizure disorder, we're probably looking at anywhere from five to six specialty referrals that will be sent to the Seattle Children's Hospital. Then we have a nurse case manager that works in our clinic. Once I get the family set up for that initial visit, then our case manager will step in, and she will do coordinating care of all these referrals as well as advocating for this family with other needs of the child.

**DR:** These are families that children may not have attended school, which in the United States we value that every child, no matter what their needs are, that they will receive an education. We start very early talking about school, knowing that this will be a process.

**DR:** There are many things that I have learned from this role and working with families in that learning that everything is a process. Where we may feel very compelled to work through things very fast to get all these services for this child, unless it is urgent, a medical type of urgent necessity, what we've learned is to take it a little bit slower. Prioritize with families. Work with them so that they can embrace the next steps that will occur instead of becoming so overwhelmed and can sometimes not necessarily reject, but it becomes very complicated and difficult for them to adjust to this new environment.

**DR:** The other thing to keep in mind with a case like this and the things that we consider on our end from a care management side is there will be DME that's involved. We'll provide once that insurance is up and running, and again our resettlement partners are great at making sure that happens very quickly. I would say generally anywhere from three to five days, we really have insurance coverage for these children so that we can then get access to DME supplies, like diapers, we can get nutritional supplements. We talk about housing.

**DR:** Again, housing is very difficult, but recognizing that these are children who are in wheelchairs. To look for housing on ground floors to prevent any barriers down the road for school access and to make sure that they do actually have wheelchairs. Sometimes they do not arrive with wheelchairs. Again, that specialty service of getting them connected at the hospital for their physical therapy, DME, fitting is great. Then we also try to search and look within our community of services that may be able to donate wheelchairs to help children as well. I think that's probably about it. That was a lot. [laughs] Did I miss anything?

**BDH:** Diane, there are a few questions that have come up about connecting children with school. Do you mind expanding a little bit on that? Dr. Mary, please feel free to jump in there as well.



## How do we connect children with school?

**DR:** Yes. School can definitely be a little complicated. What is important is, again, working closely with your resettlement agency. Again, I have that conversation very early on as a reminder that this child, even though they do have medical complex needs, they may have intellectual disabilities, they will still go to school. I encourage and talk through the process of making sure—I think the biggest step in that process, at least in the state of Washington, is making sure on that school enrollment side of things that you indicate that this child does have complex medical needs, that there is something going on.

**DR:** I've had some families and resettlement agencies work on this together. I think for families who may not acknowledge that there is anything wrong with their child because there is not for them—this is the child that they love. Sometimes what we're seeing as flags that could be medical concerns for that parent, these are just their children. They don't always flag the fact that there is something medically wrong that's going to require an IEP or some sort of special ed services at the school.

**DR:** Once that application goes in, I ask the resettlement agencies to let me know where that enrollment is so that we can, on the medical side of things, start reaching out to the school and start that dialogue. Because the biggest thing from the medical perspective is to make sure that they have all the forms that are going to need to be signed to make sure we start talking about that dialogue.

**DR:** Again, this is not a quick process, and that's what I try to explain to the family and to the resettlement agencies. Just because we enroll, I can tell you it will be a very lengthy time before we actually get that child into school and start that school process.

**MF:** For some of these children, if they're intellectually disabled, often schools don't do that initial evaluation due to the language barrier. They say we can't tell if the child has intellectual disability or not because they don't speak the language. The resettlement agency knows this also, but we really push hard. If I think the child has an intellectual disability, we really push hard to get that child evaluated again using appropriate interpretation and especially if I have safety concerns about a child.

**MF:** If I think they could be a flight risk in school, or if there's other issues, I'll certainly reach out to the resettlement agency and then also to the school to express my concerns and the urgent need for an evaluation or just a safety evaluation. Because the last thing you want is a child to be at school and not be safe to be placed in a regular classroom. Typically in Philadelphia, you don't get an evaluation for 90 school days. That's a long time. [laughs]

**DR:** I'll add to that. I think what's key to what Mary was saying in regards to various barriers within our school system, it really requires advocacy. The medical side definitely does ongoing advocacy for this, but you also do need that support where that caseworker comes into play because I think the families do not understand the process enough. I think families are very excited and thankful and grateful just to have this opportunity to have their child go to school, but they don't necessarily recognize all the services that these children deserve to have. Therefore the advocacy that you would expect, perhaps you and I would do for our own children, looks very different for a newcomer family who is just happy to have their child going to school.

**BDH:** I think to build on that, there have been a few questions in the chat around interpretation. We expect everyone to interface with interpreters for all federally funded services. We're working with interpreters in all of



these scenarios, and the school system is expected to as well. One of the pieces that we do in our primary care practice, where I work with Diane, is ensuring that families understand that they have a right to interpretation.

**BDH:** Of course, we are well aware that things are not perfect with interpretation everywhere, and there are often shortages of interpretation. I think providing the information to families that that's an expectation of their care is important. Then knowing where they can speak up if they're not having their needs met from a language services perspective is important. I wanted to address a couple of other things that came up in the chat before we transition to our formal question and answer.

**BDH:** There've been several people who have asked questions about connections to specialty care or connections to specific equipment. One example of that might be formula. In our clinical practice, what we've done in that case is to work with the resettlement agencies that we partner with to help them ensure that they can get access to formula. If you're having trouble getting access to formula as primary care providers, so pediatricians and nurses and pediatric practices on this call, in some context, it might be a family practice colleague or an internal medicine colleague. All of these individuals could write prescriptions for formula.

**BDH:** I'm curious if you're having trouble getting formula. First, kudos for recognizing they need the formula. Because sometimes that's confusing and not clear. Second, having a partnership with a clinic may help you get access to that sooner, even a primary care clinic. You might not need a gastroenterology specialist or a GI specialist. You might just need the primary care doctor.

**BDH:** Another thing we talk a lot about in our practice is that we see people frequently for preventive care, and not everyone has had the privilege or the opportunity for that around the world. When we see children 10 times in their first three years of life, that can seem startling, and we consider that the opportunity to start to build trust and to have a lot of curiosity and cultural humility about partnering with families.

**BDH:** One of the questions that came up in the chat was,

[How do you approach working together across language difference, across cultural or religious differences?](#)

**BDH:** We really think of this as being a relationship-based navigation. Really encourage all of those preventive care visits [which] actually create a great place to do that. I recognize it's sometimes hard to get into those visits, but I think an ongoing partnership with a clinic can help to do that. Jasmine, I wanted to see if there are other things you would be interested in adding from the State Refugee Health Coordinator perspective.

**JM:** I noticed a theme in a few different questions that was around access or more rapid access to care. I want to name as well that in many parts of the country, there are delays in getting access to initial primary care visits or refugee medical screening visits. I think that's not different in Washington. We have delays in this area, too. We've tried to really try and prioritize and meet the level of care needed for people based upon where they're at.

**JM:** The specialized pathway that Diane described is meant to facilitate access for people with the highest level of need. Also, recognizing that people who don't have immediate needs may also be waiting in some contexts. I just wanted to frame that a little bit as well, just recognizing that I know that particularly post-COVID, there are delays in a lot of places in our country around access to health care.



**BDH:** Great. Thank you, Jasmine. We're going to transition to talking about answering your questions and adding additional pearls from the cases here. Please feel free to add thumbs up to vote for participants' questions that are in the chat. We make sure to elevate those things and type your questions in the question and answer as well. We'll spend the remaining portion of the presentation going through this, and at the end, we'll provide you with some additional recommended resources as well as a survey to continue to improve this for everyone else.

**BDH:** One question to start, since we are a multidisciplinary group, I noticed that Dr. Maggie Brunski Isaacs asks whether or not we have routine interdisciplinary care conferences. Dr. Mary, I thought maybe you could start by sharing your perspective from Pennsylvania.

**MF:** What is the exact question, Beth? Sorry. [laughs] I'm scrolling through the question.

**BDH:** You're great. It's a question at the very end. It says,

[A great presentation. Do you have regular interdisciplinary provider case conferences to discuss patient needs progress, or is this mainly coordinated through the caseworker? Also, can you comment on the role of child life and how they're involved?](#)

**MF:** Okay. We don't have interdisciplinary case conferences. We do, at our office, if the patient is very complex, we get them a nurse care manager that helps to coordinate all the care. Then we will communicate pretty regularly with the specialists to make sure that everything is being done.

**MF:** I can think in one mind we had a kid with Down syndrome who was incredibly needle-phobic and needed a lot of evaluations. We tried to coordinate everything that he needed at once. He needed to be sedated for a procedure. We tried to get his blood work, his dental care, everything done at one visit. That took one sedation. That took a lot of coordination, but we had a nurse care manager that worked with the case manager from the resettlement agency and with the specialty providers. That worked really well. It depends on the complexity of the patient. We haven't necessarily had interdisciplinary conferences.

**Beth:** Thank you.

[Lubna and Diane, do you want to talk about... the ways that you interact with each other in King County, Washington?](#)

**DR:** Yes, I can jump in. Like I said, Lubna and I, we communicate quite a bit when we are working on a case together. That will either be via email... There are numerous emails from the very beginning that go back and forth. That communication is about in regards to that child's arriving in preparation of. Once that child is actually established themselves in the clinic, then there is this ongoing dialogue of making sure that the agency is aware also of all these specialty clinic appointments as well as whatever appointments are going on in our clinic.

**DR:** We want the family to be aware of this, but we also want the supporting agency to be aware so that they can help with the transportation needs of the client, making sure that they do get to these appointments. We also, in that communication, just bring the caseworker up to speed on any other thing that we may have learned. If we want to make sure that the child is connected to WIC, any of the nutritional supplements that we may be getting, let them know that there's been DME ordered.





**DR:** There's this constant communication, especially in that first probably a couple of weeks where housing may be temporary and moving into permanent housing, this kind of ongoing dialogue between us to make sure that nothing is missed in regards to any of the services that we're trying to get the family connected to. Then, like I said, a lot of this will happen via email, but then there's also a lot of phone conversation as well.

**BDH:** Thank you.

Dr. Harith, you're often working behind the scenes ensuring someone with SMC conditions arrives safely. You're also having a form of interdisciplinary care conferences. Do you mind sharing a little bit more about how you do that?

**HM:** From our side, also, about the SMC cases, as soon as the case is booked for departure, we start our communication with the sending mission to make sure that the child has all the needed documentations, all the referrals are done. If the case is very complex, and the specialists are not available, you have been involved also for consultations. We send... We have an agreement with University of Minnesota-based consultants.

**HM:** In case that we have any complex case, and we have recommendations from different specialists overseas, we request the sending mission to initiate a consultation request. Then we reach out to our colleagues from University in Minnesota, and you are part of this consultations. We always have these ongoing conversations with the missions from the time the case is booked for departure until they depart.

**HM:** Also, from the receiving side, we also act a liaison with the receiving side if the case is complex and requires immediate attention at the final destination. Sometimes we ask the resettlement agency to connect us directly with the receiving physician, so we make sure that they have all the information that they need. What's the best way to make sure that the child [is] receiving the timely treatment that they need? We act based on that. We always have these conversations with the overseas... with [the] sending mission and domestically with the receiving side as well. Thanks.

**BDH:** Thank you, Doctor. Please, Jasmine.

**JM:** Yes, about the interdisciplinary calls, the ones that I've gotten to be a part of, one of the things I've really observed our clinicians doing that I think is really helpful is talking about what a diagnosis means for a family, so everyone is on the same page in really practical terms because not everybody has had that clinical training and background and so necessarily knows that a particular diagnosis means we're going to be back and forth going to the hospital every couple days to do these tests and these specialists.

**JM:** Really setting that expectation both for the family and for the case management team is really helpful, so everyone stays on the same page. Also recognizing that there's so much information coming to a family in the first period of time that they're processing both about their resettlement process and about their child's diagnosis. Repeated consistent messages are very helpful.

**BDH:** Thanks so much for bringing that up, Jasmine. Go ahead, Diane.

**DR:** Can I just tack onto that too? Again, in part of our model in our state, one of the things that's wonderful about the partnership that we have with our resettlement agencies is that we do, there is so much room on the medical side. I spend a lot of time talking with the agencies. There's been training sessions of talking about



different diagnoses of children as to what to expect so that they too become more comfortable and are in a space where they can ask more questions about different diagnoses and how to approach different things.

**DR:** We also have monthly meetings with two of our larger resettlement agencies to discuss the cases that we're both partnering on. I think what's been great about that as well is that it is this more... an open forum, an open space where we're all sitting together in a Zoom-type meeting, but it allows us to really talk about things that are coming up with different families that are related to diagnoses and how that's really affecting their social situation. I think, again, that that relationship that I'm fortunate to have with the resettlement agency is really important for the success of the family.

**BDH:** Thank you. Jasmine, on a different level of thinking about interdisciplinary conferences,

*I'm curious if you might share a little bit about the New Arrivals Working Group.*

**BDH:** Because I think that's another example of interdisciplinary meetings, not necessarily about a specific case but about how our broader public health, health systems and resettlement agencies work together.

**JM:** Sure. The New Arrivals Working Group is a group in the King, Snohomish, and Pierce County region in Washington State. We have five resettlement agencies in that region. It's a meeting that we host every two months or so that brings together a multidisciplinary group of partners, and it is intended to both share information about what we're seeing in terms of current arrivals and also to problem-solve with partners across the spectrum.

**JM:** That might include thinking about health insurance or medical transportation or updating factors around screening. It's another forum where service providers focused on health can come together and share information with one another and try and really create relationships to solve problems and support our clients well.

**BDH:** Great. Thank you so much for that, Jasmine. Lubna, we've had a few questions about,

*Whose role is it to orient people to the health system? Is it the case manager's role? Is it the health system's role? How do you think that works well or could be better?*

**LA:** That's a great question. To come here and start a new life with a child who has complex medical needs... I come from a family that was resettled with a child who had complex medical needs. It is extremely stressful to add into that. There's a language barrier. There's a missing family and friends. You don't know what your future is going to look like. Whatever you tell them in the first week, second week, first month, a lot of that information is going to go missing the next day or within a week.

**LA:** Initially, at the airport pickup that first night and then that initial home visit the second day, that's a case manager's role to explain to them emergency access, like emergency services, 911, interpretation access, hospitals, ER versus urgent care. Then during that 90-day period, there's also cultural orientation classes that are required for all of our clients. We schedule that around their own schedule, whatever makes sense to them.

**LA:** We either do it at their home... Although we do encourage families to come to our office to get comfortable with the space, with the staff. We make sure we have in-person interpreters. We use visuals a lot. Those



classes are basically focused or have pictures of the local clinics. This is HealthPoint, this is the building, this is Harborview, the medical taxis that we use. It's really basically everybody's job on the team to give those reminders to families. It comes in different shapes and forms. It's the classes that we have. It's the home visits that we have to do within certain timelines across the resettlement period.

**BDH:** Thank you. Does anybody have anything else they want to add to that?

**DR:** I just want to add as Lubna said, I think it is important for us all to remember that families are very overwhelmed. I think that it can be in our roles, in our jobs when we're working with multiple people, you have to remind yourself on a daily basis that to be patient, that you will repeat yourself. It is not because no one was listening to you. It is just because they are incredibly overwhelmed.

**DR:** As I said, when I first speak to a family, I really try to set the stage in a very simplistic way of what that visit will look and touch upon what health care in the United States looks like. It is ongoing, every time you engage to talk about why you're going to this doctor, why you would come back to your primary care doctor. I think as Lubna said, it takes time. It's not something that is retained in that first month. It's really not anything that's retained in that first 90 days quite truthfully. It's just a matter of reminding ourselves to be patient, that people are trying to settle and adjust accordingly.

**HM:** Dr. Beth?

**BDH:** Oh, please, yes.

**HM:** Dr. Beth, just wanted to highlight also the education and orientation part—it starts even before departure. For the SMC cases, we ask all panel physicians to orient the patient and the family about what to expect at the final destination. Even if the case is planned for medical handover or hospitalization, we share the information in advance with the sending mission overseas so they can inform the family about what to expect when they arrive. We also do this in each stage of travel. Even when they arrive at the port of entry here in the United States, our team will meet them.

**HM:** We will reconfirm that the information that the medical escort has all the information for the handover at the final destination. We educate them that in case of any emergency, you will need to talk to your case manager. Also, we have a project here, we distribute prepaid phones for cases traveling with the medical escort to the final destination to make sure they have a way to communicate with the case manager or with 911 in case of emergency. We keep track of all these steps. Thank you.

**BDH:** Thank you, Dr. Harith. One of the other questions that's come up a few times is,

[\[Can you talk about\] getting people into specialty care and the timing of that?](#)

**BDH:** My experience working with IOM colleagues overseas is often that recommendation is based on something that a specialist has shared from another context, and they may or may not have familiarity with how long it will take someone to get into specialty care here. It's based on their best recommendation.

**BDH:** My advice is to really try to lean on getting people connected to primary care because, as was mentioned in one of the most recent questions, sometimes it can be hard to get people into specialty care. Unfortunately,



in our complex health system, often physicians calling physicians, or nurses calling nurses, or physicians calling nurses are the way that you're going to get people the care that they need.

**BDH:** I wish it were not so. I wish it was possible for our colleagues at resettlement agencies to call a health system and get someone in as fast as possible. To be very honest, that has not been my experience. My experience has been that once we get someone into primary care, then we will work within the system to try to get advocacy for someone to get in. I think some of our colleagues who don't have the privilege of partnering with care with people who have migrated aren't necessarily familiar with the concept that, "Okay, here's a new arrival with congenital heart disease. It's not repaired. We need to get them care."

**BDH:** They think to themselves, "If this child was born here, then they would've had all of these opportunities to get connected to care." Sometimes we need to advocate to our specialty colleagues, "No, no, this person just came into our clinic and our community yesterday, and now we need to bring them up to speed." That's not something that everyone is familiar with. If you have a primary care partner you can lean on to really push a health system, that can really help carry cases forward.

**MF:** I think, Beth, if I can add to that too, once I see the patient, I really prioritize some of those specialty visits and some of the things that maybe are further down on my list. I don't push as hard, but when I really feel like someone needs to have that visit immediately, I think a person-to-person contact with a specialist is the most important thing.

**MF:** Then the other thing to remind specialists is that all these refugees were invited by the U.S. government to come to the United States. All of these refugees are going to have health insurance. Even if they don't have that immediately, that will happen. These are invited guests to the United States, and it's really important that we help them be as healthy as they possibly can here. I consider that part of my mission is getting these kids in to get what they need and helping the families.

**DR:** I'll add to that. That's the purpose and the role that I have in our clinic, and our nurse care manager and what nurses love to do more than anything is to advocate. I think with our specialty services being at another institution, we spend the majority of our time. Even those referrals have been made, we are constantly still following up to make sure that those referrals are completed and the children are getting the care that they need accordingly.

**JM:** I wonder about, Lubna,

[Would you be willing to share a little bit about how you approach the documentation from a resettlement agency side when there's medical paperwork that says you need to do this thing versus our clinical care team here has said we have primary care connection we're working on the specialty care side?](#)

**LA:** To start with, we're not medical professionals in any way. Most of the time we cannot read these MEFs, SMCs. We rely on Google, but also our Harborview and HealthPoint partners will review those for us and explain to us what the diagnosis is, what type of support they will need. There's a lot of big terms that are put on there. We're happy to have that support here help us understand the conditions. As far as the paperwork— Jasmine, would you specify, as far as filling in applications or just reviewing—



**JM:** I've heard worry before from case managers who are newer, saying IOMS paperwork says they have to get in to see a heart specialist within two days, and that actually what's happening is that they will be seen by a clinician in that timeframe, but it isn't a heart specialist. I'm curious how you guys document or share like, we have connected this child appropriately to care within your paperwork.

**LA:** For compliance purposes, we have to make sure somebody had looked at the SMCs and the medical records. We have a case-loading system where we put that in. We have a reception plan that has to be documented as well. Those type of details have to be recorded in the reception plan and in the medical review case notes as well. When we have a case that says they need to be seen by a cardiologist in two days, we can't just take the child and go to Seattle Children's and knock on the door and just go in. There's a searching process that we have to follow. That process is also explained to the family.

**LA:** We have to run through by a PCP family physician first and then get to the specialist. Obviously, if the family physician thinks it's completely super urgent, they'll help us facilitate some visits sometimes. Honestly, last week or two weeks ago, we had to take a kid to the ER to get them seen sooner because it wasn't possible for them to go through the steps. That's okay. We're here to help with those situations.

**LA:** Obviously, when we go see the physician, and then another week we'll see the cardiologist, this might be seen as a delay since the MEF or the SMC is recommending a two-day or 48-hour to see a cardiologist. However, for compliance purposes, the most important thing is that you reviewed it, and you have medical professionals that are supporting the timeline that this has gone through. Even though it took seven days total, the most important thing to know is that you did not make that decision. A medical professional looked at the case, saw the child, and everybody did their best in making those decisions, and the case made it to the specialist eventually. All of those steps have to be extensively recorded in case noting and in the forms. Hopefully, that answered your question.

**BDH:** That was great. Thank you.

**HM:** [crosstalk]

**BDH:** Oh, please go ahead, Dr. Harith.

**HM:** If I can add also to this... I think Lubna and other resettlement agencies are lucky to have Jasmine and her team to assist. About the point of the follow-up within one week, from our side also, I take every meeting with the panel physicians to also educate them about the health system, that it'll be impossible to see a specialist within one week. We encourage all panel physicians, any requirement for a medical appointment within one week or less, it should be with a family physician or primary care provider.

**HM:** Even sometimes I think we miss a few SMC forms, but if from our side, when we see an SMC form with a follow-up requirement within one week, and they indicate a specialist, we go back to the mission and ask them to change the SMC form to make it within one week with the follow-up with a family physician or primary care provider. For other resettlement agency who do not have support to check with the State Refugee Health Coordinator about the medical funds, if they have any questions, they're not sure what to do for a follow-up, if a requirement was with the specialist and they cannot arrange this, please do not hesitate to reach out to IOM medical team.



**HM:** We always receive questions from the resettlement agency like this case, the affiliate can confirm that they cannot schedule appointment within this timeframe. Is it possible to schedule with the primary care? We'll be more than happy to assist the resettlement agency with any question they have about any SMC case arrival. Over, thank you.

**BDH:** I'm mindful we haven't finished quite all the questions. We'll try to answer a few more questions in the chat. I'm going to turn it over to Sarah Clarke. Thank you all for being in conversation with us today.

## Conclusion

**SC:** There's a huge thank you to all of the speakers today for your invaluable information and also to all the attendees for your great questions and your enthusiasm and participation. We know this is a very complex topic, and the work that everyone's doing is incredibly important. I know we're just about at time, so I'm just going to quickly go through our last slides.

## Recommended Resources

**SC:** This one is a list of recommended resources we have, particularly for case managers, on the Switchboard website, such as how to help clients prepare for their medical appointments or assist them with navigating the U.S. health care system. Switchboard will send these out in an email along with the webinar recording in the coming days.

## Reviewing Learning Objectives

**SC:** Again, we know this is a complicated topic, but we hope that now you will have a bit more familiarity with the overseas medical examination and the ways that resettlement agencies and others are working to serve children with significant medical conditions.

## Feedback Survey

**SC:** Lastly, just to plug again, can you please take this very quick survey, just three questions, to let Switchboard know what did you think about the training today, how can we improve in the future, or what topics would you want to see in the future? Just giving people a few seconds to do that survey. You can use the QR code, or there's a link in the chat.

## Stay Connected

**SC:** Then lastly, if you have any other training or technical assistance needs, please feel free to reach out to Switchboard. The Society of Refugee Healthcare Providers has partnered with Switchboard on health technical assistance requests.

**SC:** On behalf of our speakers and Switchboard, thank you for learning with us today, and we hope to see you again soon. Thank you, everyone, and thank you again to our speakers. Take care.

**HM:** Thank you all.



**MF:** Thank you, everyone, for joining us.

**DR:** Thank you.

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