Humanitarian Immigrant Mental Health Rescreening in Primary Care: A Pilot Project

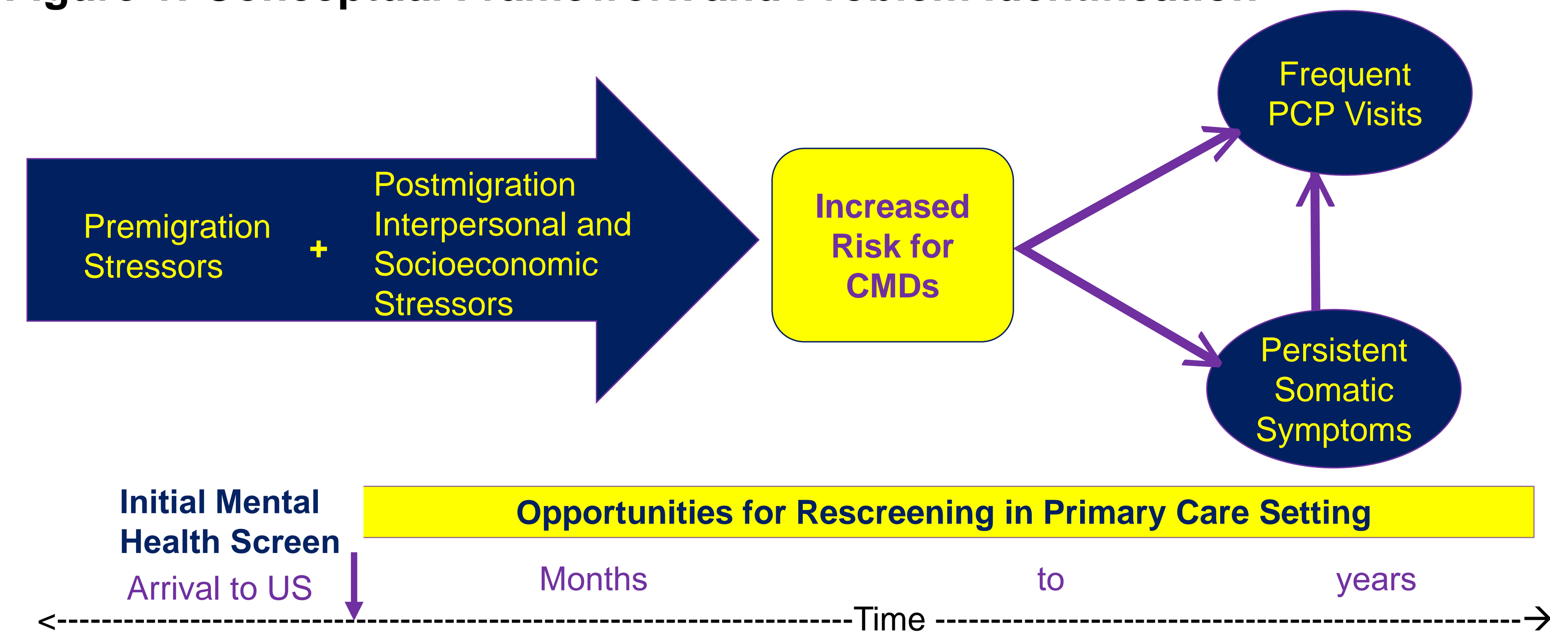
Jehan-Marie Daley Adamji, DNP, RN, FNP-BC, Deborah Baker, DNP, RN, CRNP, Rita D'Aoust PhD, RN, ANP-BC

JOHNS HOPKINS
SCHOOL of NURSING

Background to the Problem

- Humanitarian immigrants (HI) such as refugees and asylees are at an increased risk for developing common mental health disorders (CMD) such as depression, anxiety, and PTSD due to a combination of migration stressors[1]
- Despite a relationship between these disorders, somatic symptoms, and high utilization, CMDs are often under-diagnosed by primary care providers (PCPs)[2, 3]
- Domestic health exams that include mental health (MH) screening usually take place upon initial resettlement, well before exposure to post-migration stressors.
- CDC recommends ongoing MH screening occurs in primary care setting

Figure 1: Conceptual Framework and Problem Identification



Purpose and Aims

Purpose: pilot a practice change initiative to screen HI for MH needs in post-resettlement, primary care setting, 9-15 months after their initial domestic resettlement health exam.

- **Aim 1**: Evaluate outreach and scheduling program
- **Aim 2**: Increase positive screening rate when compared to initial screening
- **Aim 3**: Increase rate of completed behavioral health (BH) consults for positively screened individuals
- **Aim 4**: Evaluate the impact of this project on case identification among those with frequent health care visits for somatic or pain-related complains

Methods

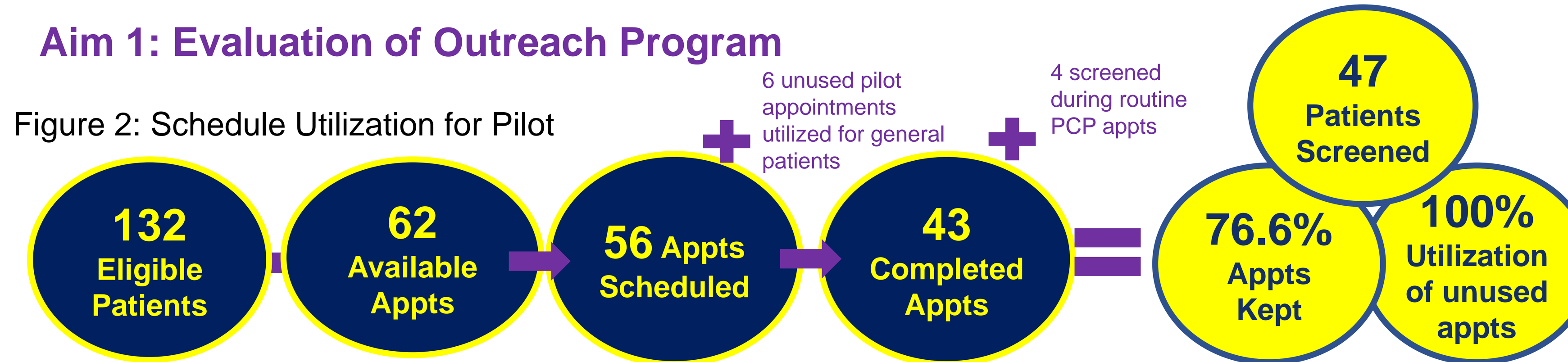
Design: Quasi-experimental pre-post quality improvement project
Setting: Resettlement program at mid-Atlantic Federally Qualified Health Center
Sample: Humanitarian immigrants age 14 and older who completed initial domestic health exam between July 2018 and March 2019
Intervention: Outreach to eligible patients via interpreters for MH rescreening appointments in designated PCP clinic sessions.
Measures:

- Refugee Health Screener-13 (RHS-13) administered by trained medical assistant. Positive score ≥ 11[5]
- Retrospective chart review to record number of somatic or pain-related diagnoses during PCP encounters since initial health exam

Results

Aim 1: Evaluation of Outreach Program

Figure 2: Schedule Utilization for Pilot



Demographic Characteristics	Sample Population n=47
Age, M ± SD	31 ± 14.2
Age Groups, no. (%)	
14-23	20 (42.6)
24-34	5 (10.6)
35-50	17 (36.2)
51-65	5 (10.6)
Sex, no. (%)	
Male	22 (46.8)
Female	25 (53.2)
Family Size, M ± SD	4.6 ± 2.6
Months in US, M ± SD*	11.4 ± 1.9

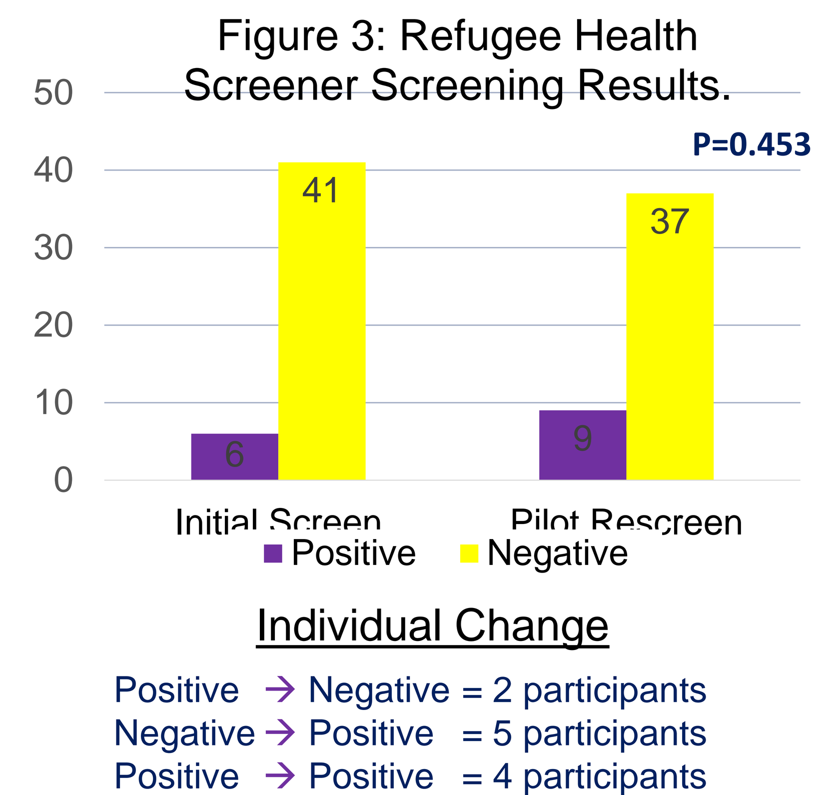
Table 1: Baseline Demographics for Pilot Sample Population

*Excludes outlier who resettled approx. 5 years ago

Category	Sample Population n=47
Immigrant Type, no. (%)	
Refugee	42 (89.4)
Asylee	5 (10.6)
Country of Origin, no. (%)	
Eritrea	19 (40)
Congo	12 (25.5)
Colombia	6 (12.8)
Nepal	3 (6.4)
Nigeria	2 (4.3)
Pakistan	2 (4.3)
Other	3 (6.4)

Table 2. Immigrant Characteristics for Pilot Project Sample

Aim 2: Evaluation of Screening Outcome



Aim 3: Evaluation of Treatment Outcome

Table 3: BH Referral Outcome for Positively Screened Individuals

BH Visit Outcome	Initial Screen n=6	Pilot Rescreen n=9
Completed, no. (%)	3 (50%)	3 (33.3%)
Did not complete, no. (%)	3 (50%)	6 (66.6%)

Aim 4: Case Identification

Figure 4: Median Number of Visits with Somatic Diagnoses Between Groups

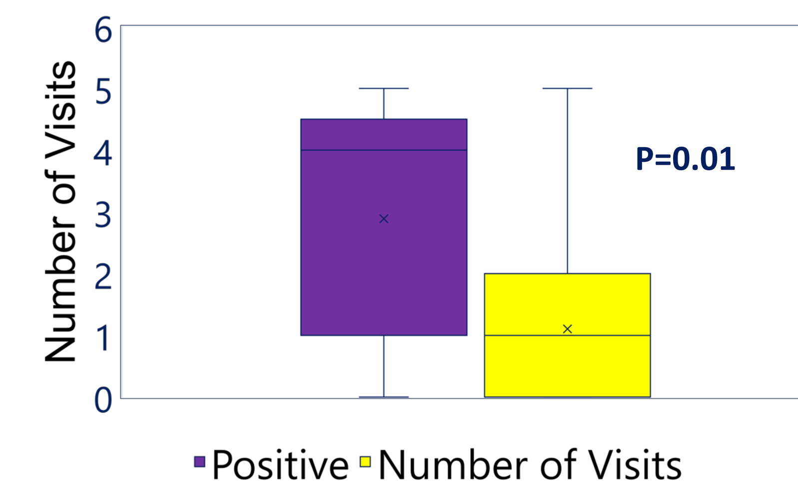


Table 4: Somatic Diagnoses for Sample PCP Visits

Somatic Symptom or Complaint	Proportion* of cases out of patients with at least one PCP visit for a somatic complaint n=32
Headache	0.34
Stomach Pain	0.31
Joint Pain	0.31
Back pain	0.25
Pelvic Pain in Non-Pregnant Females	0.23
Chest Pain	0.09
Dizziness	0.06
Fatigue/Weakness	0.03

*A case corresponds to a patient given diagnosis at least once

Discussion

- One of few projects to examine impact of timing on screening outcomes and link between MH screening results, somatic complaints, and health care utilization
- Outreach and scheduling through use of interpreters was successful due to staff motivation and dedicated time for project management by pilot lead
- Lack of a statistically significant change in positive screening rates perhaps impacted by sample (age, family size, country of origin) with fewer risk factors, not generalizable.
- Finding for aim 2 reinforces understanding of variability in occurrence, presentation, and course of CMDs among, between, and within HI populations[7]
- Findings for aim 3 consistent with literature regarding the relationship between health care utilization, somatic symptoms, and CMDs.[2, 3]
- Whether screening in this time frame is more effective at identifying those at risk than standard practice remains a question

Limitations

- Relatively small, convenience sample with family groups, not representative of populations resettled in past 5 years[6]
- Initial screen administered by one nurse; Rescreen by 1 of 4 medical assistants
- Chart reviews for somatic diagnoses relied on individual provider assessment and diagnosis, could have under or over diagnosed
- Warm hand-off to behavioral health for positively screened individuals during initial screening but not during pilot rescreen

Conclusion

- Outreach to HI patients one-year post-resettlement is feasible and sustainable
- Must continue to explore and develop reliable strategies to provide ongoing MH screening
- Translation to practice:
  - Clinical site considering MH screening during language-based flu clinics or a standard for one-year follow-up resettlement visits
  - Dissemination of findings may impact practice of PCPs who care for HI
- Further pilot projects should consider:
  - Larger, more representative samples to evaluate the impact of timing on identification and treatment outcomes
  - Potential to improve outcomes, increase provider satisfaction, and reduce health care spending if MH screening takes place while managing somatic complaints of HI

References

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