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

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 stressors1
• 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-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
• Retrospective chart review to record number of somatic or pain-related diagnoses during PCP encounters since initial health exam

Figure 2: Schedule Utilization for Pilot

Table 1: Baselinc Characteristics for Pilot

Table 2: Immigrant Characteristics for Pilot

Table 3: Referral Outcome for Positively Screened Individuals

Table 4: Somatic Diagnoses for Sample PCP Visits

Results

Aim 1: Evaluation of Outreach Program

Aim 2: Evaluation of Screening Outcome

Aim 3: Evaluation of Treatment Outcome

Aim 4: Case Identification

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
• Findings for aim 2 reinforces understanding of variability in occurrence, presentation, and course of CMDs among, between, and within HI populations4
• 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 years4
• Initial screen administered by one nurse. Rescreen by 1 of 4 medical assistants
• Chart reviews for somatic diagnosis completed 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 and 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