

Empowering Refugees In Resettlement

By MARY ALESSIO

I am a refugee resettlement director for Catholic Charities and a storyteller on the side. Unlike many of you, I will never facilitate a cure, prevent an illness, or contribute to the physical or mental health care of an individual. But I can tell you how to save a life.

No doubt many of you have assisted refugees with their health care. You might have cared for women draped in burqa scarves and men speaking Arabic, Burmese, Somali or Nepali. You may cringe a bit when you see them approach, because you know it takes longer to care for them, because many of them need interpreters and because most of them don't understand the health care system in which they have landed. On a bad day you may wonder, "Why are these people here when they don't know the language or the culture? Don't we have enough people to care for in this country?" Those are questions I don't take lightly.

I remember questioning my parents about exactly that on several occasions. My youngest brother Kevin was born with cystic fibrosis, and my parents were always juggling to make ends

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meet. I saw them send money overseas to refugee children when times were tough in our own house. I witnessed them inviting people to dinner when it was apparent there would be less spaghetti for the rest of us. They reminded my brothers and me on a daily basis that God would provide for what we truly needed and that we were expected to be his instruments, his "hands" in caring for those less fortunate.

Once my brother Patrick and I told our mom that maybe God would deem it OK, considering that we had lots of needs in our own family, if she and dad just took really good care of us. We thought "really good care" might mean getting a pair of the newest style of Nikes our friends were wearing. I am a Chicago girl, and those "Michael Jordans" were especially sweet. Instead we were reminded that in God's eyes, family consisted of more than my six brothers and me; it included children in other parts of the world who didn't even have shoes.

Patrick and I didn't win the argument, nor did we get those Nikes. In fact that very day our family sent the money that would have bought us Nikes to our "brother" halfway across the world, so he would at least have a pair of shoes. Little did I know that years later, I would be in Rochester, Minn., caring for children like him.



Child with Mary Alessio, refugee resettlement director, Catholic Charities, Rochester, Minn.

My staff and I greet refugee families when they arrive at the airport with their life's possessions tucked away in two suitcases. We serve as their family in this "home away from home." These families have fled their countries of origin because of persecution. Parents fear for their children's lives. They have left their homeland to travel to a host country that grants them temporary residency while they seek out opportunities to begin a new life in a safer part of the world. Even after successfully making their way to a host country, the challenges are terribly difficult, sometimes insurmountable. After they have filed an application for refugee status, it may take years of interviews and repeated assessment before one is approved and can begin to contemplate a life of peace and safety. Of the refugees we care for, 75 percent are children.

Refugee resettlement agencies have a 90-day period in which to accomplish goals with newcomers. During those 90 days, our staff connects families with more than 25 service providers in order to provide needed skills for self-sufficiency and extend some hope for new beginnings. My responsibility is to ensure that refugees are in safe, stable and affordable housing, and to provide

for their basic necessities. As director, I work constantly to improve public awareness. The enormous generosity of individuals in our community accounts for 98 percent of the household items for refugees that are required by U.S. Department of State guidelines. Gently used donations can be invaluable. Because our outreach efforts are successful, and we have the hands and hearts of many assisting us, we are able to use the major portion of a \$1,000-per-person resettlement and placement grant from the Department of State/Bureau of Population to pay ahead several months of rent for modest apartments. We place \$125 per individual in an emergency account for families with special needs. The goal of our work is always empowerment. Parents arrive with a desire to work in order to provide for their families.

Adults are enrolled in English as a Second Language (ESL) classes, and children are enrolled in public schools. Refugees arrive with many skills and talents that will enhance our communities, and it is our charge to enable them to use those gifts to make a difference in the world. Case managers are responsible for ensuring that refugees can use appropriate and relevant systems — navigating appropriate transportation, purchasing food and basic necessities, obtaining Social Security cards and other documents of identification, accessing health care and other eligible services, connecting with employment service providers and developing an understanding of U.S. laws and cultural practices. Beyond those basics, we are committed to creating innovative concepts that go above and beyond the required service provisions. I don't believe I can inspire greatness in those I serve, if I don't aspire to greatness myself.

One of our innovative resources for refugees who have questions and concerns about how to navigate health care is a document we created that can be used for a medical orientation at the Mayo Clinic. This document was prepared to answer many of the questions refugees regularly bring to us, and it helps familiarize newcomers with this large, sometimes overwhelming health care facility. Case managers also address these concerns if people are being cared for at Olmsted Medical, another major provider of health care in our area. Neither Mayo Clinic nor Olmstead Medical has a designated refugee clinic, but both work with our public health department to care for referred refugees.

For the last two years we have received the United Way Award of Excellence in the area of financial stability. We created a mandatory two-day financial literacy workshop for adults and teens so they are equipped with skills to budget wisely and build assets. Many people don't realize that refugees arrive with a "travel loan." Those flights that brought them here were not free rides.

It is not unusual for a family of 4 to have a \$4,000 debt when they land. We teach our refugees how to budget a portion each month to pay off that loan. Although it will take years to pay in full, we explain that their timely payment each month builds good credit history. Among the boards I sit on is a health collaborative that includes our local public health department and Mayo Clinic

HEALTH CARE SERVICES FOR REFUGEES

Besides the need for monthly case assistance, nearly all refugees require health care services. Recipients of cash assistance are usually automatically eligible for medical coverage, with a few exceptions. The income and asset limits vary widely depending upon a person's basis of eligibility. A person with excess income may also be eligible for partial coverage by being responsible for medical bills in the amount of the excess.

Eligible individuals receive an identification card that they may present to a medical provider to receive services. Some services require prior approval by the state. Persons may generally choose their own provider. However, in some localities the choice is limited to the selection of a health maintenance organization (HMO).

Medical Assistance (MA)

Medical assistance or MA is a federal program established under Title XIX of the Social Security Act to provide health care to needy people. Funding is a combination of federal and state monies. Eligibility generally is limited to persons under age 21, over age 65, blind persons, disabled persons, pregnant women and persons receiving MFIP (Minnesota Family Investment Program) benefits. Adults without children and with incomes at or below 75 percent of the federal poverty guideline became eligible for MA on March 1, 2011. Effective Jan. 1, 2014, adults without children and with incomes at or below 133 percent of the federal poverty guideline are eligible for MA. As well, effective Jan. 1, 2014, adults with children ages 19 and 20 and who are under age 65, not pregnant, not receiving Supplemental Security Income benefits and whose income is below 133 percent of the federal poverty guide-

line) are eligible for MA.

The Minnesota Department of Human Services has implemented the Pre-paid Medical Assistance Program (sometimes referred to as MA-managed care) in the major metropolitan counties as an alternative mechanism to provide payment and delivery of Medicaid services. Enrollees are asked to select one of the participating HMOs after receiving written material about the health plans or attending a half-hour presentation about the HMO choices.

Recipients of MFIP generally are eligible for MA. Persons who lose eligibility due to employment may be eligible for up to 12 months of additional MA coverage.

MinnesotaCare

MinnesotaCare is a health care plan subsidized by the state. Persons not covered by any other health insurance and who have not had access to employer-subsidized health insurance may apply. Income limits are 275 percent of the federal poverty guideline for families and 250 percent of the federal poverty guideline for singles and childless couples. Enrollees pay a monthly premium based on income and family size. There are also some co-payments for adults.

MNSure

MNSure is the health insurance marketplace in Minnesota. The website (<http://mnsure.org>) provides instant and easy access to coverage options. It provides a searchable directory of certified assisters (navigator and brokers).

Refugee Health Screening Services

MA covers health screening services.

Information provided by Minnesota Dept. of Human Services



physicians, where we routinely discuss what can be done to ensure that our health care services not only deal with physical conditions but also empower refugees to gain knowledge and independence.

I suspect that most of the people reading this article grew up with a primary care physician: If your child had a bacterial infection, an antibiotic was prescribed and filled. If some disease was diagnosed, treatment was arranged. But for the majority of refugees we see, adequate health care has been nonexistent. In my years of welcoming refugees, I have seen a woman with no eyes and men with faces disfigured from explosions. The children that disembark the plane are sometimes missing limbs, have blown eardrums, are blind or paraplegic, suffer from malnutrition and rotten teeth. The saddest of all are young eyes that don't sparkle, eyes that are fearful and lack hope.

We care for uneducated families whose children knew no other home than a tent in a refugee camp, as well as educated families who walked away from homes with pictures on the walls, yards for children to explore, and cars in their driveways. I have cared for fathers tortured by terrorists and mothers arriving without husbands and fathers because their loved ones had been killed or kidnapped.

Of course, I feel deeply and passionately for the people we serve because I know their stories and feel their heartache. But, as I mentioned, I am a storyteller, not a refugee. Let me tell you a story.

A couple years ago, I took a call while teaching some college students about our refugee program and was faced with my own refugee moment as I was given my diagnosis of breast cancer. According to the charts and statistics, everything had been in my favor. I had no predictors of cancer. That diagnosis turned my world upside down in the blink of an eye. Due to the love of many and the exemplary care I received, I am back in good health. Had I been living in a refugee camp, however, chances are slim that I would be writing this today. Thanks to the strength and support of my health care providers, I was sure I could handle whatever came my way. I may not have spoken a foreign language or worn a burqa, but I was a refugee within the health care system. It was "you"

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who empowered me, healed me and allowed me another chance to make a difference in this world.

So I, too, have experienced a refugee moment. We all have refugee moments — the loss of a job, death of a loved one, divorce, financial struggles, natural disasters or illness. They are the times in our lives when our world is turned upside down and we need to pick up the pieces and start over, usually with the assistance of someone who helps us get back on our feet.

Perhaps some of you may have seen the movie *The Doctor*. If you haven't watched this gem, I suggest you pop some corn and enjoy it some night. A prominent surgeon whose bedside manner is clearly lacking finds out he has throat cancer. The doctor becomes the patient and it turns out that saving his life has little to do with curing his cancer. The miracle is actually the transformation of the doctor, brought about through suffering, pain, loss, humility — the blessing of having a refugee moment. He experiences the kind of life he has associated with those for whom he normally cares, and he has an opportunity to feel their pain. Because he develops compassion after walking in their shoes, he is saved. His life is never the same. And those for whom he cares in the future are also transformed, because he can now see them differently. When he cares for his patients, he sees his wife, his brother, his children, himself. Dare I say ... he begins to see Christ in the eyes of those he serves? I don't suggest that the transformation of health care providers and those they serve comes only when they receive a frightening diagnosis, but I do believe transformation comes when we practice the virtue of empathy.

So while I will never facilitate a cure, prevent an illness, or contribute to the physical or mental health care of an individual, I can tell you how to save a life.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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