University of Utah
UNDERGRADUATE RESEARCH JOURNAL

REFUGEE FAMILIES LIVING IN PERMANENT SUPPORTIVE HOUSING: PERCEPTIONS OF UTILIZATION AND BARRIERS TO HEALTH CARE

Austin Waters (Sara Hart RN, PhD)
College of Social and Behavioral Science; Health, Society and Policy Program

ABSTRACT

Background: Healthcare spending in the United States has reached nearly 20% of the national GDP. Attempts to mitigating such high spending have targeted 'high utilizers' of healthcare services. Refugees have previously been identified as high utilizers of healthcare services. Attempts to address high utilization have primarily been implemented within health systems, however some of the most effective strategies occur outside of the hospital walls. One of the more successful programs to reduce high utilization is permanent supportive housing. Permanent supportive housing is issued primarily to individuals who are chronically homeless but in recent years has been expanded to refugees facing significant housing barriers. This study aims to identify trends in self-reported healthcare utilization of refugee families living in permanent supportive housing and to identify barriers to healthcare as perceived by refugee families living in permanent supportive housing and their providers at University of Utah Health.

Methods: This survey-based study was administered to 11 refugee families, totally 54 individuals, living in permanent supportive housing. One survey was given to each family and case management of the housing authority building assisted in translation of medical

terminology. Utilization data was assessed for adult and children separately but barriers to care were not. An online survey was also administered to two University of Utah Health clinics, 12 providers responded from a variety of fields including medicine, nursing and physical therapy.

Results: Refugee families reported overwhelmingly appropriate healthcare utilization. A majority of healthcare encounters for both adults and children were with a primary care physician. University of Utah Health providers were asked their perceptions of refugee families' healthcare access type and frequency comparable to the general population. The provider perception of healthcare use did not align with the self-reported utilization of refugee families living in permanent supportive housing. Refugee families also identified multiple barriers that are still of concern to accessing healthcare services including language, cost, transportation and health system literacy. Again, the provider perceptions of barriers to care were generally not congruent with the self-reported barriers.

Conclusion: Refugee families living in permanent supportive housing, overall, had appropriate healthcare utilization but continue to face serious barriers to accessing healthcare. University of Utah Health providers perceptions of refugee utilization and barriers to care consistently deviated from the refugee reported trends. This descriptive study provides important about the studied population and highlights areas for future investigation.

INTRODUCTION

Healthcare costs continue to rise globally. In the United States, per capita healthcare spending remains the most expensive of all The Organization for Economic Co-operation and Development (OECD) countries at $10,348 (Hartman, Martin, Espinosa, Catlin,2018). Individuals with complex physical and mental health needs, often identified as high utilizers of healthcare, have received increased focus. High utilizers can be defined as individuals or populations who access health services at a rate that is far above the average. Often high utilization can be contributed to single or multiple structural or social determinants of health.

It has been demonstrated that healthcare accounts for only 10% of health (Schroeder, 2007) and other factors including social determinants of health, genetics and health behavior have a much greater influence. Some of the social determinants of health include environmental exposure, education, housing, socioeconomic status, discrimination and the built environment. National health care reform has largely been aimed at reducing healthcare expenditures through the reform of health care delivery. Population health interventions are largely missing from these efforts, as are efforts to address social determinant of health through increasing access to housing, nutritious food and quality education. Poor social determinants of health make life harder to live and induce high levels of stress. Addressing the social determinants of health has the potential to drastically reduce healthcare expenditures and increase health outcomes.

Beyond the previously mentioned determinants of health, emotional stability and an individual's ability to cope with adverse experiences also impacts healthcare utilization. Emotional coping mechanisms have been linked with positive perceptions of health encounters and ultimately a decrease in healthcare utilization (Gidron, Duncan,

Lazar, Biderman, Tandeter, Shvartzman, 2002). Individuals who frequented clinics with no biological explanation for their symptoms report that 66-75% of the visits did nothing to improve their health. However, within the same study a very similar second cohort was asked to disclose stressful experiences in writing at their appointments. This disclosure cohort saw increases in health outcomes, increase in immunocompetence and a decrease in clinic in visits (Gidron, 2002).

There have been many attempts to reduce utilization within hospitals and clinics including focus on increasing the quantity of case managers, yet this has resulted in minimal cost reduction for high utilizers (Williams, 2015). This is not to say that the health of high utilizers has not improved rather that the effect on cost control was unexpectedly low. One of the main contributing factors to this low control of cost is that many high utilizers are transient and tend to only access healthcare at a point of crisis. It is also important to note that the individuals marked as high utilizers now are not necessarily the individuals who will be in the future (Williams, 2015). High utilization is not based on condition, but rather inappropriate use of health services driven by medical crisis, incredibly high stress or somatization.

Hospital side measures such as case management are not the only attempts at controlling costs while improving health. Other more socially oriented measures have been implemented to attempt to reduce utilization, maintain health and avoid crisis' and stress. One of the more notable and effective programs is permanent supportive housing. Permanent supportive housing is a model that aims to house individuals who are experiencing homelessness or substantial barriers to gaining housing. These individuals would not be able to maintain housing without supportive services. Most permanent supportive housing facilities offer low-income affordable living spaces and onsite wrap

around supportive services that are not time dependent. Permanent supportive housing has been shown to increase stability in housing instable individuals, increase health outcomes and decrease over all utilization of health services such as the emergency department (Martinez, Burt, 2006). Permanent supportive housing is traditionally reserved for chronically homeless individuals, however with thought of stress reduction and stability as strengths of permanent supportive housing, facilities have recently been opened to refugees facing housing barriers.

Literature on healthcare utilization shows that individuals experiencing homelessness are fairly consistent in their inappropriate and over-use of high cost healthcare services. Most studies are specific and focused solely on one sub-group of individuals experiencing homelessness, such as women, veterans or youth. However, studies on the broader utilization trends of individuals experiencing homelessness have shown a clear association between homelessness and increased quantity of visits to high cost healthcare services including emergency services (Lam, Arora, Menchine, 2016) is linked to unmet mental and behavioral healthcare needs. (Thakarar, Morgan, Gaeta, Hohl, Drainoni, 2015).

There is also a plethora of literature about the utilization trend of refugees on much smaller scales and often within racial/ethnic groups of certain cities or regional areas. The utilization trends of refugees are much harder to generalize as refugees flee from a very wide variety of regions, countries, cultures, traditions and languages. Not only do refugee populations vary vastly from each other, the health systems that serve them also vary widely. Elsouhag (2015), found that Iraqi refugees in Michigan utilized healthcare services at a rate higher than Arab immigrants and the general population of the state. Kiss, et al (2013) reported similar findings in Alberta, Canada with refugee

populations utilizing health services at a higher rate than the general population. Semere (2017) using electronic medical records found that Southern Connecticut refugees during resettlement had higher healthcare utilization than the general population. The current literature assessing healthcare utilization of refugee populations span from arrival to roughly 1.5-2 years. Most resettlement agencies across the United States operate on a 2-year resettlement timeline.

Healthcare utilization research is a fairly new field and has a variety of literature gaps, including assessment of healthcare utilization by refugee populations beyond the resettlement period. To our knowledge no current studies have reported healthcare utilization of refugee populations once resettlement services have been terminated. This is important for further research due to the unique barriers that refugee populations face and that, could be exacerbated by a lack of support once resettlement services end. Another area lacking study is the health system variability and provider side perceptions of such refugee utilization.

The purpose of this study is to assess the perceived utilization of healthcare systems and the barriers to healthcare for a refugee population living within local housing authority's permanent supportive housing in Northern Utah. This study will further inform permanent supportive housing case management and local healthcare systems about possible discrepancies between refugee and provider perceptions of utilization and barriers to care.

METHODS

Overview

This study took place in a mixed income housing facility that is partially managed by a northern Utah housing authority and at multiple clinic sites within the University of Utah Health system. The apartment complex where refugee families were identified and surveyed is a mixed income facility that includes units rented at market value and units that are part of the housing authority's permanent supportive housing program for refugee families. This study looked specifically at refugee families that currently live in the refugee designated permanent supportive housing units. There are multiple criteria that refugee families must meet in order to qualify for such units, including a past of facing significant or insurmountable housing barriers, an income cap and/or disability status.

These permanent supportive housing units provide affordable quality housing and onsite case management. Case management is offered 6 days a week from three case managers who speak a multitude of languages and are refugees. This firsthand refugee experience allows them to more easily connect with the residents and build trust. Case management services are wrap around in nature, but do not include health services. The multiple permanent supportive housing facilities and units of this northern Utah county housing authority are funded partially through general funds from the United States Department of Housing and Urban Development (HUD) and partially through a HUD program Shelter Plus Care, designated for individuals who have a disability and have previously experienced homelessness.

Study Procedure

This study was approved by the University of Utah Health's Institutional Review Board (IRB). This study was survey-based and administered to refugee participants currently living in permanent supportive housing and to U Health providers. Surveys were disseminated to each household in English. Because only one survey was taken per household, case management at that facility identified all households where at least one individual in the home spoke English. Case management also assisted with survey translation of medical terminology. No incentives were offered for completing the survey. Consent was obtained through a consent coversheet, providing the individual with the risks and benefits of participating.

A similar IRB approved survey was administered via REDCap to University of Utah Health providers at two clinical sites including an emergency department and an outpatient health center. The survey asked about the providers perceptions of refugee utilization of healthcare and potential barriers to accessing healthcare. It is assumed that providers that had experience and valid input would be the individuals who filled out the survey.

Data Analysis

Data on perceived utilization was thematically coded for health-service-type and frequency of use. It was then used as discrete data to find trends in types of health services accessed and frequency of utilization. The survey was written to gather data on the adults and children in the home. Utilization trends were assumed similar for other individuals in the household. Barriers to accessing health care were assessed on a five-point Likert scale (Agree, Somewhat Agree, Neutral, Somewhat Disagree, Disagree).

Survey data were analyzed to locate common barriers or non-barriers to accessing healthcare among the residents. Utilization data were split into adult utilization and pediatric utilization while barriers to accessing healthcare was not.

RESULTS

Resident Characteristics

Refugee families living in permanent supportive housing in a northern Utah housing authority funded program come from very diverse backgrounds. Of the 11 units, heads of household were roughly even in gender distribution, six being female and five being male. The mean age of the head of household for these residents was 40.10 ± 17.0. These families, came from 8 different countries in 5 different regions including Eastern Africa, Central Africa, South Asia, Western Asia, and Central Asia. The largest proportion of refugees represented in the study came from Somalia, 29.63% of the 54 residents. One of the most variable measures was the number of years that each adult has been in the United States. While only 9 of the 11 homes surveyed have children occupying them,

Table 2. Comparison of characteristics of Refugee residents living in permanent supportive housing

Resident Characteristic	**(n = 54)**
	N (%) or Mean ± SD
Country of Origin	
Afghanistan	3 (5.55)
Bhutan	7 (12.96)
Burundi	3 (5.55)
Congo	7 (12.96)
Iraq	9 (16.66)
Kenya	6 (11.11)
Myanmar	3 (5.55)
Somalia	16 (29.63)
Number of Years in US* (n=21)	**4.7 ± 8.2**
2-3.9	5 (45.45)
4-5.9	2 (18.18)
6-7.9	3 (27.27)
8-9.9	1 (9.09)
Unit Occupants	**4.9 ± 2.2**
Adults per Household	**1.9 ± .9**
Children per Household	**3.7 ± 2.5**

* Only adults were included in this calculation sicne children could have been born in the US

children still out-number adults at a nearly 2:1 ratio. The number of children in each home was highly variable with a mean of 3.7 and a standard deviation of ± 2.5. Each family had been in the United States for over 2 years but less than 10 years. Five of the 11 families had been in the United States between 2-3.9 years.

Table 1. Comparison of characteristics of 11 Refugee Heads of Household living in permanent supportive housing

Head of Household Characteristic	(n = 11)
	N (%) or Mean ± SD
Gender	
Male	5 (45.5)
Female	6 (54.5)
Age	**40.1 ± 17.0**
18-29	4 (36.36)
30-49	4 (36.36
50-69	3 (27.27)

University of Utah Health Provider Characteristics

The study survey was sent electronically to all providers at two University of Utah Health clinics, a total of 12 providers responded. 75% of respondents were female providers, all respondents hold a variety of titles including attending physician, nurse practitioner and physical therapist. The mean number of years working in their clinic was 8.5 years.

Utilization

Utilization was assessed through two measures, one being sources of health care including emergency department, urgent care, primary care physician, and specialty care. The other utilization measure was the frequency of access to each of these health care services for each refugee adult living in permanent supportive housing. These measures were separated into adult and pediatric care to be able to see the potential prioritization of either type.

Table 3. Comparison of refugee residents sources and frequency of use of health care systems

Adult Residents	**(n = 21)**
	N (%)
Sources of Health Care	
Emergeny Room	13 (61.90)
Urgent Care	12 (57.14)
Primary Care Physician	20 (95.24)
Specialty Physician	17 (80.95)
Encounters per Year	
Emergeny Room	30 (13.16)
Urgent Care	25 (10.96)
Primary Care Physician	134 (58.77)
Specialty Physician	39 (17.11)
Pediatric Residents	**(n = 33)**
	N (%)
Sources of Health Care	
Emergeny Room	20 (60.61)
Urgent Care	22 (66.67)
Primary Care Physician	33 (100.00)
Specialty Physician	7 (21.21)
Encounters per Year	
Emergeny Room	69 (20.60)
Urgent Care	79 (23.58)
Primary Care Physician	181 (54.03)
Specialty Physician	6 (1.79)

Refugee Adult Self-Reported Utilization

The self-reported sources of health care for adult refugees living in permanent supportive housing was variable across health care types. All adults but one, 95% of individuals surveyed, indicated that they see a primary-care physician as a source of their healthcare. The number of individuals who indicated the use of specialty physician as a source of healthcare was 81%. Seeing a specialty physician follows seeing primary care physicians closely. Urgent care and emergency departments were used as a source of health care for considerably less of the adult refugee residents, 57% and 62% respectively. While most refugee adults use all of the listed types of health care, the

actual frequency of utilization is quite different for each type. The 21 adult residents had a combined 228 health care encounters across all types of health care. A majority of these encounters, 58.77%, were with a primary care physician. Other types of health care services were responsible for less than 20% of the total healthcare encounters.

Refugee Children Parent-Reported Utilization

Pediatric sources of health care were quite similar to the adult sources with the exception of specialty physician care. Only 21.21% of refugee children living in permanent supportive housing access a specialty physician for their health care. Every family surveyed indicated that the children in their family see a primary care physician as a source of health care. Over the course of a year, the 33 residents under the age of 18 had 335 encounters with a health care system. While a majority, 54.03%, of the health care encounters were with a primary care physician the percentage of the health care encounters at the emergency department and urgent care was almost double the percentages of the adult residents. The number of encounters with a specialty physician was only 1.79% of the 335 encounters.

University of Utah Health Providers

University Health providers were asked similar questions regarding refugee family healthcare utilization. Healthcare providers were asked their perception of refugee families' access of each type of care more/less/unknown/or at the same frequency as the general population. The use of emergency department services was split with 42.86% of the providers indicating more frequent use and 42.86% of the providers indicating less frequent use. Half of the University of Utah Health providers also indicated that in their

experience refugee families access primary care physicians less frequently than the general population.

Barriers to Care

Six themes were identified as barriers to accessing health care services; health system literacy, language, transportation, health insurance and cost, culture and medicine and preventive care. Each of these themes encompassed 2-4 questions. These questions were asked both to refugee families living in permanent supportive housing and University of Utah Health providers.

Health System Literacy Barriers

A large majority of refugee residents indicated that they understood the healthcare system, knew how to schedule appointments and what to expect at their appointments. 87.04% of residents selected ‘agree’ to understanding the healthcare system while 64.81% of residents knew how to schedule appointments and what to expect at their appointments. A majority of University of Utah Health providers, 80%, ‘somewhat disagree’ or ‘disagree’ that refugee families understand the healthcare system.

Language Barriers

The consensus seen in health system literacy was not seen surrounding language barriers. English fluency and confidence in their fluency varied widely. Most residents either indicated that they ‘somewhat agree’ or ‘agree’ that they feel embarrassed with their ability to speak English when speaking to their doctor. This was mirrored by a majority of University of Utah Health providers who indicated that they ‘somewhat

agree' or 'agree' that refugee families feel embarrassed with their English proficiency when seeking healthcare.

Transportation Barriers

Most refugee residents, 70.37%, indicated that they had reliable transportation. Of the residents with no reliable transportation, 12.96%, indicated that lack of transportation stops them from seeking health care. A majority of healthcare providers, 70% indicated that transportation issues inhibited refugee families from seeking healthcare.

Health Insurance and Cost Barriers

All of the families surveyed indicated that they had health insurance, therefore lack of insurance was not a barrier to obtaining care. Understanding how that insurance works and potential out of pocket costs was much less clear, with around 53.19% of residents indicating the 'agree' with knowing how their insurance works and 44.44% indicating they 'agree' with knowing how much it will cost them to access care. Of the healthcare providers surveyed 40% indicated that they 'agree' that refugee families do not know how much healthcare will cost them and 'disagree' that refugee families understand how their insurance works.

Culture and Medicine Barriers

83.34% of residents indicated that they either 'somewhat agree' or 'agree' with having a positive perception of western medicine. While only 5.56% of residents indicated that they 'agree' to seeing their cultural or traditional medicine as a replacement

for western medicine. University of Utah Health providers were much more scattered in the section regarding culture but tended to gravitate around 'neutral' on each question.

Preventive Medicine Barriers

All of the residents surveyed indicated that they 'agree' with the importance of a seeing a provider regularly and a family doctor at least once a year. However only around half of the residents indicated that they 'somewhat agree' or 'agree' that they understand what preventive medicine is. A majority of healthcare providers surveyed answered 'neutral' on questions regarding refugee families understanding of preventive medicine.

Table 4. Self-identified refugee barriers to Health Care services

Barriers		Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree
Health System Literacy						
I understand the Healthcare System		12.96%				87.04%
I know how to schedule an appointment with my doctor		35.19%				64.81%
I know what to expect when I show up to my doctors appointment		7.41%	11.11%		16.67%	64.81%
Language						
I speak Fluent English		48.15%	11.11%		12.96%	27.78%
I feel confident in English proficency when speaking with my doctor	n=51	37.25%	13.73%	19.61%		29.41%
I feel embarressed with my english proficiency when seeking healthcare		27.78%		5.56%	25.93%	40.74%
I find it difficult to obtain a translator for my doctors appointments	n=51	78.43%				21.57%

Transportation						
I have reliable transportation		24.07%			5.56%	70.37%
Lack of transportation stops me from seeking health care		81.48%			5.56%	12.96%
Health Insurance and Cost						
I do not understand how much healthcare will	n=45	22.22%	20.00%	6.67%	6.67%	44.44%
I cannot afford to go to the doctor		55.56%	22.22%			22.22%
I have health insurance						100.00%
I understand how my health insurance works	n=47	14.89%	12.77%		19.15%	53.19%
Culture and Medicine						
I have a positive perception of western medicine		5.56%	5.56%	5.56%	16.67%	66.67%
I do not see a doctor for cultural reasons		83.33%	16.67%			
I see my cultural medicine as a replacement for western medicine		53.70%	11.11%	29.63%		5.56%
Preventive Care						
I understand the importance of seeing a doctor yearly						100.00%
I do not know what preventive medicine is		35.19%	11.11%		16.67%	37.04%
I understand the importance of seeing a family doctor regularly						100.00%

Table 5. Healthcare provider perceptions of refugee barriers to Health Care services

Barriers	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree
Health System Literacy					
Refugees understand the health care system	20.00%	60.00%	20.00%		
Refugees typically know how to schedule an appointment with their	20.00%	40.00%	30.00%	10.00%	
Refugees typically know what to expect when they show up to their doctors appointment	20.00%	40.00%	30.00%	10.00%	
Language					
Refugees typically speak fluent English	60.00%	40.00%			
Refugees typically feel confident in their English proficiency when speaking with their doctor	60.00%	40.00%			
Refugees typically feel embarrassed with their English proficiency when seeking health care		10.00%	20.00%	30.00%	40.00%
Refugees typically find it difficult to obtain a translator for their doctors appointments	20.00%		30.00%	30.00%	20.00%
Transportation					
Refugees typically have reliable transportation	30.00%	20.00%	40.00%	10.00%	
Lack of transportation stops Refugees from seeking health care			30.00%	40.00%	30.00%
Health Insurance and Cost					
Refugees typically do not understand how much healthcare will cost			10.00%	50.00%	40.00%
Refugees typically cannot afford to go to the doctor			40.00%	40.00%	20.00%
Refugees typically understand how their health insurance works	40.00%	50.00%	10.00%		

Culture and Medicine					
Refugees typically have a positive perception of western medicine	10.00%	20.00%	40.00%	20.00%	10.00%
Refugees do not see a doctor for cultural	10.00%	20.00%	50.00%	10.00%	10.00%
Refugees typically see their cultural medicine as a replacement for western medicine	10.00%	20.00%	40.00%	20.00%	10.00%
Preventive Care					
Refugees typically do not know what preventative medicine is		30.00%	50.00%	10.00%	10.00%
Refugees typically understand the importance of seeing a family doctor regularly		30.00%	60.00%	10.00%	

DISCUSSION

Utilization

When considering the self-reported utilization of refugee families living in permanent supportive housing it is important to note that all of the residents surveyed in this study have lived in the United States for longer than 2 years and come from diverse countries of origin. The self-reported access and use of primary care physicians among this sub-population of refugees was incredibly high, 95% of adults and 100% of children. Not only was access to primary care physicians higher than any other type of health care, over 50% of the health care encounters in the last year were with a primary care physician, totaling 315 visits. This self-reported utilization trend contradicts the perception of refugee healthcare utilization held by University of Utah Health providers

who were surveyed. A majority of providers continue to have a perception about refugee utilization being primarily inappropriate.

Adult residents did access and use specialty physician services at a higher rate than the pediatric residents. Almost 30% of the adult residents were over the age of 50 this in combination with high levels of trauma and stress that is common among refugee populations could be a possible explanation for the increased use of specialty physicians. However, the self-reported number of visits to specialty physicians for all of the adult residents is still quite low, 1.85 visits per year per person, 39 visits per year for the 21 adult residents. Both emergency department and urgent care frequency of visits were even lower, both totaling less than 15% of the encounters each for adult residents. However, a majority of University of Utah Health providers indicated that the emergency department was being used at a higher frequency by refuge families, which contradicts the refugee self-reported utilization.

The frequency of use for the emergency department and urgent care for pediatric patients was naturally higher than the adult population. This phenomenon is to be expected as children's health is often prioritized over adult health in all populations. Pediatric emergency department and urgent care visits are also expected to be a bit higher than adult visits due to the inability of very young children to articulate their pain and illness. Over all, the self-reported sources and frequency of health care types for refugee residents living in permanent supportive housing is skewed heavily toward use of primary care physicians and away from more costly emergency services.

Barriers to Care

The United States health care system is a complex patchwork system that can often times become convoluted and difficult to navigate. This is especially true for marginalized and immigrant populations. Barriers to accessing health care can look very different for different subpopulations. From the six themes tested in this study, findings indicated that some of these potential barriers were not as inhibiting as hypothesized and other potential barriers are still significant barriers to care. The perception of each barrier from the refugee participants and healthcare providers varied widely.

Language barriers continue to exist even though all hospitals and clinics have translation and/or interpreter services. 21.57% of residents surveyed indicated that they find it difficult to obtain a translator for their appointments. Highlighting that just because there is a service available for individuals it does not mean that this service will function correctly for everyone and there is room for improvement. Additionally, this question only encompasses translation in the direct clinical setting. Often translation cannot be obtained for direct medical care, it would be much more difficult to obtain translation for indirect medical care such as picking up prescriptions or following written instructions. Refugee residents also indicated that their English proficiency was especially concerning when speaking to health care providers, a majority of the refugee residents indicated that they felt embarrassed by their proficiency level. This was mirrored by University of Utah Health providers 70% of who indicated that refugees typically are embarrassed by their English proficiency when seeking healthcare.

Transportation and health system literacy however seem to not play a significant role as a barrier to care. A large majority of refugee residents indicated that they had reliable transportation and an even larger majority indicated that lack of transportation

does not stop them from seeking health care, implying use of social network or public transportation to find rides to medical appointments. Again, the perceptions of the University of Utah Health providers was not congruent with the refugee families. A majority of providers indicated that refugees typically lack transportation and that this lack of transportation inhibits them from seeking healthcare. Health system literacy was much less of a barrier than hypothesized, as well. Large majorities of refugee residents indicated that they understood the health care system and logistically how to schedule appointments and what to expect when they arrived at their appointments. This large majority defies the common stereotype of difference in health systems being one of the main barriers to care for immigrant populations at large, which was evident in the responses of the University of Utah Health providers.

Perceptions of preventive medicine in refugee residents was quite positive as well. 100% of residents indicated that they understood the importance of seeing a doctor regularly. While the distribution of individuals who indicated that they actually knew what preventive medicine is was more scattered. This philosophical commitment to primary care is also mirrored in the frequency of visits to a primary care physician in the Utilization section above. Provider perception of refugee understanding of preventive medicine was primarily neutral.

Another common perception of refugee populations is where individuals place value in terms of health care. It a common judgement of refugees that they do not have positive perceptions of western medicine or that specific cultural or traditional medicine is used as a replacement to western medicine. This line of thinking is overwhelmingly not true for these refugee residents living in permanent supportive housing. The vast majority of this population has a positive perception of western medicine, does not see cultural or

traditional medicine as a replacement to western medicine and does not avoid seeking health care for cultural reasons. University of Utah Health providers were primarily neutral in regard to culture as a barrier to accessing healthcare.

CONCLUSION

Multiple past studies indicated that refugee populations may utilize healthcare services at higher rates than the general population. This descriptive study was not designed to be generalizable to the general refugee population nor meant to be compared to the general population at large. Rather, it collected the perceived utilization trends of refugee families living in permanent supportive housing to lay the framework for future studies. This study has produced a number of findings regarding refugee families living in permanent supportive housing. These findings include overwhelmingly appropriate health care utilization, logistical barriers around language, cost, transportation and health literacy to accessing health care and that society and health care providers continue to hold beliefs around utilization and barriers to care that are not congruent with the self-reported trends of the surveyed refugee families.

REFERENCES

Elsouhag, D., Arnetz, B., Jamil, H., Lumley, M. A., Broadbridge, C. L., & Arnetz, J. (2015). Factors Associated with Healthcare Utilization Among Arab Immigrants and Iraqi Refugees. [journal article]. *Journal of Immigrant and Minority Health, 17*(5), 1305-1312.

Gidron, Y., Duncan, E., Lazar, A., Biderman, A., Tandeter, H., & Shvartzman, P. (2002). Effects of guided written disclosure of stressful experiences on clinic visits and symptoms in frequent clinic attenders. *Family Practice, 19*(2), 161-166.

Hartman, M., Martin, A.B., Espinosa, N., Catlin, A. (2018). National Health Care Spending In 2016: Spending And Enrollment Growth Slow After Initial Coverage Expansions. *Health Affairs, 37*(1), 150-160.

Kiss, V., Pim, C., Hemmelgarn, B. R., & Quan, H. (2013). Building Knowledge About Health Services Utilization by Refugees.. *Journal of Immigrant and Minority Health, 15*(1), 57-67.

Lam, C. N., Arora, S., & Menchine, M. (2016). Increased 30-Day Emergency Department Revisits Among Homeless Patients with Mental Health Conditions. *Western Journal of Emergency Medicine, 17*(5), 607-612.

Martinez, T. E., & Burt, M. R. (2006). Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults. *Psychiatric Services, 57*(7), 992-999.

Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare Barriers of Refugees Post-resettlement. *Journal of Community Health, 34*(6), 529.

Schroeder, S. A. (2007). We Can Do Better — Improving the Health of the American People. *New England Journal of Medicine, 357*(12), 1221-1228.

Semere, W., Agrawal, P., Yun, K., Di Bartolo, I., Annamalai, A., & Ross, J. S. (2017). Factors Associated with Refugee Acute Healthcare Utilization in Southern Connecticut. [journal article]. *Journal of Immigrant and Minority Health*.

Thakarar, K., Morgan, J. R., Gaeta, J. M., Hohl, C., & Drainoni, M.-L. (2015). Predictors of Frequent Emergency Room Visits among a Homeless Population. *PLoS ONE, 10*(4), e0124552.

Watts, D.-J., Friedman, J. F., Vivier, P. M., Tompkins, C. E. A., & Alario, A. J. (2012). Health Care Utilization of Refugee Children After Resettlement. [journal article]. *Journal of Immigrant and Minority Health, 14*(4), 583-588.

White, C. C., Solid, C. A., Hodges, J. S., & Boehm, D. H. (2015). Does Integrated Care Affect Healthcare Utilization in Multi-problem Refugees? [journal article]. *Journal of Immigrant and Minority Health, 17*(5), 1444-1450.

Williams, B. (2015). Limited Effects of Care Management for High Utilizers on Total Healthcare Costs (Vol. 21): *American Journal of Managed Care*.