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Can the delivery of primary care to refugees be improved? Findings from an Australian cluster randomized trial

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Context:
The global community is experiencing unprecedented levels of human displacement - with 26.4 million refugee or asylum seekers in 2018. Australia has resettled over 180,000 refugees in the last decade. National guidelines recommend a health assessment be offered to all new arrivals from refugee-like backgrounds soon after arriving in Australia.

Objective:
We asked whether an outreach facilitation intervention could increase the conduct of comprehensive health assessments for General Practice (GP) patients from refugee backgrounds.

Study Design:
Pragmatic, cluster randomized controlled trial with stepped wedge allocation to early or late intervention groups.

Setting or Dataset:
The study was conducted in 31 primary care practices across 3 urban regions of high refugee resettlement in Victoria and New South Wales, Australia.

Population studied:
Patients from a recent (5 years) refugee source country who had visited the practice in the previous 12 months.
Intervention/Instrument (for interventional studies):
Trained facilitators employed by our health service provider project partners, made three visits to practices over 6 months, using structured action plans to help practice-based improvement teams to optimize routines of refugee care.

Outcome Measures:
We used extracts from clinical practice software to calculate the proportions of recently arrived refugees who had received refugee health assessments (RHAs) in the previous 6 months. Results: The final sample comprised of routinely collected data from 14,633 patients from the 31 practices that completed the trial. Mixed effects modelling found the proportion of patients with an RHA in the previous 6 months significantly increased post intervention from 19.1% [95%CI 18.6%-19.5%] to 27.3% [95%CI 26.7-27.9%], OR 1.9 [95%CI 1.4-2.5]. RHAs were more frequent in practices that were smaller (<4 full-time-equivalent GPs), had higher baseline percentages of refugee patients, had received refugee health training in the last 12 months, and had higher baseline use of RHAs.

Conclusions:
Our pragmatic intervention is the first to show that structured, low intensity outreach facilitation may improve a key component of quality primary care for refugees. That facilitators were existing health services staff shows the potential of integrated approaches to improve the quality of primary care delivered to this vulnerable population.