Refugee Care

Bridge Clinic

Bridge Clinic is a specialized centre, in the Evergreen Community Health Centre in East Vancouver, providing a variety of primary and preventative health care services including: screening for communicable diseases; mental health; primary health care, including women’s and children’s health; and referrals to community services and support groups such as housing. Some specialist services, such as pediatrics and internal medicine, are also provided. Medical care of these patients and the ensuing transfer to community clinicians can be challenging due to language issues, culture, unique medical diagnoses and non-standard medical coverage.

- Clinic staff see nearly 100% of all Government Assisted Refugees (GAR) new to B.C.
- In 2014, the Bridge Clinic saw 1,824 clients.
- Clinic has physicians, nurse practitioners, nurses, a social worker, and consultants (psychiatrist, pediatrician, internist).
- The clinic currently has 1300 active clients, seeing between 18 and 30 clients a day.
- The clinic acts as a “bridge” until refugees can access care through family doctors in their new home communities, which is typically a year to 18 months after arrival to Canada.

Clients

- Approximately 80% of patient visits require interpreters.
- Most of the refugees who arrived in 2015 were from Iraq, Iran, Syria, Eritrea, Somalia, and Myanmar.
- Refugees often arrive in poor health because of years spent in refugee camps and war-torn countries. As a result they may experience malnutrition, intestinal parasites, chronic infections, chronic diseases, depression and post-traumatic stress disorder.
- Refugees encounter all the barriers new immigrants face, including poverty, language, high levels of stress and difficulties navigating the Canadian government and community services.

Client Timeline

- Weeks 1-8 post arrival: Staff will screen new refugee clients for current medications/refills, acutely ill needing immediate treatment or transfer, and prenatal needs.
- 2-6 months post arrival: initial primary care, ongoing care, follow-up visits and discharge assessment.
- 6-14 months post arrival: ongoing care, follow-up visits and discharge planning. Stable clients transitioned to family doctors, other services, etc. If clients live in other health authorities they will be transitioned to services in their new home communities.