Understanding Barriers to Care for Refugee Patients: Lessons From Focus Groups

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ABSTRACT

Background: Refugee populations resettled in the United States face health disparities and barriers to accessing care. Better understanding of the barriers this population faces may help clinicians address them.

Methods: Focus groups with refugees were held in Wisconsin. Discussion prompts such as "What could be done to improve health in your community?" were used. Notes from the focus groups were organized and coded using MAXQDA.

Results: Six themes were identified from the focus groups regarding health care barriers and experiences: language, interpretation, pharmacy, insurance, transportation, and respect.

Discussion: Clinicians working with refugee populations can strive to minimize barriers to care for refugee patients by being aware of the barriers, implementing changes in their practice, and/or community advocacy.

BACKGROUND

In the United States, refugees face health disparities in numerous areas, including chronic conditions,[1] perinatal morbidity,[2] oral health,[3] and mental health.[4] Compounding these issues, refugees experience challenges in accessing services to address these conditions.[5] Health care providers are in a unique position to address these barriers. To better understand and address the specific health challenges refugees face, a series of focus groups with resettled refugees was designed by community health workers (CHW) and the State of Wisconsin Refugee Coordinator's office.

METHODS

Focus group guides with prompts were developed collaboratively with CHWs from target communities, the Wisconsin State Refugee Health Program, and the State Refugee Coordinator's Office, with funding from the Refugee Health Promotion grant. The groups were designed to collect data on the community's health needs for the purpose of guiding the development of appropriate health-related programming. Focus groups were held in southern Wisconsin during 2015-2017 by the Department of Health Services, Division of Public Health, Refugee Health Program. The 7 groups ranged from 5 to 15 participants (mean = 9) and were organized by language (Arabic, Burmese, Chin, Karen, Rohingya, and Somali).

Discussions were facilitated by CHWs in the language of the participants. Consistent with recommended methodology for research in refugee populations,[6] confidentiality was an important consideration; as such, names of participants and other identifying data were not collected. For participants' comfort, groups were not recorded; instead, notes were taken by moderators and observers during and after the discussion. These notes comprise the data for this project. After completion of the focus groups, the results were discussed and addressed by CHWs through workshops—a method recommended and requested by CWHs themselves.

The Institutional Review Board (IRB) at the Medical College of Wisconsin granted approval for the use of this previously collected data for the purposes of research; the focus groups notes

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Box. Focus Group Discussion Guide - Example Prompts

Having come to the United State from a different country, knowing how to maintain your own and your families' health is very important. What does your family need to be healthy here?

What kinds of things are people struggling with in your community?

What are the top health-related concerns for people in your refugee community?

What could be done to improve health in your community?

were analyzed under an IRB-approved waiver of consent because there was no identifiable patient data. An initial review of the notes was used to develop a codebook of keywords, issues, and topics that arose during the discussion. The codebook was applied using MAXQDA software, and key themes related to health and barriers to health were identified and are described herein.

RESULTS

Participants discussed a range of topics, and 6 main themes were identified: language, interpretation, pharmacy, insurance, transportation, and respect.

Theme 1: Language

Participants described language as a barrier in different ways: making appointments, understanding voicemails and voicemail menus, provider communication, and filling forms. One participant described how language barriers interrupt care: "One woman, a single mother, had a situation where one of her children wouldn't eat. A physician suggested a procedure that was supposed to help. The woman had difficulty understanding the procedure and why it was necessary due to language barriers… she was asked to sign something saying she understood [the proposed] procedure. [Because] they didn't explain it well enough [she didn't sign]. They thought she was refusing [but] she really just didn't understand and wanted to before consenting to the procedure."

Theme 2: Interpretation

Related to but distinct from language barriers, participants described challenges regarding interpretation: insufficient time, discordance in dialect, perceiving that the interpreter was not communicating everything, and fear of breach of confidentiality if from the same community as the interpreter. Participants said that if they have concerns, they have no way to report it and described situations in which interpreters were asked to practice beyond their defined roles. One participant relayed how an interpreter advised them to change their HMO plan; now with their new plan, some of their prescribed medications are no longer covered.

Theme 3: Pharmacy

Participants described barriers related to pharmacies: not understanding refills, prescriptions not being covered, and no interpretation. One participant said: "…we ordered two medicines and they gave us only one. We want to ask why they didn't give us the other one, but we don't speak English and they don't have [an] interpreter." Another said, "Sometimes the pharmacist talks a lot when we pick up our medicines, but we don't understand what they say."

Table. Summary of Barriers Identified in Focus Groups and Potential Actions to Address Them

Identified Barrier	Potential Provider Actions
Language	Budget for sufficient in-person interpreters. Provide staff training on use of in-person and telephonic interpretation. Use interpreters when leaving appointment reminders/confirmations. Make forms available in multiple languages and provide in-person interpretation for forms.
Interpretation	Allot extra time for appointments that require interpreters. Use well-trained, linguistically appropriate professional interpreters. Do not put interpreters in situations where they may be asked to function outside their scope. Confirm if patients are comfortable with the "regular" in-person interpreter. Consider using phone interpretation if patient not comfortable with available in-person interpreter.
Pharmacy	Provide thorough counseling on prescribed medications (importance, use, side effects, timing) in office. Advocate for commercial pharmacies to utilize telephone interpretation services.
Insurance	Be aware of patient's insurance coverage when prescribing medications. Use or promote the use of insurance navigators.
Transportation	Be cognizant that transportation may be a barrier for patients. If requested and possible, schedule families together. Consider weekend or evening appointments to accommodate transportation and childcare barriers. Advocate for enhanced funded transportation system (non-emergency medical transport).
Respect	Train all staff in cultural competence/cultural humility. Respect appointment times. Respectfully communicate delays. Respect the patient's preference of sex of clinician or interpreter.

Theme 4: Health Insurance

Participants acknowledged the essential need for insurance but also described challenges: misunderstanding its use and limitations, difficulty navigating plans, difficulty resolving billing errors, insufficient insurance when changing to an employer plan, and difficulty accessing noncovered prescribed medications.

Theme 5: Transportation

Participants described ways in which transportation was a barrier: lack of a car, not knowing the clinic location, difficulty

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navigating roads. One participant said: "For example, you know how to drive but the problem is you don't know how to get to your appointment because of the language, also the technology stuff like GPS." When transportation assistance was provided through the non-emergency medical transport (NEMT) service, participants reported difficulty communicating with the service. Further, because children often cannot ride along in NEMT, childcare becomes an additional barrier.

Theme 6: Respect

Some participants reported receiving respectful care, others reported disrespectful treatment. Disrespect manifested as long waits (hours past appointment time), not being provided same-sex clinicians when requested, delays in referrals, and general discrimination. Participants described situations when, although the clinician showed respect, their experience was negatively affected by interactions with staff, such as nurses or receptionists. One participant said staff "…treated us like we are not people who deserve care. Every time we go for appointments, we have to wait at least 2 or 3 hours to see the doctor, even when we have the appointment."

DISCUSSION

The focus groups provide insight about challenges faced by refugees when interacting with the health care system. Practice implications based on each theme are summarized below.

Theme 1: Language

Language is a well-known barrier to care,[7] yet solutions remain elusive. Clinicians must look to reduce language barriers in ways that are appropriate for their practice setting. Possibilities include enhanced awareness of their body language, increased availability of interpreters, coordinating patient appointments with appropriate interpreter availability, training staff on the advantages/disadvantages of telephonic interpretation, using interpreters to make reminder calls, simplifying voicemail menus, and providing help with forms.

Theme 2: Interpretation

Even with an interpreter present, barriers to effective communication remain. To ensure understanding, clinics should utilize interpreters who speak the correct dialect, are well-trained, and have enough time. Interpreters should not be put in situations where they need to act in a capacity beyond their scope. When a clinic has a "regular" interpreter, consider avenues for patients to express when they are uncomfortable with that individual (such as calling them with a telephonic interpretation and asking if they prefer the "regular" interpreter or a telephone interpreter). While in-person interpretation can seem superior, when a patient desires a more anonymous experience, telephonic interpretation may be preferred.

Theme 3: Pharmacy

Commercial pharmacies often do not provide interpretation. In these cases, medication counseling is more effective at the clinic where there is interpretation. Clinicians should advocate for the regular use of at least telephonic interpretation in pharmacy settings and must understand that problems with insurance at the point of medication pickup will be extremely difficult to resolve due to unavailability of interpreters.

Theme 4: Health Insurance

Clinicians should be aware that it may be difficult for some patients to obtain medications if they are not covered by their plan, and care should be taken to prescribe accordingly. While efforts have been made to assist patients in understanding insurance,[8] providing insurance navigators with appropriate interpretation services may be useful.

Theme 5: Transportation

Clinicians should be aware that transportation and childcare can be a barrier for patients who rely on NEMT. Offering evening or weekend appointments could potentially ease difficulty in finding childcare. Family practices could consider scheduling children's appointments before/after parents appointments so that they could be transported together by NEMT. Providers can advocate for an improved transport system, encouraging services to better meets the needs of patients by giving them a place at the table when deciding policies.

Theme 6: Respect

Clinicians should be aware that dignified care starts with the receptionists and other staff. Staff should be provided training in cultural competence/humility. Wait times should be reduced. When possible, choices should be provided to patients regarding their clinicians, their interpreters, and their treatment plans.

While the perspectives presented do not represent the experiences of all refugees, nonetheless they provide an opportunity to hear some refugee voices and consider how to address barriers to care. This report complements previous literature[9] on this topic by reinforcing some already known barriers to care at a local level, by providing some unique examples of how these barriers manifest on an individual level (including examples of serious health implications, such as a mistaken refusal for a procedure), and by considering actionable solutions to mitigate these barriers.

Because clinics have varying levels of resources, this report provides a range of potential solutions—from specific actions to simply being aware of these issues. We acknowledge that many of the proposed solutions require investments of time or money at a time when clinicians are being asked to do more fewer less resources. However, with the current administration indicating an intention to increase refugee admissions in the coming years,[10] attention to these issues is timely and important. Clinicians striv-

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ing to provide equitable, quality care will be aided by maintaining awareness of these issues and, when possible, implementing systems to improve care to refugee communities.

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REFERENCES

1. Yun K, Fuentes-Afflick E, Desai MM. Prevalence of chronic disease and insurance coverage among refugees in the United States. *J Immigr Minor Health*. 2012;14(6):933-940. doi:10.1007/s10903-012-9618-2

2. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med*. 2018;16(1):89. doi:10.1186/s12916-018-1064-0

3. Keboa MT, Hiles N, Macdonald ME. The oral health of refugees and asylum seekers: a scoping review. Global Health. 2016;12(1):59. doi:10.1186/s12992-016-0200-x

4. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. *BMC Int Health Hum Rights.* 2015;15:29. doi:10.1186/s12914-015-0064-9

5. Szajna A, Ward J. Access to health care by refugees: a dimensional analysis. *Nurs Forum*. 2015;50(2):83-89. doi:10.1111/nuf.12051

6. Veena P, Mosier-Mills A, Khoshnood K. Methodological and ethical challenges in research with forcibly displaced populations. In: Allotey P, Reidpath D, eds. *The Health of Refugees: Public Health Perspectives from Crisis to Settlement.* Oxford University Press; 2019:chap 11.

7. Kotovicz F, Getzin A, Vo T. Challenges of refugee health care: perspectives of medical interpreters, case managers, and pharmacists. *J Patient Cent Res Rev.* 2018;5(1):28-35. doi:10.17294/2330-0698.1577

8. Health insurance how-to sheets. Covering Wisconsin. Accessed January 22, 2020. https://www.coveringwi.org/learn

9. Worabo HJ, Hsueh KH, Yakimo R, Worabo E, Burgess PA, Farberman SM. Understanding refugees' perceptions of health care in the United States. *J Nurse Pract.* 2016;12(7):487-494. doi:10.1016/j.nurpra.2016.04.014

10. Statement by President Joe Biden on refugee admissions. News release. The White House; May 3, 2021. Accessed June 6, 2021. https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/03/statement-by-president-joe-biden-on-refugee-admissions/

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