Caring for Refugee Patients: An Interprofessional Course in Resettlement, Medical Intake, and Culture

Alana Petrassi, MD; Melissa Chiu, MD; Kelsey Porada, MA; Bryan Johnston, MD; Michael Toppe, PA-C; Michael Oldani, PhD; Caitlin Kaeppler, MD

ABSTRACT

Introduction: Refugees access health care at rates similar to US citizens. Many clinicians, however, do not feel prepared to care for them. This study evaluated whether an interprofessional presentation could improve knowledge of refugee health and cross-cultural comfort.

Methods: The session consisted of a lecture and 3 small-group sessions. Students from various health care programs attended via Zoom. Participants completed pre- and postsurveys to assess cross-cultural comfort and knowledge of refugee health.

Results: Of 161 attendees, 63 completed the presurvey (39%) and 49 completed the postsurvey (30%). All 9 knowledge questions demonstrated statistically significant improvements, while only 1 cross-cultural question showed significant improvement.

Discussion: The session improved knowledge of refugee health but not cross-cultural comfort, indicating the need for further interventions.

INTRODUCTION

Over 3 million refugees have resettled in the United States since 1975,[1] and the annual resettlement cap is expected to rise significantly in the next few years.[2] Through the Office of Refugee Resettlement, these new arrivals receive complete medical coverage for their first 8 months. Afterward, they are eligible for the same insurance options as US citizens[3] and have been shown to use primary care services at comparable rates.[4] So for health care providers, the question is not "Is refugee health relevant to me?" but "Am I prepared to care for refugees?"

In a survey of 42 trainees (74% medical students, 17% medical residents, 7% pharmacy students, and 2% nursing students) conducted in 2019, 51% of respondents reported they had no class time dedicated to medical issues unique to immigrants and refugees.[5] Only 21% reported that they were adequately comfortable caring for patients who speak a language other than English. In order to address this, we hosted a refugee health education night in January 2019. Survey data demonstrated that attendees had improved knowledge about the refugee resettlement process and refugee health. In addition, attendees said they were more confident in providing care for non-English speaking patients ($P = 0.023$).

Other medical educators have devised various curricula to address this education gap. A comprehensive review of the various curricula was published in June 2020.[6] Twenty-four curricula were evaluated. The authors found that workshops and simulations were the most beneficial and that students participating in these curricula reported increased comfort in providing care to refugees.

Considering the results of our previous survey and this review, we modified the curriculum from our 2019 session and expanded our audience to a large interprofessional venue at the Our City of Nations conference in November 2020. Our objective was to familiarize students with the refugee resettlement process, discuss clinical concepts unique to refugees, introduce the concept of cultural humility, and improve trainees' understanding of the refugee experience.

• • •

Author Affiliations: Medical College of Wisconsin, Milwaukee, Wisconsin (Petrassi, Chiu); Department of Pediatrics, Medical College of Wisconsin (Porada, Kaeppler); Department of Family Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin (Johnston); Concordia University Wisconsin, Mequon, Wisconsin (Toppe, Oldani).

Corresponding Author: Alana Petrassi, email Apetrassi@mcw.edu.

Published online May 25, 2022.

METHODS

Curriculum Development

We had intended to format our curriculum as 5 distinct interactive sessions, but due the COVID-19 pandemic, we chose to condense and host it virtually. We developed a 2-hour session that included a didactic presentation on the resettlement process, the refugee demographics of our state, and an introduction to cultural humility. This large-group session was followed by 3 small-group sessions: Clinical Considerations and Medical Intake, Systems Approach, and The Refugee Experience. Content for this curriculum was based on literature review, material from our January 2019 education night, and the Immigrant Partnership and Advocacy Curricular Kit (I-PACK), a module-based refugee and immigrant health curriculum.[7]

Implementation

Our session was hosted via the video conferencing app Zoom. All attendees remained in 1 large group for the introductory didactic session and were then assigned to 1 of 3 small groups. Each small group rotated through 3 breakout rooms that were moderated by a physician or medical student. Every breakout room included firsthand accounts from refugees and local experts, including case managers and health workers.

Evaluation

Electronic Qualtrics surveys were administered before and after the sessions. The presurvey was split into 3 parts: demographic information, assessment of comfort in cross-cultural interaction, and assessment of knowledge. We used The Cross-Cultural Competency Survey (CCCS) as a guideline for our questions assessing cross-cultural comfort.[8] No question was taken directly from the CCCS. Questions were reworded or combined to better address the themes most pertinent to refugee health. The postsurvey contained 2 parts: assessment of comfort in cross cultural interaction and assessment of knowledge. Survey responses were multiple choice on a 5-point Likert scale. Pre- and postsurvey responses were correlated using a unique 5-character identifier. Wilcoxon signed rank testing was used to assess changes for paired surveys, while Mann Whitney U testing was used to assess changes for unpaired surveys.

RESULTS

One hundred sixty-one participants were present for this session. We received 63 presurvey responses (39%) and 49 postsurvey responses (30%). The majority of the respondents were enrolled in graduate health programs throughout Wisconsin (see Table 1).

Table 1. Demographics of Survey Respondents (N=86)

Institution	N	Degree Program, if Applicable	N
Concordia University	24	Physician Assistant	23
Medical College of Wisconsin	18	Medical degree	16
University of Wisconsin	10	Pharmacy	6
Milwaukee Public Schools	2	Pediatric residency program	2
Alverno College	1	Nursing	2
Loyola University Chicago	1	Global Health degree BA	1
Michigan State University	1	Community Psychology MS	1
Neighborhood House of Milwaukee	1	Industrial Engineering PhD	1
		Public and Community Health PhD	1
Community Health Worker	1	Urban Planning	1
Jewish Social Services	1	N/A	3
Did not specify	26	Did not specify	29

Those who completed the presurvey also were asked to rate the amount of dedicated class time they had addressing refugee health. On a 5-point Likert scale (1 = none at all, 2 = a little, 3 = a moderate amount, 4 = a lot, 5 = a great deal), the median response was 2. The survey, however, did not inquire into prior experience participants may have had with the refugee community as a primary motive of this study was to evaluate the current state of formal refugee health education.

From the pre- and postsurvey responses, 26 pairs were identified. The Wilcoxon signed rank test was used to interpret paired changes. Unpaired presurvey responses were numbered at 37, while there were 23 unpaired postsurvey responses. The Mann Whitney U test was used to interpret changes between unpaired surveys.

Three survey questions evaluated participant comfort and confidence with cross-cultural interaction (see Table 2). Changes in response for the 26 paired surveys demonstrated a statistically significant change only for the question addressing comfort/confidence when interacting with an individual who speaks a language other than English ($P = 0.015$). Changes in response from pre- to postsurvey were not statistically significant for any of the 3 questions for the unpaired surveys.

Nine questions evaluated participant knowledge of refugee health (see Table 3). Evaluation of the 26 paired surveys demonstrated a statistically significant increase for all questions. The unpaired surveys demonstrated statistically significant increases for 5 questions. The 4 questions that did not demonstrate statistically significant increases centered on being able to define refugee status and an understanding of cultural humility. These results could indicate that more time should be devoted to highlighting these foundational topics.

In comparing these results to those of the 2019 survey, they are similar but differ in 2 notable ways. First, the 2019 survey demonstrated that 51% of respondents received no class time dedicated to refugee health, while the 2020 survey demonstrated the median response on a 5-point Likert scale was 2, indicating that students, on average, had at least a little dedicated class time. Second, the 2019 survey found a statically significant increase in participants' confidence in providing culturally sensitive care to refugees ($P < 0.01$), while the 2020 survey did not.

Published online May 25, 2022.

DISCUSSION

The value of our curriculum lies in its obvious need. With so little student-reported instruction time, it is not surprising that many trainees are at least somewhat uncomfortable providing care for refugees. Our study demonstrates that short educational seminars may be an effective means to improve knowledge on refugee health.

The power of our study, however, was limited by the relatively low number of paired pre-post data sets (n = 26) and by the fact that our surveys were not themselves validated. The individuals who failed to complete the surveys were likely very similar to those who did, in that they were primarily graduate students in health care programs. The large discrepancy between the number of participants and completed surveys could have resulted from virtual lesson fatigue or from the difficulties in survey distribution. Only participants who had preregistered received the survey links via email, and though the survey links were shared multiple times via Zoom chat, participants could only see them if they were logged in at the moment it was sent. Additionally, although some of the survey questions were modeled after the Cross-Cultural Competency Survey, our surveys were not themselves validated.

Another limitation of this session was the lack of physical interaction between participants and presenters. Though we saw statistically significant changes in knowledge, we saw only minor changes in cross-cultural comfort. Not being able to physically interact with presenters and refugees may have left participants less engaged and unable to form interpersonal connections. The only significant change observed was in comfort/confidence when interacting with an individual who speaks a language other than English. Though the curriculum did not directly address language, all 3 small-group sessions allowed students to ask refugee participants for advice in overcoming a language barrier. This change could represent the effect of the insights offered. Cross-cultural com-

Table 2. Comfort/Confidence Survey Responses Analysis

Survey Item	Paired Responses (N = 26)			Unpaired Responses (N = 37; N = 23)		
	Presurvey Mean (IQR)	Postsurvey Mean (IQR)	*P*[a]	Presurvey Mean (IQR)	Postsurvey Mean (IQR)	*P*[b]
I feel comfortable/confident interacting with individuals who speak a language other than English	4 (2-5)	4 (3.75-5)	0.015	4 (2-5)	4 (4-5)	0.258
I feel comfortable/confident interacting with individuals with different cultural values, practices, and beliefs.	4 (3.75-5)	4 (4-5)	0.095	5 (4-5)	5 (4-5)	0.920
I feel comfortable/confident providing care to refugees in my field of practice	4 (3-4)	4 (3.25-4)	0.084	4 (3-5)	4 (4-5)	0.897

Abbreviation: IQR, interquartile range.
[a]Wilcoxon Signed Rank test.
[b]Mann Whitney U test.

Table 3. Knowledge Survey Responses Analysis

Survey Item	Paired Responses (N = 26)			Unpaired Responses (N = 37; N = 23)		
	Presurvey Mean (IQR)	Postsurvey Mean (IQR)	*P*[a]	Presurvey Mean (IQR)	Postsurvey Mean (IQR)	*P*[b]
I can accurately describe the factors, as defined by the UN, that makes an individual a refugee.	4 (2-4)	4 (4-5)	0.001	3 (2-4)	4 (3-4.25)	0.165
I have an understanding of the process through which a refugee must undergo to be resettled in the United States.	4 (2-5)	4 (4-5)	0.003	4 (2.5-4)	4 (4-5)	0.267
I am able to clearly differentiate between an individual with refugee status and an asylum seeker.	2 (2-4)	4 (3.75-5)	0.001	3 (2-4)	4 (3-5)	0.057
I believe I am aware of and am able to reflect on my own cultural biases.	4 (4-4.25)	4.5 (4-5)	0.005	4 (4-5)	5 (4-5)	0.038
I understand what is meant by the term "cultural humility."	4 (4-4.5)	5 (4-5)	0.006	4 (4-5)	5 (4-5)	0.114
I am aware of the components of refugee medical intake, including the overseas and domestic exams.	2 (1-3.25)	4 (4-5)	0.001	3 (2-4)	4 (4-4.25)	0.007
I am aware of the role that the federal government plays in the refugee resettlement process.	3.5 (2-4)	4 (4-5)	0.001	3 (2-4)	4 (4-5)	0.005
I am aware of the role that state and local government plays in the refugee resettlement process.	2.5 (2-4)	4 (4-5)	0.001	4 (2-4)	4 (4-5)	0.001
I am aware of the organizations and community groups that provide services to refugees in the Milwaukee area.	2 (2-4)	5 (4-5)	0.001	3 (1.25-4)	4 (4-5)	0.002
I have had dedicated class time to learning about issues specific to refugees. (Pre-survey only)	2 (1-3)		-	2 (2-3)	-	-

Abbreviation: IQR, interquartile range.
[a]Wilcoxon Signed Rank test.
[b]Mann Whitney U test.

Published online May 25, 2022.

fort is a lifelong process that requires developing cultural self-awareness, gaining cultural knowledge, recognizing power imbalances, and holding power structures accountable.[9] The results of the review of refugee health curricula made clear that cross-cultural comfort is best achieved through interactive, longitudinal experiences that allow for both reflection and applied use of knowledge.[5]

Lastly, it would be prudent to consider the applicability of this intervention to practicing physicians. Though attending physicians have never been polled, resident physicians have. Their responses have affirmed a deficiency in education and comfort in providing care to refugees. Given that cross-cultural training is a relatively new addition to medical education, older physicians may, in fact, feel less prepared. It is likely that similar, if not better, results would be seen if practicing physicians were to complete the intervention.

Even considering these limitations, our session did greatly improve participants' knowledge of refugee health and deepened their appreciation of the refugee experience, providing a firm foundation upon which participants can continue to build.

Funding/Support: This work was supported with funding from a Refugee Health Promotion Grant from the Department of Health Services, Division of Public Health, Refugee Health Program.

Financial Disclosures: None declared.

REFERENCES

1. Refugees in America. USA For UNHCR. Accessed November 30, 2020. https://www.unrefugees.org/refugee-facts/usa/

2. Amos D. Biden plans to reopen America to refugees after trump slashed admissions. *NRP*. November 11, 2020. Accessed November 30, 2020. https://www.npr.org/2020/11/11/933500132/biden-plans-to-reopen-america-to-refugees-after-trump-slashed-admissions

3. Office of Refugee Resettlement. Administration for Children & Families. March 20, 2019. Accessed November 30, 2020. https://www.acf.hhs.gov/orr/health-resources

4. Guess MA, Tanabe KO, Nelson AE, Nguyen S, Hauck FR, Scharf RJ. Emergency department and primary care use by refugees compared to non-refugee controls. *J Immigr Minor Health.* 2019;21(4):793-800. doi:10.1007/s10903-018-0795-5

5. Chiu M, Petrassi A, Porada K, Cobb C, Kaeppler C. Cultural sensitivity when working with the refugee population of Milwaukee. Poster presentation at: MCW Engage; May 3, 2019; Milwaukee, WI.

6. Rashid M, Cervantes AD, Goez H. Refugee health curriculum in undergraduate medical education (UME): a scoping review. *Teach Learn Med*. 2020;32(5):476-485. doi:10.1080/10401334.2020.1779071

7. I-PACK: Immigrant Partnership and Advocacy Curricular Kit. The Board of Regents of the University of Wisconsin System. Accessed November 30, 2020. https://sugarprep.org/i-pack

8. Weissman JS, Betancourt J, Campbell EG, et al. Resident physicians' preparedness to provide cross-cultural care. *JAMA*. 2005;294(9):1058-1067. doi:10.1001/jama.294.9.1058

9. Module 8: cultural competence & cultural humility. Project READY: Reimagining Equity & Access for Diverse Youth. Accessed June 21, 2021. https://ready.web.unc.edu/section-1-foundations/module-8/

Published online May 25, 2022.