

**Strategies to improve health care for patients with refugee status
in King County, WA: Voices of Primary Care Providers**

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Abstract

The purpose of this research was to help identify priority areas, related to clinical care for refugees, in need of more support, assess the desire for more information on this topic among Primary Care Providers (PCPs), and to identify common challenges and potential strategies to providing quality health care for this population. A qualitative research study, using Participatory Action Research (PAR) methods, was conducted to address these issues. Semi-structured interviews and participant observation with PCPs were used for data collection. PCPs self-identified challenges, needs, and strategies involved in providing care for recently resettled refugees. The project resulted in the collection and analysis of qualitative data and found that the identification of recently arrived refugees was a major issue, communication, difficulty obtaining health history, increased encounter time for clinic visits, inadequate reimbursement rates were among the challenges. Several strategies for working with refugees include; adaptation of the clinic structure, the use of cultural navigators, improved sharing of health records, increased collaboration among public health and social service agencies, increased collaboration among PCPs working with similar populations and increased support for enhancement of cultural competence skills were also seen as potential solutions. This project was successful in fostering interdisciplinary collaboration between different individuals working with refugees in the health and social service sectors and raising awareness of gaps at the system-level. Recommendations include enhanced support for providers at the clinic, county, and state levels in order to improve the structures, policies, and methods for ensuring the delivery of culturally competent high quality care for all.

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Overview

Washington state accepted 3,004 newly arrived refugees during 2010 (Martin, 2011, Table 5, p.4). King County, particularly south-central King County, is recipient of the highest number of these individuals in the state. Though some social service agencies and non-profit health entities receive enhanced funding as a result of this influx, some members of the private health care sector do not. Primary Care Providers (PCPs) in this area are exposed to a high number of refugee patients, often those seeking care in the U.S. health care system for the first time. PCPs, especially those in private practice, do not routinely receive extra training or resources to deal with specific needs associated with this population, nor is there a strong method for communication among providers within the county. This puts them at a disadvantage for providing high quality health services and it has the potential to have a negative impact on the health and well-being of refugee patients seeking care. The purpose of this research is to help identify priority areas, related to clinical care for refugees, in need of more support, assess the desire for more information on this topic, and to identify common challenges and potential strategies to providing quality health care for recently resettled refugees in King County. To address these issues, a qualitative research study using a participatory action framework was utilized. Semi-structured interviews and participant observation were conducted among a group of health care providers in this area.

Research Questions

- I. What is the current level of knowledge related to patients who are recently arrived refugees, among those involved in providing primary care in south-central King County, WA?
- II. What do these Primary Care Providers perceive as challenges and solutions, for providing high quality health care for patients who are refugees?
- III. What is the interest level among these Primary Care Providers in increasing collaboration with other local health and social service providers, and on receiving information specific to health needs of refugees?

**From: American Diaspora, Poetry of Displacement
Seven & Seven
by Peter Meinke**

Looking back at it now he
can see what a fool he was
but life's not a damn exam

and if being a dunce and
disgrace has dragged him to where
he kneels in this sweltering

sagging house with the shutters
hanging like drunks from a frayed
merry-go-round a pen or

a drink in his hand and her
reading a book while the dogs
circle outside maniacs

running the land no matter
which way we voted he can say
at least we tried and this the

*road we took: twisting below
the oaks the vines sucking their
trunks where unearthly shadows
mix with the smell of salt and*

*decay and the swollen threat
of rain warps the cypress boards
and softens the porous ground*

*until the house tilts like a
monk tipsy beside a stream
that murmurs the drunkard's dream:*

Everything can be fixed O
Lord anything can be fixed

Background

There are an estimated 10.5 million refugees in the world at the beginning of 2011 (UNHCR, Refugee Figures, 2011). This is a dramatic increase over the past 60 years. In 1950 the United Nations High Commission for Refugees (UNHCR) was established by the United Nations (UN) General Assembly. This agency was originally created to help Europeans who were displaced as a result of World War II. The following year, the "Convention Relating to the Status of Refugees" was held in Geneva with the aim of "developing a body of international law, conventions and guidelines to protect refugees" (UNHCR, Refugee Convention, 2011). This convention led to the modern definition and understanding of refugees. The convention culminated in the development of a treaty that clarified the definition of a refugee and described their rights. This initial definition by the UNHCR states that a refugee is an individual who:

As a result of events occurring before 1 January 1951, owing to a well-founded fear of being persecuted or reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country. (UN Convention Relating to the status of Refugees, Article 1A, 1951)

The Convention also outlined the principle of non-refoulement, the right of the refugee to be protected from forcible return to the State, or any State, in which they would be at risk. The treaty reads, "No contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion" (Article 33). In addition, each State ratifying this treaty agreed not to refuse entry to "refugees at the frontiers of their countries of origin," (Article 24), as well as to provide certain facilities to refugees, including administrative assistance (Article 25); identity papers (Article 27), and travel documents (Article 28); to grant permission to transfer assets (Article 30); and to facilitate naturalization (Article 34). (UN Convention Relating to the status of Refugees, 1951). The Convention formed an international social

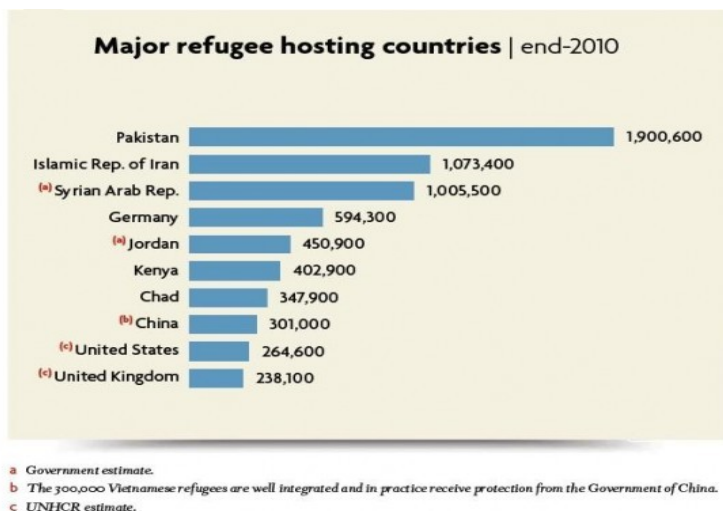
contract, agreed upon by the global majority, stating that to deny such rights to individuals defined as refugees is a violation of fundamental human rights.

Although the United States (U.S.) remains one of only a few countries who have not yet signed the convention document, it influenced the current national refugee resettlement practices. In 1964, the "New York Protocol," was drafted, in which protection and rights established for the refugees displaced in Europe, was expanded to include displaced people globally and it included a modification of the 1951 definition of a refugee, in which the statement, "As a result of events occurring before 1 January 1951," was altered. The new protocol declared, "The present Protocol shall be applied by the State Parties hereto without any geographic limitation, save that existing declarations made by States already Parties to the Convention" (UNHCR, Protocol Relating to the Status of Refugees, New York, 1967).

The resulting UN treaty and the New York Protocol were signed and ratified by the U.S. in 1968 with the following comments, "The United States of America accepts the obligation of paragraph 1(b) Article 24 of the Convention except in so far as that paragraph may conflict in certain instances with any provisions of title II (old age, survivors' and disability insurance) or title XVII (hospital and medical insurance for the aged) of the Social Security Act. As to any such provisions, the United States will accord to refugees lawfully staying in its territory treatment no less favorable than is accorded to aliens generally in the same circumstances" (U.S. Accession of the Protocol Relating to the Status of Refugees, 1968). By this definition, anyone who the U.S. defines as a refugee, is eligible for certain social services. These regulations are similar to many other countries where refugees are resettled, those refugees are also eligible for similar benefits. One major difference is that in most places where refugees resettled, health care is freely available for all citizens. By contrast, the U.S. operates under a privatized health care system in which health insurance is required for accessing primary care. In an effort to both comply with the UN standard and U.S. social reality, refugees are eligible for Medicaid health insurance for their initial 8 months, after which time they assimilate to the population and must seek private insurance independently.

Since the U.S. Accession of the New York Protocol in 1968, those who meet the definition for refugee status have legal means by which to appeal for asylum.

Refugees emerge from many countries each year. In 2010, Afghanistan and Iraq were the origin for the highest number of displaced people worldwide, as well as the places of origin for the greatest total number of displaced people who crossed an international border, and became refugees, totaling 3 million and 1.7 million respectively. These numbers make up almost half of the total number of refugees worldwide, 10.55 million (UNHCR, Global Trends, 2011). Other countries from which significant numbers of displaced people and refugees include Somalia, Democratic Republic of Congo, Myanmar, Columbia, Sudan, VietNam, Eritrea, and China.



(UNHCR, Global Trends, 2011, p.12)

Hosting displaced people has become increasingly well monitored and regulated with increases in the number of people fleeing and increased attention on the plight of refugees. Interestingly, in 2010 Pakistan hosted the largest number of refugees, 1.9 million, followed by Iran with 1.1 million and Syria with 1 million (UNHCR, Global Trends, 2011). This data is even more dramatic when examined in comparison to the size of the economy of the host country. According to the UNHCR Global Trends: 2010 report, “countries with strong economies are more likely to be capable of absorbing and supporting refugees” (UNHCR, Global Trends, 2011, p. 12). This report compares the average income of a country, measured in Gross Domestic Product (GDP), and the refugee population within that country. According to this report, in relation to the size of their economies, poor countries carry a disproportionate refugee burden. In 2010, “42 percent of the world’s refugees, resided in countries whose GDP per capita was below USD 3,000” (UNHCR, Global Trends, 2011, p.12). The GDP per capita in the U.S. was USD 46,702 in 2010 (World Bank, GDP per capita, 2012).

In 2010, the U.S. accepted 73,293 refugees (Martin, 2011, p.1). Each year a quota is established by the federal government, to determine a limit on the number of refugees accepted by region. In 2010 the ceiling for refugees admitted into the U.S. was set:

Refugees Entering the United States, 2010		
Region	Ceiling	Actual Admitted
Africa	15500	13305
East Asia	18000	17716
Europe/Central Asia	2500	1526
Latin America/ Caribbean	5500	4982
Unallocated Reserve	500	0

(Martin, 2011, p.2)

(Cultural Orientation Resource Center, 2012)

The number of individuals with refugee status actually admitted into the U.S. is determined by the U.S. Department of Homeland Security. Each month, they meet to decide on the number of refugees to be admitted for the following month, and in which city they will be resettled. These numbers are defined in terms of nationality, though it is important to recognize that ethnic groups within a particular nationality may be an ethnic minority group previously living within that nation. For example, Bhutanese refugees accepted into the U.S. are nearly all ethnically Nepali. They were persecuted as an ethnic minority living in Bhutan. Resettling different ethnic groups coming from one country of origin has led to ethnic tension in cities where resettlement occurs. There have also been cases where conflict or transition of power from a person's country of origin has fueled ethnic tension between ethnic groups from that nation who are living in the diaspora. In other cases, no ethnic distinction might be made at all. For example, in the case with Ethiopian refugees, "it is impossible to distinguish those individuals who left for political reasons from those who left because of poverty and economic stagnation – often there was an element of both – but, overwhelmingly, the international community agreed that the outflow from Ethiopia was a refugee crisis" (Terrazas, 2007, p.1). While the U.S. reports admission rates based on nationality, there are also ethnic characteristics which define resettled refugee groups. In 2010, those admitted to the U.S. by country of nationality include:

Refugees Entering the United States by Country of Nationality, 2010	
Country of Nationality	Number Admitted into the U.S.
Iraq	18,016
Burma	16,693
Bhutan	12,363
Somalia	4,884
Cuba	4,818
Iran	3,543
Congo (DRC)	3,174
Eritrea	2,570
Vietnam	873
Ethiopia	668
Other	5,691

(Martin, 2011, p.3)

Refugees Admitted into Washington State

In 2010, Washington State accepted 3,004 newly arrived refugees. (Martin, 2011, p.4). Each state has its' own refugee coordinator to plan for, monitor, and evaluate issues related to refugee resettlement within that state, as well as link to local and federal refugee resettlement actors. All those admitted as refugees must be sponsored by a Voluntary Resettlement Agency (VOLAG). These are private organizations who receive federal funding, in a public-private partnership, to provide refugee resettlement services in the U.S. Of the 10 such existing agencies in the US, Washington state is home to six: Catholic Community Services, Episcopal Ministries, International Rescue Committee, Jewish Family Services, Kurdish Human Rights Watch, Lutheran Community Services Northwest, and World Relief. These local NGOs are all located within south-central King County. Two also have smaller offices in Spokane. For this reason, King County, particularly south-central King County, is recipient of the highest number of refugees in the state.

Individuals seeking refugee status go through an arduous process prior to resettlement. This process begins with an application for refugee status with the UNHCR. This generally takes place

outside their country of origin and prior to entrance to the U.S. Once they have received this status, they apply for asylum in the country where they have fled, or another country willing to accept them. The U.S. sends immigration officials to refugee camps and cities with high numbers of refugees to manage this process. Individuals may also appeal to diplomats or political figures to initiate this process. A background check is among the requirements, to ensure that the applicant has not served as a combatant for either side. Other qualifications vary by region and change regularly. After months or years, individuals and their families may be accepted by a host country such as the U.S.. They then must be evaluated by a panel physician, contracted by the U.S. Department of State. The medical examination procedure may occur up to 12 months prior to departure, and consists of a physical examination, an evaluation (skin test/chest x-ray examination) for tuberculosis, and blood test for syphilis. The vaccination requirements include vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), (CDC, Immigrant & Refugee Health, 2012).

The purpose of the medical examination is to identify applicants with inadmissible health-related conditions for the Department of State (DOS) and U.S. Citizenship and Immigration Services (USCIS). The health-related grounds for inadmissibility include persons who:

- Fail to present documentation of having received vaccination against vaccine-preventable diseases
- Have a class A Medical condition including:
 - a communicable disease of public health significance
 - a physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others
 - a history of a physical or mental disorder and behavior associated with the disorder, which behavior has posed a threat to the property, safety, or welfare of the alien or others and which behavior is likely to recur or lead to other harmful behavior

- drug abuse or addiction

(CDC, Electronic Code of Federal Regulations, 2012, S.34.2)

Several active communicable conditions may also be considered when granting admission the U.S. The following conditions remain on the inadmissible list: active tuberculosis, syphilis -infectious stage, granuloma inguinale, gonorrhea, granuloma inguinale, lymphogranuloma venereum, infectious Hansen's Disease (Leprosy) (CDC, Electronic Code of Federal Regulations, 2012, S.34.2).

Refugee Experience

Once an individual has been medically and politically approved, they may be offered entry into the U.S. with refugee status. A pre-departure class, called cultural orientation, describing the expectations and realities of life in the U.S. is provided. The individual refugee is generally offered a government loan to cover the cost of their travel expenses. The next step is to bid farewell to family, friends, and community, and depart for the unknown as they board a plane bound for a new city and culture. The transition process is full of difficulties, as illustrated by a story from a study of Iraqi refugees following resettlement in Washington state:

"My name is X. I was born in the South of Iraq, Basra, eh and I left Iraq 1988 after problem with government. I stayed in Kuwait for more than a year and then the Gulf War. I was arrested in Kuwait then went back to Basra and then I participated in the uprising in 1991 eh and I left Iraq and went to Saudi Arabia. I stayed three years and three months in the refugee camp in Saudi Arabia and I get accepted by the INS and I came to the U.S. in 1994 as a refugee. And we're trying to establish ourselves here but we didn't have a chance. We were trying really hard. We really couldn't have chance to prove ourselves here or anyone can hear our voice." (Witteborn, 2008, p.211-212)

Some refugees may have lived their entire life in one village or refugee camp, while others may have been displaced multiple times prior to resettlement. Once an individual arrives in the U.S., their story is not over; there is a standard resettlement pathway that most follow. The Refugee Act

of 1980 is national legislation designed to systematize entry into the U.S. and standardize some resettlement services. This legislation outlined the regional quota system described previously. It also allocated money specifically for resettlement activities. Financial resources are distributed to the VOLAG who sponsored and supported the refugee initially. The VOLAG offers support for a duration of one to six months, providing cultural orientation and guidance to get connected with basic social services, initial housing, food, clothing, medical services, and an introduction to other social service organizations such as those offering classes in employment or language skills, with the goal of assisting the individual to achieve financial self-sufficiency as soon as possible.

While refugees emerge from a variety of situations and communities around the world, there are also several unique attributes which have been applied to this category of people. In fact, according to some research, people with refugee status, especially those who go through the resettlement process, possess a high level of strength, resiliency, flexibility, and adaptability. One author asserts that, "refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity" (Muecke, 1992, p520).

Most refugees have experienced direct effects of violence, war, or natural disasters in insecure or unstable places. This can mean the loss of a home and friends or family members, close or actual experiences with rape or torture, hunger, living, moving, or escaping from dangerous and uncertain circumstances. "Surviving war and refugee camps is a notable accomplishment. While perhaps appearing helpless and without skills, most refugees possess magnificent survival skills" (Kemp, 1993, p22).

Upon resettlement into a foreign country, a variety of other commonalities have been noted. For example, refugees are most often described in medical literature as being at high risk for mental health issues, malnutrition, infectious disease, and uncommon tropical diseases including malaria and parasites (Clinton-Davis & Fassil, 1992; Adams et al., 2004; Stauffer & Weinberg, 2009). The focus for most of the mental health literature related to resettled refugees has been on Post

Traumatic Stress Disorder (PTSD) and psychosomatic issues. In addition to these challenges, refugees face numerous barriers to accessing or utilizing health care. Barriers include linguistic and cultural differences, lack of basic medical screening or availability of treatments in the past, challenges with coping, and limited understanding of the medical system (Clinton-Davis & Fassil, 1992; Adams et al., 2004).

However, few articles discuss any positive attributes common among this population, nor articulate advantages to the health care system related to an influx of refugee patients. Despite this, it is clear that individuals with refugee status who have been resettled into a new community, have dealt with obstacles and met adversity. Facing challenges related to language, culture, and social status, enables refugees to develop techniques to cope and persevere. According to Kemp, these incredible survival skills as well as many circumstances from which individuals came, can often go unrecognized by the dominant culture in the country of asylum (1993, p.22).

**From: American Diaspora, Poetry of Displacement
The Refugee
By Vijay Seshadri**

He feels himself at his mind's borders moving
down the fifteen rows of laid-out soil,
and out to the fence where the mulch heaps spoil
beside the rust-scabbed, dismantled swing

and the visions that disturb him sometimes spring
up from a harmless garden hose coil:
the jack-booted armies dripping spoors of oil
that slick the leaf and crap the wing . . .

He sees each rifle as we who see him,
in the crystal blizzard of a century's static,
try to reach him without two-bit magic
who escapes us to roam in the garden:
too clear to look through or distant to ask;
pinned like a flower on the genocidal past.

Disease Burden

Due to civil disruption in the refugee's community, many refugees from different countries of origin share common health issues. In addition to spending time in a context ripe for disease, many refugees have poor or disrupted access to health care resources (Kay et al., 2010). Limited access to medical care can mean that there is either no health care available, or that it is only available intermittently resulting in incomplete services. Furthermore, Kemp explains, "health [of refugees] in general is compromised. Problems include untreated communicable diseases, especially tuberculosis, resulting from crowded and/or primitive living conditions; chronic conditions exacerbated by lack of health care; and nutritional problems resulting from famine, war, poverty or some combination of the three" (1993, p. 21). Based on existing research, refugees are at risk for acute and chronic illness due to difficult circumstances prior to arrival in host countries. Refugees resettled in the U.S., the U.K. and Australia have been shown to have an increased risk of suffering with malnutrition, anemia, lead poisoning, tuberculosis, malaria, HIV, hepatitis, and intestinal parasites (Ackerman, 1997; Lifson et al. 2002; Miller et al. 2000; Varkey et al. 2007; Stauffer & Weinberg, 2009).

Although "severe mental disability" is an inadmissible condition for individuals with refugee status entering the U.S., it remains a known risk for refugees to have mental health issues for a variety of reasons. People arriving as refugees may have witnessed or participated in traumatic and/or horrifying events. While some people may have had mental health support, many have not had the opportunity to formally process the things they have witnessed. In addition to traumatic experiences which some people have been involved in, all refugees have been uprooted from their

community, separated from extended family members and social support, and abruptly relocated. For some, this has happened multiple times over their lives. For others, the trip to the U.S., or other place of resettlement, may be the first. Relocating and the process of integrating into a new culture are both stressful. "The process of acculturation is acknowledged to be stressful and can be associated with social and psychological problems" (Berry, 1998, p. 5). In fact, the current literature on mental health of refugees often highlights the multitude of stresses associated with displacement itself. Miller and Rasco point out several examples including "social isolation and a loss of traditional social support networks, uncertainty regarding the well-being of loved ones unable or unwilling to make the journey, a lack of income-generating opportunities and a corresponding lack of economic self-sufficiency, discrimination by members of the host country, the loss of valued social roles and a corresponding loss of meaningful role-related activities, and a lack of access to essential health, educational, and economic resources" (2004, p.17). All of these circumstances place this group at high risk for mental health needs.

Barriers to mental health delivery are similar to the barriers refugee patients face in other aspects of health care in the U.S. such as language and culture (Hollifield et al., 2002). Gong-Guy, et al. explain that, "because access to language-appropriate inpatient psychiatric care is particularly limited, refugees often receive treatment at inappropriate levels within the mental health system" (1991, p. 644). Additional barriers include the issue related to stigma and mistrust of interventions, which may occur more frequently in cultures other than that of dominant culture. Finally a lack of familiarity with available mental health services has an impact (Gong-Guy, et al., 1991, p. 644).

Mental health is certainly a priority area for recently arrived refugee patients, yet research related to the mental health of refugees is limited. In one study, despite refugee subjects experiencing high stress levels, the researchers found it difficult to determine clinical problems, "as many respondents had not visited a doctor or been given a diagnosis" (Phillimore, 2011, p. 587). The lack of mental health diagnosis among this population may also be influenced by a lack of appropriate or culturally appropriate tools to do so. In fact, one meta-analysis examining instruments

to measure trauma and mental health issues found that “no empirically developed instruments assess the complete range of trauma experiences in refugees” (Hollifield et al., 2002, p.618). Thus the tools themselves may not be culturally appropriate, or may not be available at all. Another study showed that 48% of refugee minors resettled in the Netherlands felt that their need for mental health service was not met (Bean et al., 2006). Lack of identification of those at risk, lack of tools, lack of interpretation, and lack of resources all contribute to a gap in appropriate mental health care for refugee patients in need. This is evident in much of the literature in this area, as one author points out, “in most resettlement sites scant attention is devoted to chronic and mental health conditions” (Morris et al. 2009, p. 529). Further research and attention are needed in the area of mental health for refugees in their country of resettlement.

Adjustment & Acculturation

Acculturation involves the modification of individual or group beliefs, styles, or behaviors as a result of prolonged exposure to a new culture. One study describes acculturation as a commonality among refugees from all points of origin, who were all resettled within the same city, during the same time period (Morris et al., 2009, p.529). The authors of this study define acculturation as “the merging and adoption of behavior patterns between cultures as a result of prolonged contact” (Morris et al., 2009, p.534).

Acculturation and assimilation can be a huge challenge for many due to the multitude of factors involved, such as language, culture, social norms, and behaviors. Making appointments, understanding the complicated referral process, and travel logistics are often as confusing as other social norms including shopping at the grocery store, bringing the correct paperwork to the department of motor vehicles, or initiating the job hunt. Local food, languages, expressions, colloquialisms, norms, and expectations are a great challenge for most refugees during their first few months in the U.S. regardless of their origin.

U.S. Policy emphasizes a wide distribution of refugees across the entire U.S., to prevent any

one community from incurring an overwhelming burden and to hasten adjustment to society. The second component involves sponsorship: refugees should be resettled within 50 miles of a VOLAG and with blood relatives when possible (Westermeyer, 2011). There is a heavy focus on financial independence that is reflected in the policies, "resettlement officials (located in the State Department) applied the same two-step policy as described previously, augmented by a "job first" initiative, aimed at getting refugees economically self-sufficient before other acculturation efforts (ie. Language, vocation training or advanced education)" (Westermeyer, 2011, p.532).

**From: American Diaspora, Poetry of Displacement
Poem for a Vietnamese Student
By Leroy V. Quintana**

Some words have tongues sharp as punji stakes.
They lie awake in the ambush as long as necessary,
sometimes in the shadows of other words: gobbledygook.

They know the future because they have no regret
for the past. They are ill-mannered, pretend to be deaf
as clocks, in love with the sound of their names.
They lie awake in ambush as long as necessary,
sometimes in the shadow of other words: gobbledygook.

They find their way into our blood, and haunt us.
We pay with our lives all our lives.
Welcome to America. Sin loi. Get your dictionary,
go to the board, look up a new word: write down
guide words, entry word, phonetic spelling, learn
how to pronounce the word, which syllable is stressed.
Repeat after me: gobbledygook, gobbledygook, gobbledygook.

Acculturation & the Health Care System

It is critical that those who study refugee health and health-related needs consider the diversity and complexity of the circumstances from which refugees come prior to entering the U.S. health care system, in addition to the barriers a refugee might face in accessing the health care system. "Increased understanding of health needs and potential barriers to accessing health care of these resettled refugees is a critical priority for better allocation of sparse health care funds and

improving refugee health” (Morris et al., 2009, p.530).

Acculturation is a process which occurs over time. For many refugees, the transition period can be very abrupt. While this is not the case for all people with refugee status, some leave a particularly low resource setting such as a displacement camp, board an airplane, and land at SeaTac airport, leaving little time for transition or acculturation. The process of acculturation occurs at different rates for different people and is influenced by a variety of factors. Unlike many other immigrants, or asylum seekers, individuals with refugee status have access to considerable federal, state, and local support including access to health care. The relatively short time period in which support is available coincides with the period in which the refugees are learning to navigate the health care system during the process of acculturation. One researcher explains this process, “refugees resettled in the U.S. have 8 months to become economically independent before cash assistance from the U.S. Government terminates and they then become subject to standard eligibility requirements of Medicaid. Few studies have examined utilization of health care services after governmental assistance has ended and how this might relate to post-resettlement health conditions” (Morris et al., 2009, p.529-530).

Numerous barriers are present in entering and assimilating into the medical culture in the U.S. Known barriers to health care, expressed by refugees include: locating practices, making appointments, language, difficulty building rapport with one provider (due to changing providers within one practice as well as needing to move to other practices when directed by insurance) and not being taken seriously by providers (Bhatia & Wallace, 2007). Language and miscommunication between refugee patients and providers is consistent in the literature as one of the greatest barriers to health care access for this group (Sheikh-Mohammed et al., 2006; Lipson & Omidian, 1992; Uba, 1992). Providers may depend on verbal communication to complete medical history and assessment, in which case the ability to communicate in the same language is very valuable

Several studies have examined the effect of culture on health. One study shows that culture “directly affected refugees’ concept of prevention services, independence, expectations of care and

stigma around health conditions -all of which influenced their health care choices" (Morris et al., 2009, p. 535). The process of acculturation can be examined from two perspectives. The first, mentioned above, are those factors which are related to the immigrant or refugee who is entering the system. The other relates to the patient-provider relationship. This is influenced by the culture of western biomedicine. "European American culture is embedded in many health care system activities that seem logical only to people from that culture" (Chrisman & Zimmer, 2000, p.67). This concept is also found in the literature on mental health and refugees. As people coming from a different culture, refugees may have "ways of understanding and responding to emotional distress that differ from the explanatory and treatment models that guide the work of Western-trained mental health professionals" (Miller & Rasco, 2004, p.30). The implications are that those with emotional distress or mental health concerns may express symptoms that are culturally bound, making it difficult for a provider who is not familiar with that particular culture to properly identify or address mental health concerns. The health of refugees seeking care in the U.S. can be impacted by the multifaceted elements that are a part of acculturation. One element is the time it takes for refugees to become familiar with social norms, behaviors, and expectations in the place where they are resettled. Another element includes culture and training of the health care providers.

Barriers for Health Care Providers Treating Refugees

Medicine has always been more than a system of scientific ideas and practices; it has also been a symbolic system, expressing some of the basic underlying values, beliefs, and moral concerns of the wider society. In a more secularized age, religious ideas of sin or immorality often seem to be replaced by ideas of health and disease.

(Helman, 2007, p 125)

This section addresses components of the U.S. health care system as they relate to individuals with refugee status. By focusing on the primary care setting and Providers working in that area, this research project was designed to illuminate challenges and solutions to providing health care for a vulnerable population while simultaneously bringing an awareness of the issues to the PCPs who are involved.

Primary care is the field of western medicine, defined as the level of the health service system that provides entry into the system. It is in this setting where screening is offered and all new health needs or issues should be addressed. Primary care should focus on care for individuals (rather than focus on a particular disease). Finally it should be the entity which coordinates or integrates care provided elsewhere or by others (Starfield, 1998). This makes the primary care setting uniquely well-suited to interface with patients who are refugees. However, as one researcher points out, "Because the existence of both medicine and psychiatry is predicated upon the necessity of pathology or problems, they cannot take primary account of the strengths and resilience of refugees" (Muecke, 1992, p 520).

In fact, primary care was designed in such a way that should be a perfect environment to meet the unique health needs of this population. Primary care emerged with popularity in the 1950s in the U.S. with a focus on the health needs of people in contrast with the availability and distribution of health care resources. The focus on primary care was embraced at the conference in Alma Ata. "According to the Alma-Ata Declaration, primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made accessible to all individuals and families in the community through their full participation and at a cost that the community can afford, in the spirit of self-reliance and self-determination" (Vuori, 1986, p. 399).

Primary care is recognized internationally as central to healthcare; strong primary care is associated with better population health, improved patient outcomes, and lower-cost care. Nationally, both the strength of primary care and system-level performance are closely linked to

improved patient outcomes and lower costs. Costs of care represent a critical policy issue due to their effects on the overall economy. One of the most important strategies to reduce costs and improve quality for all Americans is to increase the primacy of primary care (Committee on Integrating Primary Care and Public Health; Board on Population Health and Public Health Practice; Institute of Medicine, 2012).

Although universal health care is not yet a reality in the U.S., other concepts emerged from the Alma Ata conference which can be seen in the structure of the modern health care system in the U.S. Primary care delivery in the U.S. consists of overlapping contributions in a variety of settings from at least three types of generalist physicians (general internists, general pediatricians, and family physicians), nurse practitioners, and specialists (Franks et al., 1993). This provider group functions as the gateway to healthcare. They are the first point of care for most individuals with health insurance, who are seeking care. For those entering the U.S. as refugees, PCP's are not only the first point of care within the system, they are often among the first health care providers from the U.S. healthcare system that this population encounters overall.

The Institute of Medicine defines primary care as "the provision of integrated, accessible healthcare services by clinicians who are accountable for: addressing a large majority of personal healthcare needs and developing a sustained partnership with patients practicing in the context of family and community"(Institute of Medicine, 1994, p. 15). Providers today are challenged with not only the vast array of ever increasing medical information and technology, the complex medical needs of their patients, and the business aspects associated with insurance and reimbursement structures, but also the evolving roles that they play within the healthcare system itself.

Chirsman & Zimmer point out that:

Understandings and perceptions that formerly served us well have disappeared. Nowhere is that more true than in the health professions. . . We now recognize that the individuals with whom we work are just as much social and cultural beings as they are biologic beings, and more important, that this new understanding makes a difference in how we care for patients. (2000, p.65)

Prior to examining the literature related to refugees in Primary care, it is important to recognize "refugees" have often been objectified in the health and social science literature and that creates problems of it's own. "The preoccupation with disease pervaded refugee-related policy, program development, and research. . . the unplanned effects include a medical definition of the refugee, such that medical problems became the primary route for refugee recourse when in any kind of pain, whether medical, social, or emotional. In the United States, medical opinion and diagnosis have determined eligibility for special economic benefits. Refugees were classed rather than personalized in the health and social service programs and literature" (Mueke, 1992, p. 519).

Several studies exist examining the perceptions of providers who encounter refugees in their clinics. In one qualitative study with health care providers seeing refugee patients, the providers described differences in the economic and health systems from the country of resettlement, and that of a refugee's native country as a reason for under-utilization of health care and preventative services. Health care providers in this study perceived that a major barrier to providing care includes the cultural differences among refugees, in particular refugees relying on homeopathic treatments and spiritual healers and having an overall negative perspective of western medicine (Morris et al., 2009).

In other studies, refugees are perceived by general practitioners to have a multitude of needs and have a greater number of challenges associated with their care. For this reason, some refugee patients are even refused admission into a practice (Burnett & Peel, 2001; Kmietowicz, 2001). Throughout the literature findings confer that being able to identify refugees, and particularly recently arrived refugees is challenging (Hargreaves et al., 1999; Grant & Deane, 1995). Limited knowledge about the specific health issues endemic in the refugees' country of origin or in the regions where refugees have traveled through is cited as a common concern among health care providers (Kay et al., 2010). According to the same research study, "the lack of concordance with health beliefs and difficulties with communication can complicate the presentation and management

of their illness” (Kay et al., 2010, p101).

Local Context

County Level Systems

Issues within King County, WA are similar to those seen nationally. Historically, policy related to refugee health care has been focused on prevention of the spread of communicable diseases. Few resources are available to address challenges during the acculturation process, for the delivery of preventative care, or the promotion of continuity of care. No resources are available in King County to monitor or track the health of refugees over time. This lack of data limits the potential for targeted health interventions to improve the quality of health care for this population. As one author, points out, “once screened for tuberculosis, hepatitis B, several other communicable diseases, and childhood immunizations, many refugees ceases to exist from the perspective of the healthcare system” (Kemp, 1993, p. 22).

In King County, nearly all refugees who enter through refugee resettlement programs visit Public Health- Seattle & King County (PH-S&KC) for the Public Health Department's Refugee Screening Clinic. This clinic provides vaccinations and assesses titers for hepatitis B, as well as screening for TB, hepatitis B, and HIV (patients have the option to refuse HIV screening). The nurse at the Refugee Screening Clinic also completes a comprehensive family health history. Immunizations that are provided are then entered into the Washington State Immunization Information System (previously Child Profile). The results from the screening are mailed to the patient. A photocopy of the health history is handed to the patient and they are requested to bring it to their first visit with their PCP. Some patients have not yet been assigned a provider at the time that this screening takes place, others have already made one or more visits to their PCP.

Clinic Level Systems

The clinic level, rather than the individual level, provides a critical context to assess and

implement strategies to the challenges faced by refugee patient populations. It is feasible to address some of these issues at a clinic level by taking into account the built environment, the clinic structure, and clinic culture.

Research has indicated that the environments influences patient's health, well-being, and recovery from illness. One study showed that everything from the location of the building, to the space and artwork in the waiting area can influence the anxiety or comfort level of the patient (Rice et al., 2008). Being purposeful in the structure of clinic designs and health care environment can have a positive impact on health outcomes (Douglas & Douglas, 2005). While it may not always be practical or possible to alter the clinical environment, it is worth recognizing the features that contribute to the ease and accessibility of patients. Moreover, it is useful for health practitioners to note that the elements which are comforting to them, may be interpreted differently by those accustomed to other styles. Similarly, the culture within a clinic may be one that is comfortable for the providers but interpreted in different ways for the patients. Kleinman notes that the biomedical model itself is "freighted with Western cultural assumptions and saturated with a particular theoretical and value orientation, but that it has no means for taking into account patient and lay perspectives on a given sickness episode, to say nothing of alternative therapeutic formulations held by other healing systems" (Kleinman, 1980, p. 18).

Some other examples of clinic structure and culture, that may have various interpretations, include appointment making, waiting room expectations, provider-patient interactions, reimbursement policy, and time. Some components of the provider-patient interaction that are influenced by the physical surroundings of the clinic: waiting room space and exam room space. Daily routines and interactions might be influenced by cultural background and physical space. In the context of the provider-patient interaction, the provider holds the power and therefore directs the nature of the interaction on one level. The economic power is often controlled by clinic administration or by the insurance company and can influence several aspects of the interaction, such as time allocation, treatment options or modalities, and potential for further testing by

specialists.

The culturally influenced expectations of the provider may not be consistent with the culturally influenced understanding and expectations of the patient. For example, cultural constructs of time vary. Some people observe routines based on time delineated by hours and minutes, while others may organize activities around sunlight, meals, or other natural patterns. As one author points out, "in capital based cultures, time is understood as a unit of economic value, a resource to be managed, manipulated or controlled by organizational systems to maximize achievement or objectives" (Fox, 1999, p.73). Fox goes on to explain that time is often viewed as a resource to be managed, manipulated, or controlled by a reimbursement system. "In order to be efficient in a capitalistic economy, time is appropriated by its commodification as work; time becomes equated with money" (Fox, 1999, p.75). This understanding of time is based on a set of cultural values and expectations which may not be shared by all. The adaptable structure and culture at the clinic level in primary care settings, provides an opportune environment to identify and address the needs, expectations, and challenges posed by newly resettled refugees.

Individual Provider Level

PCPs (physicians, nurse practitioners, and physician assistants) hold unique potential. Although some research shows that due to cost containment and preventative care methods used by managed care, "the private provider networks have not shown that they have the capacity, infrastructure, or quality assurance mechanisms to assure access to needed services for disadvantaged populations" (Mathis et al., 2012, p.10). While infrastructure, quality assurance, and capacity or economic viability may be challenges, there are strategies that may be implemented to mitigate some of them. Primary care may be the perfect setting for refugee health needs to be recognized and the health of refugee patients to be optimized.

Research Based Strategies

Successful models for addressing the primary care health needs for patients who are refugees and immigrants include the modification of clinic structures. Examples of clinic structure adaptation include:

- A variety of specialists & multi-disciplinary staff under one roof (i.e. adult, pediatric, maternal, and child health providers, nursing, behavior or mental health specialists, and social services)
- Providers with expertise in cross-cultural health care
- Availability of professional medical interpreters
- Bilingual and bicultural staff

(Gozdziak & Bump, 2008)

Other strategies used to improve the quality of care for these patients, and particularly for initial screenings of refugees, can be observed in several clinics across the U.S. who specialize in this area. For example, the A.F. Williams Family Medicine Center is a family medicine residency facility, supported by the University of Colorado & Colorado Refugee Service Program. This clinic faced many of the same barriers prevalent in the literature regarding care for refugee patients including; limited availability of interpreters, a patient's need to visit multiple facilities on multiple occasions without easy access to transportation, and a lack of adequate mental health screening. Barriers specific for Providers included; limited experience training or working with interpreters, lack of cultural knowledge and competence, lack of understanding about the circumstances from which particular refugee groups come, lack of recent experience or training in medical recognition of after-effects of torture, identification of mental distress or PTSD, and overall inadequate clinic time to address the needs of refugees in the course of typical medical practice because working with interpreters requires more time than standard medical visits (Kennedy et al., 1999). In response to these challenges, the A.F. Williams Family Medicine Center established a practice integrating the following components:

1. Utilization of a multidisciplinary team consisting of VOLAG staff, interpreters, a Medical Director, administrative coordinator, health screening coordinator, a medical assistant, follow-up and referral nurse, and a psychologist.
2. Development of a structured comprehensive screening process. This process is initiated when a caseworker from the VOLAG notifies the clinic of new refugee arrivals who are seen at the practice during dedicated blocks in order to maximize the use and cost of interpreters. Standard screening includes a review of overseas health history, screening tests, and follow-up occurring at a second visit.
3. Comprehensive health assessments, including mental health screening, for all refugees rather than case-by-case.
4. Creation of a data collection system to track health conditions and trends among refugees resettled in Colorado to provide the basis for evidence-based improvement of resettlement programs.
5. Adequate training and resources to enhance cultural competency among providers.
6. Ensuring a comprehensive and effective system of referral and follow-up for refugees for all specialists, particularly tracking follow-up care for TB, hepatitis B, parasites, mental health conditions, and dental needs.
7. Providing trained, professional, experienced medical interpreters.

(Kennedy et al., 1999)

Generally, in the U.S., health outcomes are not tracked based on PCP or location. Despite the lack of health outcome data, other measures have shown some of these clinic level changes to be successful. One study looked at the effects of open access scheduling or same day visits without prior appointment in a clinic with a residency training program. The results of this research showed that open scheduling was beneficial to overall clinic revenue, improved employee morale, and decrease in nursing work over the telephone. Finally results suggest that continuity and patient

satisfaction is improved (Kennedy & Hsu, 2003).

Other examples of clinics which have altered their structure to address the specific issues related to treating refugee patients include the Center for International Health in St. Paul Minnesota and the North Hamilton Community Health Center (NHCHC) in Ontario, Canada. The Center for International Health in Minnesota began identifying and addressing issues with immigrant and refugee health from its founding in 1980. This center has become so successful that a book was written about its growth and evolution. This book highlights some Provider's questions which arose among at the inception of this clinic including, "I've got some people with TB. How can I get them to take their medicine?" and "Should an annual physical exam for a Vietnamese patient be different from the one we give our American patient?" (Young, 2008, p.135) In response to these and other questions like them, the center's practices and policies were developed. The clinic attempted to address concerns and issues common among health care Providers.

The clinic identified and addressed many issues using similar strategies as did other clinics with refugee and immigrant populations, including the use of professional interpreters, or staff hired by the facility from similar cultural, ethnic, or linguistic groups as the patients seen there. "If American doctors do not speak the language of their immigrant patient, they must make use of professional interpreters. If they don't know a patient's culture, they must learn it. And American doctors must be aware of and be able to recognize the diseases that their patients from other lands are likely to have, whether they're immigrants or long-term visitors" (Pat Walker, in Young, 2008, p. 136).

Culturally competent employees are a key component of the success at the clinic in Minnesota, "these doctors recognize the power of cultural beliefs, respect their patients' need to honor centuries of traditions, and remain flexible in bending the conventional model of Western medicine to work more successfully with their patients in treating their ills" (Young, 2008, p. 182). They value research and training and set up a residency program to specifically address issues in medicine that relate to immigrants and refugees. They also published information for the general

health-care workforce called, *Health in any Language*. Among the examples provided, the research and education component are unique to this clinic.

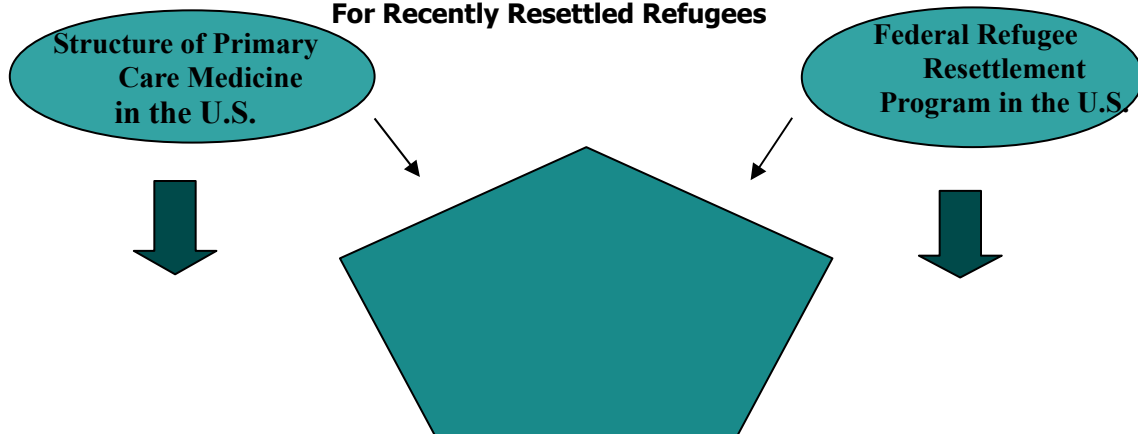
The NHCHC in Ontario hires multilingual staff, “a practice that has provided links to a variety of cultural communities” (Fowler, 1998, p.390). Once again, a multidisciplinary team including Medical doctors, OBGYNs, physiotherapists, nutritionists, social workers, and interpreters. Community health workers are a part of the multidisciplinary team, they help patients “negotiate the complex social, health, and immigration systems . . . including immigration process, social assistance, health insurance, drug benefits, tenancy issues, and worker's compensation claims . . . health coverage, and immigration systems” (Fowler, 1998, p.390). A referral system is in place for people with mental health issues and victims of torture. Organized support groups were organized with some clinic resources. Finally community health surveys help collect data to better understand population served by this clinic (Fowler, 1998).

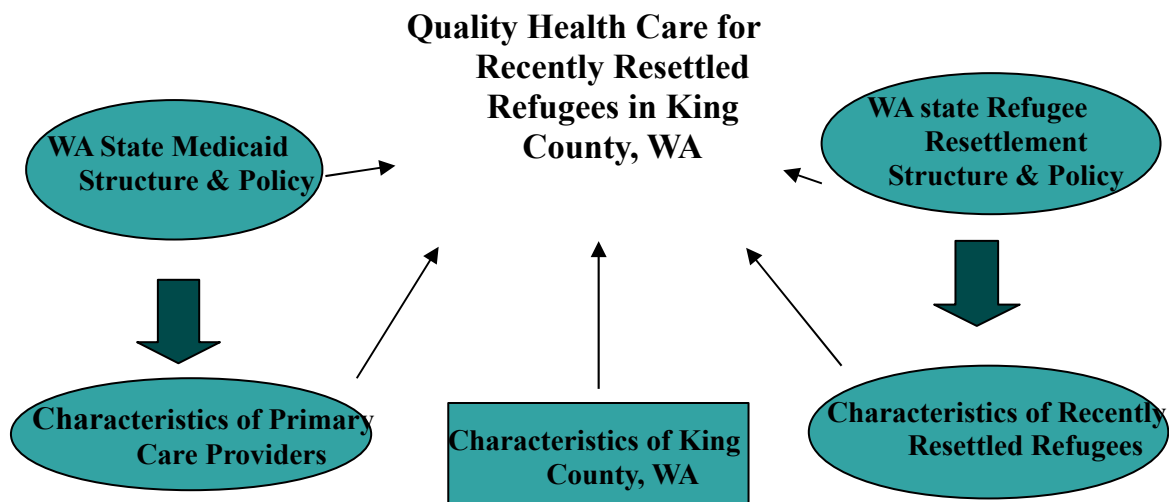
Addressing the challenges and barriers to providing quality health care for recently resettled refugees can be done at the clinic, rather than individual level. While individual providers may be struggling with unique challenges, it is likely that some challenges may be shared among a group of providers. Furthermore, providers at one clinic location may be able to provide strategies that they use to address particular challenges. Therefore, despite the limited literature on the impact of system or policy level changes related to the quality of care for refugees and the lack of specific health outcomes for this population, the culture, structure, and policy at a clinic level suggest that it might be the most efficient place to examine and address these challenges.

Research Framework

Factors influencing Quality Health Care

For Recently Resettled Refugees





Summary of Research Objectives

Problem: Primary Care Providers, especially those in private practice, do not routinely receive extra training or resources to deal with a relatively high refugee population, in King County, WA, nor is there a strong method for communication among providers within the county. This puts them at a disadvantage for providing high quality health services and it has the potential to have a negative impact on the health and well-being of their patients. Detailed descriptions on how PCPs in King County are adapting to this unique population remains unknown.

Purpose: The purpose of this research was to help identify priority areas, related to clinical care for refugees, in need of more support, assess the desire for more information on this topic, identify common challenges and potential strategies to providing quality health care for recently resettled refugees in King County. A qualitative research study was conducted to address these issues including, semi-structured interviews and participant observation with PCPs.

Epistemology

Hermeneutics “uses lived experiences as a tool for better understanding the social, cultural, political, or historical context in which those experiences occur” (Polit & Beck, 2008, p.223). An interpretive phenomenological approach is the most appropriate epistemological orientation for approaching the research questions in this study. “The goals of interpretive phenomenological research are to enter another's world and to discover the practical wisdom, possibilities, and

understandings found there" (Polit & Beck, 2008, p.229). It is also important to recognize that researchers bring into their work, their own perspectives and paradigms (contrasting objectivity). I recognize the influences of the theoretical perspectives that have been a part of my own life, particularly by the fields of sociology, nursing, anthropology, and the influence of feminism, critical social and race theory, and postmodern constructivism. "As researchers move along in the analysis, it is their knowledge and experience (professional, gender, cultural, etc.) that enables them to respond to what is in the data" (Corbin & Strauss, 2008, p. 33). I also recognized my position as a white, U.S. citizen, middle class, female, graduate student at a large, public university, a native English speaker, and a nurse, to name a few, have all influenced my approach to the research. A lack of critical self-reflection endangers me, as a researcher, to reify existing power structures, despite the use of a community participation methodology.

Many theorists describe subjectivity of data collection and analysis as a virtue rather than a form of bias. According to Fox, "diverse methodological approaches can be seen as nomadic wanderings, meandering towards, around and away from 'truth', but still offering up 'truths' which can evoke, deterritorialize and transgress when taken as a part of a reflexive and engaged project. Thus, the idea that one must become a master of data, information, or results, before acting is rejected" (1999, p.132). As I engaged in this research, I acknowledged that I was physically a part of it, metaphorically a nomad within it, continuously seeking closer and more profound engagement and understanding. I also embraced the concept implicit in this research and, as described by Fox, I continuously sought awareness of the way my own paradigm shaped my research design recognizing the impossibility of discovering one ultimate truth. I acknowledged my responsibility to be open to many new possibilities along the way (Fox, 1999). Corbin and Strauss explained, "it means being able to present the view of participants and taking the role of the other through immersion in data" (2008, p.32). My positionality affords me the privilege to immerse myself in data gathered from a privileged audience whom I have access to: PCPs. It is my belief that I have a responsibility to promote social justice and equity through awareness of our position in relation to

refugees, a vulnerable and marginalized population.

While the voice of the refugee is a necessary part of this research, it is also important to recognize that, "voice is always in tension with tokenism. Tokenism occurs when minority individuals are included merely to present an illusion of equity. Whereas voice privileges marginalized perspectives in order to elucidate power relations, tokenism prefers the nominal presence of minorities to any substantive challenge to the status quo" (Ford & Airhihenbuwa, 2010, p. 1396). At the risk of imposing my own positionality on their lived experiences, and consistent with PAR ethics, I approached and conducted this research in a way that aimed to avoid exploitation of individual refugees and decrease the risk of generalizing, stereotyping, or oversimplifying issues. "Our task [as academic intellectuals] has become to extend beyond our legacy of "ventriloquism", or speaking for community members, to work in union with others to create multiple spaces (such as meetings and publications) in which the lived experience of our partners can be heard and validated" (Wallerstein et al., 2005, p.36). I am not an objective, disembodied researcher. This project was developed in order to advocate for improved health care and health equity for refugees. I sought to increase awareness and create spaces where PCPs may begin to recognize their own positions within the health care system and to recognize the voices and the unique experiences and perspectives of refugees whom they will encounter in the future.

Methodology

Participatory Action Research is a style of research in which a reciprocal relationship between research data and community change can be used to reduce health disparities and promote social justice. The aim is to create opportunities for participants to work jointly on the design and implementation of the change project. This can reduce barriers, increase ownership, and thus improve adherence. This type of research implies a greater degree of participation from the

community at each stage of the research process, from the design of the project, to the design and implementation of interventions or strategies, as well as the process of dissemination of research results and evaluation of interventions. According to Stringer, "action research is a systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives. Unlike traditional experimental or scientific research that looks for generalizable explanations that might be applied to all contexts, action research focuses on specific situations and localized solutions" (2007, p.1). Engaging in the formation of the project collaboratively with PCPs has helped to ensure that it is relevant, valid, appropriate, and acceptable to those who are most likely to be impacted by the results.

Using an action research framework, this research was designed to use cultural protocols and procedures acceptable within the biomedical and outpatient clinic culture, engage participants in mutual learning, and ensure that the research design itself was informed by PCPs actively engaged in these issues. Interviews were conducted in as many clinics as possible that provide care for refugees. In accordance with qualitative research expectations, sample size is adequate when saturation of themes among responses was achieved. Visiting multiple sites provided an opportunity to engage PCPs in conversations about refugee care among groups of their own colleagues. This stimulated awareness about refugee issues as well as an opportunity to discuss common challenges and strategies. The PCPs were involved in the development of the research design itself. In an initial informational interview, one provider recommended focus groups rather than individual level interviews, another proposed including participant observation in order to gain a deeper understanding of the existing challenges. Therefore, consistent with the fundamental principles of PAR, the research process itself contributes toward a solution to some of the issues. According to Yolanda Wadsworth a contributor to the on-line journal, Action Research International, a very comprehensive definition of PAR is as follows:

Essentially Participatory Action Research (PAR) is research which involves all relevant parties in actively examining together current action (which they experience as

problematic) in order to change and improve it. They do this by critically reflecting on the historical, political, cultural, economic, geographic and other contexts which make sense of it. ... Participatory action research is not just research which we hope will be followed by action. It is action which is researched, changed and re-researched, within the research process by participants. Nor is it simply an exotic variant of consultation. Instead, it aims to be active co-research, by and for those to be helped. Nor can it be used by one group of people to get another group of people to do what is thought best for them - whether that is to implement a central policy or an organizational or service change. Instead it tries to be a genuinely democratic or non-coercive process whereby those to be helped, determine the purposes and outcomes of their own inquiry. (Wadsworth, 1998, p.10)

For this research the initial step involved preliminary conversations with many members of the community. I engaged in a process of community-driven identification of the issues relating to refugee resettlement. In alignment with the objectives for my Public Health Practicum experience, completed in my second year of graduate school at the University of Washington, I was able to learn about many problems and issues faced by refugees and refugee communities in King County. I spent time with many individuals and families, developed trust, and engaged in dialogue. Through informal conversations, storytelling, and practicum activities with refugees and local social service providers, assets and problems were mapped out. Using this community based pre-assessment method is a feature of Community Based Participatory Research (CBPR), one type of PAR. "A fundamental premise of community-based action research is that it commences with an intersect in the problems of a group, a community, or an organization" (Stringer, 2007, p. 10).

My Public Health Practicum led to a series of pre-assessment, data gathering interviews which were conducted prior to formalizing the design of this research project. Information gathered during this time helped to define the goals of the research while raising awareness of shared resources and challenges among members from different sectors within the community. This defines some principles of CBPR, "starting where the people are, emphasizing and building on community

strengths and assets, and using the power of dialogue -as they help inform community, rather than researcher-driven identification of community assets and selection of issues” (Minkler & Wallerstein, 2003, p. 138). Some notable challenges to CBPR models include, difficulty ensuring immediate benefits to the community and the discoordination between the timeline of the researcher and the richness of participation (Kieffer et al., 2005, p. 162).

Once a research focus and questions were defined using this collaborative process, an application was submitted to the Institutional Review Board at the University of Washington to conduct a qualitative research study. Although I attempted to examine the issues around refugee resettlement from as many perspectives as possible, the formal qualitative data was collected exclusively from Primary Care Providers in King County.

The refugee voice is represented without engaging in formal interviews with this vulnerable group. Instead, refugees can be heard through poems and dialogue from case studies, written or expressed by refugees themselves. Many of the same sentiments that I heard from refugees in King County, during my practicum experience, are expressed beautifully in these previously published documents. This method acknowledges the voice of the refugee without objectifying or exploiting any individuals with whom I developed trust. Ideally, a comprehensive PAR study would collaborate directly with individuals from within the refugee community to develop, conduct, and analyze the research. However, an ethical question arises when the timeline of the researcher does not fully allow the voice and understanding of community members to manifest (Kieffer et al., 2005, p. 162). Additionally, it avoids the risk that one or two token stories become generalized or lead to stereotypes about a particular ethnic group or about refugees overall. Finally, there is potential harm to the participants when an interviewer, coming from a position of power, conducts formal research with a vulnerable group. “Conducting research in refugee communities is fraught with both methodological and ethical challenges . . . ethical issues in refugee mental health research are particularly important to consider given the potential vulnerability of this population” (Ellis et al. 2007, p.460- 461). This is particularly the case when the benefits of the research will likely not

improve conditions immediately. More importantly for this research is the process of engaging multiple parties in the development of the research itself, thereby raising awareness of issues surrounding the quality of health care for refugees, and advocating for individual PCPs to actively seek the unique voice of each refugee patient whom they encounter. For this reason, qualitative semi-structured interviews and participant observation techniques, within a PAR framework, were limited to PCPs in clinics known to treat refugee patients.

Study design

Design: Descriptive

This research used a descriptive study design due to its flexibility and ability to be responsive. A descriptive study design was selected due to its high degree of representativeness and the ease with which a researcher might obtain the participants' opinion (Polit & Beck, 2004, p. 50). This design is most appropriate when little is known about the topic and the scope of the problem is desired. It allows for greater exploration of the research topic.

Sampling Method: Stratified Purposeful

A stratified purposeful sampling method was used to conduct this research. Inclusion criteria for this research was defined as: individuals who are Primary Care Providers, Nurse Practitioners, and Physician Assistants, working in primary care offices in south-central King County, working in a practice where medicaid is accepted.

A purposive subset of these target subjects (listed above) was identified through key stakeholder interviews with caseworkers in each of the voluntary refugee resettlement agencies (VOLAGS) in King County. They were asked to identify clinics and/or providers in private practice or public clinics where recently resettled refugees are routinely referred or are known to often seek care. Three separate groups were outlined; those working in private practice, those working in a Federally Qualified Health Center (FQHC), and those working at a clinic affiliated with a University and residency program. This sampling strategy was utilized because it helped to facilitate

comparisons between and among subgroups. This strategy was also optimal to address the research question in this study because it targeted clinical settings where patients who are refugees are known to frequently seek care. Thus the targets were clinic sites most likely encounter refugees.

The unit of analysis selected for this research was the clinic level. It is assumed that many providers receive information about process and flow from the clinic in which they work. While some barriers and strategies to caring for refugees may be individual and others may be related to state or national policies, the main focus will be on those at the clinic level. It is at the clinic level where there is the greatest potential and it is most realistic for change and improvement to occur through modification of clinical standards, policies, and procedures.

Recruitment strategies & enrollment

Interview/Participant Observation Recruitment: As the Primary Investigator (PI), I emailed clinic directors and/or clinic administrators to request volunteers for interviews or participant observation. I made visits to clinical locations to determine which sites were interested in participating.

Limitations to this strategy: There are a variety of reasons that PCPs or clinical directors may opt not to participate that are unrelated to the research topic, such as time or logistics.

Interview/ Participant Observation Consent: The risks and benefits of the research process was explained in-person with each participant prior to data collection. Written consent was obtained prior to the interviews and participant observation.

Ethical considerations while working with human subjects: Approval for this project was obtained from the Institutional Review Board at the University of Washington prior to the initiation of data collection from focus groups and participant observation.

Qualitative Data Collection

Overview of Activities			
Method	Site/ Participant Role	No. of Interviews	No. of Participants
Pre-Assessment Data Gathering	Primary Care, Providers	8	8
	Primary Care, Office Managers	3	3

	Primary Care, Metal Health/ Behavioral Health Specialists	2	2
	Lutheran Community Services Northwest, Social workers	2	2
	Public Health, Seattle & King County, Refugee Screening Clinic, Nurses	2	2
	King County Tuberculosis Program, medical staff	1	2
	Refugee Woman's Alliance, staff	1	1
	Asian Counseling and Referral Center, staff	1	2
	Neighborhood House, staff	1	1
	Hopelink, staff	1	1
	Ethnomed, staff	1	1
	Washington State Health Care Authority, Medicaid, staff	1	1
	Washington State Department of Health Communicable Disease, Epidemiologists	1	2
Key Informant Interviews	Lutheran Community Services Northwest VOLAG, caseworkers	1	4
	Jewish Family Services -VOLAG, caseworkers	1	4
	Catholic Community Services -VOLAG, caseworker	1	1
	World Relief -VOLAG, caseworkers	1	5
	International Rescue Committee -VOLAG, caseworkers	1	4
Semi-structured interviews	Private Practice, PCPs	3	7
	Federally Qualified Health Center, PCPs	4	24
	University affiliated, residency based program, PCPs	2	11
Participant Observation	Private Practice, PCPs	1	2

Pre-Assessment Data Gathering

The preliminary information gathering process took place over a two year period. The extended process provided for enough time to encourage engagement by the resettlement community. Some were involved in informal interviews which helped to inform the research methods

and study design, and identify appropriate participants for the formal research project. PCPs were also included in preliminary interviews to identify relevant issues and constraints. Most of the data gathering and pre-assessment interviews took place in person with caseworkers from each refugee resettlement organization in King County, nurses from the Public Health Department's Refugee Screening Clinic, medical staff from the King County Tuberculosis program, Mental health/ behavioral health specialists working in Primary Care, Primary Care office managers, individuals from local NGOs interested or working on issues having to do with refugees and refugee resettlement, state refugee health coordinators, epidemiologists, and CDC quarantine officers. Several other interviews took place on the telephone, with staff from: Hopelink, Ethnomed, and Washington Medicaid. Some of the individuals interviewed were native born U.S. Citizens. Others had lived experiences as refugees, including resettlement into U.S., themselves. Others still had experienced relocating to the U.S. as immigrants. These interviews are one way that many voices from the diverse local community are represented in this research.

Engaging in this data gathering process was an important preliminary task in order to “determine the formal structure of relevant organizations . . . [to] identify and communicate with people in positions of influence and authority and gain their permission to work there . . . [and to] locate informal patterns of influence to ensure that all significant people -sometimes called opinion leaders or gatekeepers- are included in the early stages of the research process” (Stringer, 2007, p.45). It is also important to understand the nature of the research problem from as many perspectives as possible, and to begin to learn about perspectives, emotions, fears, etc. from as many parties, inside and outside the immediate scope of the study, as possible. Finally, it is valuable to learn about research that overlaps or conflicts with the research being proposed (Stringer, 2007).

Key Informant Interviews

Key informant interviews were informal and took place during the development of the research design. Caseworkers from each of the five VOLAGs were interviewed. As with the social service actors the backgrounds of the caseworkers is diverse and includes people who were

displaced, claimed refugee status, and resettled in the U.S. The interviews took place at the VOLAG office sites. The purpose of these interviews was to learn more about the process of resettlement and the interaction that takes place between VOLAGs and PCPs. Since the caseworkers play an active role in helping newly arrived refugees navigate paperwork to obtain a medical coupon, identify a PCP and navigate transportation for their initial visit, these interviews were used to determine the location where most refugees sought care.

Focus Group/ Semi-structured interviews

A stratified purposeful group of providers were identified to participate in the focused, semi-structured interview. Following approval from the IRB at the University of Washington, the office managers at selected clinics were contacted via email and/or on the telephone. All but one clinic contacted agreed to participate. In the case of the clinic who refused, the office manager made the decision without input from PCPs working there.

Group as well as individual interviews took place at the remaining clinic sites. This strategy provided an opportunity for participants to describe issues on their own terms. A total of 7 PCPs were interviewed over three separate interviews from a Private practice setting, 24 PCPs were interviewed over four separate interviews from Federally Qualified Health Centers, and 11 PCPs were interviewed from two separate University affiliated residency based programs. In total 42 PCPs were interviewed for this research study. The backgrounds of the PCPs in this study reflected the diversity of the area in which they practice. Some PCPs interviewed entered the U.S. as refugees or immigrants themselves. Group interviews all took place within the clinic where the PCPs worked. The collective nature of the interviews was especially beneficial because the group dynamic provided a context in which ideas were discussed and shared. This technique allowed for the examination of individual thoughts as well as group interactions within the clinical setting. Using the PAR method means that the researcher should devote "particular attention to facilitating the open interaction of this group, building shared understandings, unity and solidarity with these key

collaborators in the research project” (Genat, 2009, p. 107). The drawback of group interviews is that some participants may have been hesitant or unwilling to voice their thoughts without the protection of confidentiality. Semi-structured interviews and focus groups have been established as an effective way to gather data from this population. In a separate study, semi-structured interviews and focus groups were conducted to assess the experiences of PCPs caring for refugee patients (Twohig et al. 2000). Questions and probes, based on existing literature, were used to facilitate conversation during semi-structured interviews.

Respondents were interviewed individually in some cases, especially in smaller, private practice locations. In other settings, such as a larger clinic, respondents were interviewed in groups whenever possible. The benefits of group interviews were that they provided a setting in which ideas were bounced off each other, promoting synergy. Research has shown that a group interview or a focus group can function as “an incubator of local knowledge and discourse, it also functions as a vehicle for building solidarity and community” (Genat, 2009, p. 207). Challenges to group interviews included difficulties moderating the group and hesitancy among participants with sharing information among their peers. Overall, it allowed for the examination of individual as well as clinic level challenges and solutions. Discussions were audio recorded and then later transcribed using the qualitative analysis software Text Analysis Markup System (TAMS).

Respondents were interviewed in their own clinic setting. This strategy was selected for several reasons. It helped to promote a higher level of comfort and encouraged participants to share their thoughts openly. Although it is possible that some may have felt reluctant to share their concerns or thoughts openly in a work environment, in this case the issues being discussed relate directly to the clinic setting and the daily work load and flow of patients seen within that setting. Finally, conducting interviews at the clinic sites was valuable because it was convenient for busy providers, who may not otherwise have time to engage in this research.

Participant Observation

Participant observation is a method of data collection that involves observation from within. It means that the research attempts to get close to her subjects, making them feel comfortable enough that they are able to behave as they would were they not observed. "Unlike passive observation where there is minimum interaction between the researcher and the object of study, participant observation means establishing rapport and learning to act so that people go about their business as usual when you show up" (Bernard & Ryan, 2010, p. 41). Traditionally, participant observation involves observation and interaction with participants for weeks, months, or years. In this case, the researcher prepared by reading medical anthropology literature and building rapport during the initial hours of the day using a participatory rapid assessment technique.

The participant observation for this research took place with two individual PCPs in a single clinical setting; however direct patient interaction was avoided. Observation of providers occurred in their natural context where descriptions of behavior and actions were written by the PI(MS). No video or audio data were obtained for this portion of the research. No patient records, reports, or identification information were obtained. In addition to natural observation, the researcher used a list of questions and probes that were developed a priori for focused data collection. The benefits to including participant observation in this study include the ability to observe challenges and strategies to providing care that have become so ingrained that providers forget to mention them during interviews. Another benefit of participant observation is described by Bernard, "it produces the kind of experiential knowledge that lets you talk convincingly, from the gut, about what it feels like to plant a garden in the high Andes or dance all night in a street rave in Seattle" (2006, p. 242). This 'experiential knowledge' is a result of the relationship between the researcher, the participant and the context in which they are being observed, their clinic. It can result in an increased understanding and potentially increased empathy for the role that context plays on the views and values expressed by the participants.

Disadvantages to participant observation stem from the same phenomenon; i.e. the relationship that is established between the researcher and the participant are likely to bias the

results of the research. Furthermore, the situation can be ethically challenging for the researcher. In some cases they may be unable or unwilling to comment or take action if unethical behavior is witnessed (Bernard & Ryan, 2010, p. 42).

Cultural considerations for qualitative research including both interviews and participant observation include an understanding of the variety of primary care settings and expectations of PCPs and clinic staff working in those settings. For example, providers are accustomed to meetings and in-services, that include snacks or meals, during their lunch break. Research was conducted in alignment with these norms.

Data Management

Data collected from interviews was transcribed by the PI (MS), into the qualitative research analysis program TAMS (Weinstein, 2006). The audio recordings were transcribed verbatim into the program. In cases of participant observation notes were entered into TAMS for analysis. Utilizing multiple methods for data collection provided a more complex and rich data set. However, it is recognized that participant observation is affected by the subjectivity of the observer. Open coding methods were used for content analysis. Initial codes were derived from the literature review including; Communication, Interpreter issues, PCP knowledge gaps, Patient health knowledge gaps, Patient system knowledge gaps, Obtaining health history, Access/ insurance, challenges making referrals/ finding specialists. Other codes emerged from the data, such as; Ability to identify refugees, Non-Primary Care issues ie. transportation, appointments, request for time consuming paperwork or supplies, Perceived patient misuse or abuse of systems, Frequent follow up, Time, Trust, Cracks in the system, benefits to caring for refugees. Using a metacoding technique allowed for the examination of new themes as well as categories and relationships within some of the *a priori* themes. For example, the code for Communication was eventually subdivided into communication issues based on cultural differences or differences in meaning, and communication issues based on linguistic differences alone. Patient knowledge gaps were also subdivided based on

particular recurring stories ie. Patients who inappropriately call 911, patients who are not aware about how to use a pharmacy, patients who need detailed instructions to take Tylenol. Interesting relationships were noted between PCPs who reported using interpreters routinely and the ability of the PCP to identify the patient as having refugee status and being recently resettled.

Quotes were selected from the data which reflected a common theme and reported in the findings. This project was designed to use the clinic as the unit of analysis, in order to compare and contrast PCPs awareness of refugees as well as perceived challenges between clinic structures rather than between PCPs. I was surprised to find a greater degree of diversity between PCPs from within the same clinic site. For example, one PCP at a private practice is aware that refugees are seen at the clinic and routinely uses an interpreter while another PCP at the same clinic is unaware that refugees are seen there. Due to the study design, differences at the individual level were not analyzed, though that may be a consideration for future research. Because of the differences between PCPs on an individual level, it became challenging to draw conclusions about the relationships between some of the challenges and the clinic structure.

Expected Outcomes

The results of this study were expected to provide information on perceptions of PCPs' common challenges and potential solutions for providing care, referrals, and other resources for refugee patients. The results of this study and the rehearsal process itself should help to promote the application of strategies to help improve the quality of care provided for recently resettled refugees. Additionally, it should provide an assessment of the need and interest to collaborate and to receive further information related to refugee health issues and barriers to care. The collaborative research process should raise awareness about issues related to refugees and health care in King County, and provide opportunities for the voices of PCPs to be heard and reflected upon. Finally, this research has the potential to influence policy and to improve communication between the public health

department and primary care offices and could even influence state wide refugee health care policies.

Findings

Introduction

The literature review in this paper reflects some of the challenges faced by PCPs who care for refugees in their offices and clinics. Findings from this study, discussed below, corroborate findings from previous research. In addition to similarities in the issues and struggles faced by PCPs, findings from this study concerning the strategies used by PCPs were also found to be similar to strategies identified in the literature. Major challenges such as access to adequate care and reimbursement issues are aspects of the macro level health care system in the U.S. Therefore, addressing these topics would be most effective at the state and federal levels. The other findings from this research, delineated below, focus on issues which might be addressed on a county or clinic level and may therefore be most practical for implementation within the existing health care structure.

Identification of patients as refugees

An interesting finding from the interviews conducted during this research, was that most of those interviewed were unaware that they were treating patients with refugee status or, were unable to identify their patients as refugees who have recently resettled in King county. This affected research findings because it was unclear whether participants were discussing challenges specific to recently resettled refugees. Additionally, strategies that were articulated were not specific for this population within their practice. When asked how a provider recognized a patient as a refugee, the results varied. Most commonly, providers described learning that patients were recently resettled refugees by asking directly, as a part of their health and social history, during the initial exam. Other

providers explained that having a relationship with the resettlement caseworker was an effective way to determine the patient's resettlement status. Since caseworkers are connected with refugees from 3 months to 1 year following resettlement, all formally resettled refugees have a caseworker working with them. In fact, PCPs who described having a relationship with a resettlement caseworker were better able to identify patients as refugees and seemed to have greater knowledge regarding the health and social circumstances of the refugee populations they cared for.

Many providers were not able to identify patients as refugees, nor those who had recently arrived. When asked how refugees were identified, one provider described a common sentiment, "I am fairly new here [at this clinic] I don't really ask, I just see the kids, and take care of them. I really don't know." Another provider echoed, "I don't think that I see patients who are refugees. I don't recognize refugee patients. I don't ask if patients are refugees, or what their legal status in the U.S. is." In some clinics, where legal status is not a criterion for enrollment, this question may never be asked. A different provider asked, "Doesn't Harborview [regional hospital] have a refugee clinic where all those kinds of people go?"

When the data was stratified by clinic type, it was noted that PCPs at residency programs were able to describe strategies they used to identify patients as recently resettled refugees. At the other two types of clinic sites, PCPs described challenges with identification of newly arrived refugees. In both private practices and FQHCs there were PCPs using strategies to identify these patients, while others were unaware of a patient's status as a refugee.

Among the few who were able to identify patients as refugees, even fewer felt they were consistently aware of those who had recently resettled in King County. The difficulty identifying individuals with refugee status is a distinct and notable challenge among the group of PCPs interviewed for this project. Challenges with the identification of this population not only affected the data collected for this research, but also influences the type of care, testing, and treatment offered to such patients. The issues of identification can be complex, dynamic, and may be as varied as the number of patients seen, but is also worth noting. Ultimately, improvements made at the clinic level

or at the larger system level should be concerned with both providers who are aware and those who are unaware that they see refugees in their clinic.

Challenges as described by PCPs

The PCPs interviewed described a variety of challenges they faced when seeing recently resettled refugees in their clinics and offices. During analysis the data from the interviews with PCPs was organized into the following categories: communication barriers, knowledge gaps, developing trust, frustration with non-medical activities, and access/ referral issues. Themes that were intertwined throughout each of the major categories included frustrations in obtaining adequate health histories, increased encounter times, and inadequate reimbursement.

1. Communication barriers

All of the providers interviewed cited communication as a major barrier when treating patients with refugee status. Several specific components of communication challenges described by PCPs are listed below.

1.a. Interpreter services

Interpreter services were routinely used for patient encounters when the provider and patient did not speak the same language. Increased encounter time when using a telephonic or in-person interpreter creates an accounting problem described by many of the PCPs. Clinic visits are reimbursed at a standard rate, interpreter services were not always covered. In fact, four of the providers interviewed explained that using an on-site or telephonic interpreter often meant accepting that the visit would be subsidized by the clinic because the reimbursement rate was below the cost of the time spent with the patient. The lack of a cost-effective method for interpretation was described most often as the reason for having a decreased use of interpreters.

1.b. Lack of interpretation

One provider described typical encounters with patients when there was not an interpreter present, "I ask people about their stress level, how are their relationships, how are things at home,

but most of the time they don't answer me back, they just say, 'everything is fine.' I have never seen them back." A correlation was observed between those who did not use interpreter services routinely in their practice and the ability to identify patients as refugees who had recently arrived in the U.S. These providers were also less likely to identify or address mental health concerns among non-english speaking patients. While some providers worked with patients despite the interpretation challenges, others said that when they did not have access to a particular language they preferred not to see patients at all, "it bothered us, we had to turn these people away because we had no way to communicate with them."

A second issue related to utilization of interpretation services is language availability. This stems from the fact that refugees emerge from many places in the world and therefore it is not uncommon for an under-represented linguistic groups to become displaced. When the first wave from any group is resettled there are often very few interpreters. This is particularly difficult for groups speaking a less common language. Often few interpreters are available who are certified in Washington state, a prerequisite for medicaid reimbursement. One provider explained, "Then sometimes when you call Hopelink for interpretation, they don't have that language! There are also some African subgroups, we don't have those [interpreters for a particular language]." Difficulty finding interpreters for a wide range of languages and ensuring that PCPs are adequately reimbursed by insurance for time spent using the services is a very common challenge described by PCPs in this study. In some cases PCPs describe using family members or neighbors to communicate health messages. This statement reflects the perception of one PCP who does not not routinely use interpreter services and was also not aware of patients seen who may be recently resettled refugees, "The only refugee that I can remember is one coming from Bhutan. Those are the ones who I think are refugees. The main problem I had with those is that they did not have any interpreter, so it was difficult to communicate with them. They brought a companion, but their english was also very limited." Difficulty using a family member or friend for interpretation during the clinic visit was a challenge described by some PCPs. Others expressed several reasons for not using telephonic or in-

person interpretation at all, "I don't use an interpreter. I can usually tell what people are trying to say by observing body language and gestures." Increased encounter time required when either type of interpreter was utilized was a more common rationale cited for not using an interpreter, "Using the phone is a nightmare, it is hard to hear, difficult to convey the message, and time consuming- understanding the dynamics of how to speak into the phone during a human encounter."

1.c. Culture & Meaning

Among those who routinely used interpreters, other types of communication challenges were described. A person's culture influences their understanding of the world and in this case their understanding of health and medicine. In this example, the provider describes the challenge with explaining medications and basic health information to patients from other cultures. "Talking through the interpreter phone as best as you can, trying to explain the system, but it takes three times as long as another patient would take, or if you could just talk to them. Because people who grew up here know how to, you know, know what tylenol is. When you have to explain, 'this is what tylenol is, it is used for fever, this is how much you can give to your kid, and you take this piece of paper to the pharmacist, you hand it to the pharmacist, they will give you medicine, make sure you talk to them.' And I don't know that they even have interpreter services at a pharmacy for them to explain a medication, but something like tylenol is dangerous for a little kid if you give them too much." It is not only time consuming to ensure that the words are translated but also that the meaning is conveyed correctly. Multiple PCPs interviewed mentioned the need to explain the way to use over-the-counter medications such as tylenol to prevent confusion that could lead to harm.

Communication challenges also related to cases where linguistic translation was possible but meanings and understanding of medical issues remained unclear. This resulted in an inability to understand health history, symptomology, recent lived experiences, expectations, and health/hygiene information. An example of this was shared by one provider with the following case:

Another obstacle is that we have people who come in with really serious medical problems and they don't have a very good history about it. Like I saw somebody, she's

young, 35 or 36, she has had a stroke, and the only clue I had was that, she is on 3 drugs, one is warfarin, and I'm like, so does she have an arrhythmia? The other two drugs, I don't even know what they are because they are in some other language, so I am googling it to see if I can find something similar. I can hear a heart murmur, and I know she has had a stroke, but I still don't know exactly what is going on. But, you know she doesn't know why she is on this medication and she did not bring in her medical records, if she had brought in her medical records it would really help.

People from different cultures and different parts of the world may have different understandings of health, health-care, and illness. One provider told the story of a patient who asked, "Why did you give me diabetes anyway?" The provider explained, "There is also a vastly different understanding of disease. We have very different lenses."

The recognition that there are a wide variety of health constructs was reinforced during a different interview, "Sometimes it is a matter of language, I think it is in Somali there is no word for knee. In other cases, patients skew what they think I want to hear so that they can get in to see the doctor. They will tell me one thing, they'll get in to see the doctor and it will be another thing. With others it is more of a cultural thing. Some people may be very sick and will wait until their appointment to be seen because they say, 'I'll just wait, I don't want to bother the doctor.' Others will not have much wrong at all and will push and push to be seen right away. This is different from our own culture." The meaning that is applied to words, symbols, gestures, and actions influences a person's understanding of the message. This is influenced by the culture from which a person comes. These interviews show that frustration arose when differences in meaning affected communication between providers and patients.

2. Knowledge gaps

2.a. What patients don't know

Knowledge of the U.S. health care system and how to use it is can be a challenge for immigrants and non-immigrants alike. It is not surprising that those who are entering the system for

the first time, coming from something that may be very different, might struggle as they learn the pathways and expectations. This learning curve can lead to frustration among health care providers as well. One PCP explained, "This might be the most challenging, understanding the health care system: It takes people a long time, some faster than others, to make sense of what's going on here. How the ER gets used, how Primary care gets used, how to make an appointment." This sentiment was shared among many of the PCPs in this study. Many described feeling frustrated with patients who needed to be told the same message repeatedly. Others described patients who did not follow through with specialists appointments or picking up or taking medication correctly.

In addition to being time consuming to work with patients unfamiliar with the system, it was also noted to be a challenge when patients were unfamiliar with routine screening or prevention modalities. Extra time in providing detailed explanations, or to learn about what the patients' perceptions are and how they influence their behavior, was also described as a frustration experienced by these PCPs.

2.b. What Providers don't know

There was a clear lack of information about the refugee resettlement process. As one provider explained, "Well it springs from the fact that you can not get very good interpreters. You can not get a good history. You rely on what little that they tell you, and then go from there. Most patients do not arrive with a formal history with them, except their PPD letter, or if they need some immunizations. I don't know why the health department can't just give those immunizations, I think they have them all there." This provider was unaware of the refugee health screening clinic at the Public Health Department and therefore did not request results from screening done at the health department, nor the immunizations posted on Child Profile (recently renamed: Washington State Immunization Information System).

Other providers mentioned that they enjoyed keeping up with local and international politics and news and despite their effort, were not always aware of the political, social, or historical events surrounding particular groups of refugees and displacement globally. Many were unaware of how to

access regular updates or news on new waves or refugees being resettled in the U.S. Although some providers were aware that refugee health information and guidelines were available on the CDC website, few accessed it regularly or at all.

3. Developing Trust

Some PCPs in this study explained that developing trust with patients was a critical part of their responsibility. In the case of some patients with refugee status, the influence of language, culture and knowledge gaps made it much more challenging and time consuming to develop a trusting relationship. Despite being a challenge, developing trust on both the individual and at the community level contributed to improved quality of care for refugee patients. One provider explained, "that is a frustrating thing, you knock yourself out to get the right medication to the right patient, and explain it clearly, then when they come back they tell you, 'my neighbor told me not to take this.' I get that all the time. You have to get the whole waiting room on the same page, the whole community has to buy in to what you are telling them, or you won't get anywhere."

The value of developing trust within the community was illustrated in this story, "I think that buy in happens on a community level. There is some individual buy in, but they talk about it when they go back to their churches and mosques. That is not static, it is fluid. I remember when there was a certain group who just disavowed the whole concept of diabetes. Individuals from that group now come in and ask, 'why haven't you checked me for diabetes?' Certain things do change. One thing we have done is figure out ways to reach out to the communities."

The issue of trust was also affirmed by the book written about the International Center for Health in Minnesota where it was noted that, "refugees seen at the Center for International Health have lost everything, their homes, their relatives, their neighbors, their culture, a way of life they understand. Their sense of loss is profound. When they see that their caregiver is respectful, compassionate, and not rushed or in a hurry, then they respond" (Young, 2008, p. 144). A physician highlighted in Young's book (2008) explained, "if you do not first establish the relationship, the trust, nothing will happen thereafter" (p. 145).

Both on an individual and community level developing trust is a critical part of care for any patient and can be particularly important when treating patients with refugee status who may have different concepts of medicine and medical care. The time and complexity involved in gaining and maintaining trust among individuals and entire communities was a challenge for these health care providers.

4. Non-medical activities

The majority of PCPs interviewed complained of feeling frustrated with increased encounter times due to non-medical requests. For example, patients asked for things outside the scope or expertise of the provider. Some patients were noted to make requests for things such as non-medical supplies ie. toothbrushes, toothpaste, pencils, paper, vehicles. Others described being asked for paperwork for housing, social security, or disability benefits. Many questions or concerns regarding immigration or the relocation of other family members. Some providers described these requests as time consuming and sometimes uncomfortable when the requests were presented in a way that might be urgent or unrelenting. While some PCPs felt that the requests were a result of patients who misunderstood the role of the clinic and physician, others felt that patients were attempting to take advantage of their insurance benefits or of the providers themselves.

Among non-medical requests or needs PCPs were often asked to address was transportation. One provider outlined this challenge, "so we have to do all of that social work involved as well. 'Why are they standing at the desk?' Well they are waiting for somebody to take them home. Okay, well we don't have anybody to take them home. And you know, they were picked up from the airport, so it is reasonable to think that they would be taken home. They were dropped off here, so they think they should be taken home." Many providers felt that it was challenging to address non-medical issues and transportation ranked high because, as noted in the example, some patients remained at the clinic until the transportation issue was sorted out. This challenge contributed to frustration among many PCPs. The overall problem may stem from the fact that this group is learning to adapt to many new systems at once. One PCP explained this:

They come, often they've been in a state of learned dependency for many many years, sometimes decades. Then they get off the plane to what they think is paradise. Then they have 8 months to learn the language, get a job, and compete with unemployed Americans, who may just have been laid off with a high school diploma. They have very few life-lines. They have whatever established communities are already here and they have us, and not much else. Their main agenda is navigating the social system and everyone will tell them, 'You need to go see your doctor and they will sort it out.' So we've become empowered, rightly or wrongly, to take care of their need for transportation, housing, food, employment, etc.

Addressing non-medical issues for refugee patients is time consuming and frustrating for PCPs who would prefer to focus on health and medical complaints.

5. Access to specialists

Primary Care Providers act as the gateway to healthcare. They have the responsibility of making initial contact with patients, recognizing serious conditions, and referring to specialists for specific intervention or treatment, and then overall coordination of care for each patient. There were two issues that were seen as challenges when providers talked about making referrals to specialists for their patients including limited access to specialists, and language barriers at referral sites.

5.a. Insurance

The first issue is limited access. This means that PCPs were unable to get patients in to see specialists. The primary reason for this according to the PCPs interviewed was a lack of specialists who accept medicaid. "If they do have a problem, and they need to see a specialist, no specialist accepts medicaid. Except for Harborview, so we send them to Harborview. At Harborview, they review all this and then send a letter that says, 'We can schedule your patient 4 months from now' or 'We are not able to see your patient at this time.'" Another PCP added, "I understand why many specialists won't, they aren't reimbursed from DSHS [Department of Social and Health Services]."

5.b. Language barriers

A second challenge with referrals is the issue of the language barrier. Some PCPs talked about patients who were unable to make appointments with specialists at all due to offices that

would not provide interpreters for non-english speaking patients. Others described specialists who saw patients in their office without the use of interpreters. "I had one the other day, a little girl she's got some congenital eye problem, and we referred her to a eye doctor and so when she came back in for another visit, I said, 'did you see the eye doctor' and first they said 'no' and I said, 'you didn't see anybody about her eye?' and she said, 'oh yeah, we had an appointment but we don't know what happened, they didn't say anything, there was no interpreter, so we have no idea what happened.' So then, I have to get involved, get the consult note and figure out what happened, they don't always have interpreters at other sites."

These challenges may be present for all uninsured, medicaid, or non-English speaking patients and may not be unique to refugees. It is still valuable to point out that providers described this as one of the major challenges that impacted the quality of care delivered to this population.

5.c. Mental health referrals

The identification of mental health issues is also a concern. While providers did not specifically express difficulties in identifying mental health issues, many stated that they rarely noticed or referred patients to see specialists for mental health. Several PCPs, like the one below described seeing very few refugee patients who complained of mental distress. "I ask people about their stress level, how are their relationships, how are things at home, but most of the time they don't answer me back, they just say, 'everything is fine.' I have never seen them back." This quote also reflects a relationship noted between those who don't routinely use interpreters and the ability to recognize mental distress.

The issue of language and type of insurance are even more prominent when providers discussed their ability to refer patients to be seen for mental health concerns. "Basically if you speak a rare language and you have a mental health issue, you are doomed," said one PCP. Many PCPs were unaware of mental health providers in the community willing to work with these patients. "Well, I see patients with post-traumatic stress, but when we send them to another psychiatrist for evaluation, I read the notes and it always says these people are malingering, they just want to get

disability. So sometimes the providers themselves might need a cultural sensitivity training and an understanding about how people respond. If you are a refugee and you are on medicaid, I mean, we can't even admit you to Fairfax [the inpatient mental health facility]!”

As a result of challenges referring patients to mental health specialists, PCPs described dealing with the increase in encounter time that was required to address mental health issues during routine clinic visits. One PCP stated, “We often find ourselves becoming the counselor ourselves, because of the language barrier, and because there are not services available.”

Major themes in challenges described by PCPs

During the course of this research several major themes were discovered. These themes were intertwined throughout many of the different challenges described by the PCPs. They reflect a synthesis of multiple challenges and reflect some of the underlying structural issues. The major themes include: frustrations with obtaining health history, increased encounter time, and inadequate reimbursement rates. These themes may also be some of the major factors that contribute to the quality of care delivered to refugee patients.

1. Difficulty obtaining adequate health history

Many providers described challenges in obtaining health history. This particular challenge emerged as a theme throughout the interviews. Some providers found it difficult to work around linguistic differences. Others found that differences in culture and meaning impeded their ability to gain an accurate history. Some providers felt that patients were not aware of the expectation that health history would be collected by PCPs, such as whether or not it would be kept confidential. PCPs also lacked some basic knowledge about factors and conditions that refugee groups were exposed to, particularly those that could influence their health status. Given the short time allocated for clinic visits, and the extra time required when seeing refugee patients, many providers felt that time was a major barrier in obtaining a complete history. Finally, some PCPs discussed challenges in obtaining even the most recent medical history relating to the resettlement process in King County.

Obtaining medical records from the screening done at the Refugee Health Screening Clinic at PH-S&KC was sometimes described as a challenge for some providers. "It is really important to know specifics from the testing done at public health. There was a patient with concern for possible active TB, I got the report from Public Health. It was really difficult. We are all computerized, why is this so difficult? Or someone will bring in a form that says they were tested for these things, but then the results aren't there. It is not as seamless as it should be."

Obtaining health history is an important issue for providers who are motivated to provide high quality health care for patients who are refugees. Strategies that address this issue will help to improve the quality of care and simultaneously address some of the frustrations experienced by PCPs.

2. Increased encounter time

Findings from this study confirmed those from previous research suggesting that increased encounter time is common among providers working with patients who are refugees. According to Crowley (2009, p.327), "Especially during the initial encounters with refugee families, Nurse Practitioners and other healthcare providers may need to devote a substantial amount of time in helping families meet their immediate needs."

Providers interviewed in this research shared similar concerns, "So much of this we can't do in the 15 minutes we are expected to do this if we hope to stay viable as a clinic, so we have to off-load some of the work that we would like to do in the clinic to other people, other places, and other times, to know it will get addressed eventually. This is why we build the systems that we have. This is what we do." Being forced into a 15 minute appointment, allocated by medicaid, for newly arrived refugee patients does not provide time to effectively use an interpreter, collect a complete health history, or begin to navigate cultural differences in meaning. Furthermore, it does not provide enough time for the provider to begin to build trust with their patients. Building trust was rated high among strategies for working with refugee populations by the PCPs in this study as well as in other similar studies. One of the PCPs interviewed in this research described their priority building trust

with refugee patients in their clinic, "when I see them [refugees] it is just way overwhelming for me. I just have no idea. It is such a different culture from our patients who know it's quick, it's fast, 15 minutes and you're out. I mean these patients [refugees] just are already so vulnerable coming here. They don't do much talking, we end up doing so much of the talking at first. It takes so much longer to sit down, talk with them, and gain that trust and then starting. It takes time."

3. Inadequate reimbursement rates

Reimbursement rates are inexorably connected with encounter time. Most PCPs described their desire for more time to accurately and adequately care for this vulnerable group of new arrivals. Reimbursement structures are not designed to be flexible or accommodating to meet the needs of the providers and their patients. In many ways PCPs are forced to choose to either adapt their practice to fit into the medicaid system -this may mean deciding to complete patient visits without the use of interpreters, or to being unwilling to spend extra time to address the needs of their patients despite inadequate reimbursement rates, or it may mean refusing to accept patients with medicaid at all. This theme was noted in many of the components discussed by PCPs during the interviews. Since Medicaid is subdivided by categories, one PCP suggested, "The law in Olympia needs to change so that refugee patients are in a category where they can access services." In addition to the problem that providers are not reimbursed adequately for the amount of time they spend with these patients Medicaid benefits often end before the treatment or therapy is complete or they do not adequately cover the cost of the treatment or therapy at all. Inadequate reimbursement rates for time and treatments provided was a common theme in all settings during this research. In fact, during participant observation, a bulletin board in the administrative office at more than one clinic site displayed a Medicaid check made out to the provider in an amount that was less than one dollar. This act clearly displayed the sentiment of the providers in regards to the reimbursement they received for their services.

Inadequate reimbursement for services provided to patients with refugee status is not unlike reimbursement for services for many other Americans with Medicaid. Problems with changing or

dropping of insurance coverage is also not unique to those entering the system with refugee status. Therefore, this issue might be successfully addressed at a higher level in the health care system so that improvements would impact everyone equally. The problem of insurance coverage ending abruptly is not unique to refugees, but is constant in that all refugees experience disruption in service after 8 months of Medicaid coverage. New insurance coverage may begin based on employment status or eligibility for other plans. Complications that occur frequently as a result of this are highlighted in this vignette, "I have this guy on INH [treatment for TB] and he is losing his insurance next month [end of 8 month medicaid provided for all newly resettled refugees]. What do I do? Somehow we have made this system, they need to finish their medicine. It is a horrible system and a horrible problem."

It is of note that this population is vulnerable and is known to have a wide range of health risks, including communicable disease. Ultimately, addressing this health systems problem will benefit refugees, immigrants, working poor, and all Americans. As one provider put it, "some argue that by focusing on the most disenfranchised in the long term you save money. They are not going to the ER, not getting admitted. It is a wise investment to put a little bit of money up front. We have to do it on our own, but it is not a bad investment."

Benefits of working with refugees

Findings from this study include reasons that PCPs report choosing to work in settings where refugees are part of the patient population. Many simply enjoy the challenges and the variety of people who they encounter, "I do this because I like all the people who I meet, I think that they are interesting." Enjoyment from this population was echoed by another provider, "I enjoy medicine more, seeing these patients, watching them come and learn, and progress over time. Having them appreciate what you do for them. It is very rewarding, more than monetary reward." Many PCPs expressed feelings of fulfillment despite a lack of financial gain.

Others noted an element of responsibility. One PCPs expressed the common sentiment of

responsibility towards a vulnerable group, but differed from the others in this study by stating, "I have to spend so much time to explain everything to them. Most of them don't even try to learn to read or write in English. I spend between 30 to 45 minutes each with them. I don't do this for a profit, I do it because it is my responsibility." All of the other PCPs spoke of building trust and loyalty with patients, whom they respected for the amount of effort that they put forth. According to one PCP, "We are also building a foundation. We have a relationship with our patients, they are very loyal. Once they know you, and they like you, they will stick with you. So, the majority of these refugees, they become employed, after a few months, I mean they work hard." Another explained, "Overtime, they become educated, they learn the system, they become more appreciative over time. Even patients who are upset and go to other clinics eventually come back here because they see that we take time to work with them."

Some PCPs described feeling empathetic and compassionate due to their own personal experience with immigration and assimilation into the U.S. Several PCPs discussed their experience of being immigrants or refugees themselves. "I am not a refugee myself, but I had trouble myself when I came, for example communicating, they don't have the skills to find work right away. That is a problem for them, financially, just to meet their needs, to make ends-meet, for food." For this group of providers, the variety of situations, interesting stories and people they encounter at their clinic sites make their work rewarding despite many challenges. In particular, they value spending enough time to build trust, establish loyalty, and contribute to the health of their patients as these patients learn to navigate a new system, language, and culture.

Strategies described by PCPs

1. Strategies implemented clinic wide

Rewarding and frustrating as it may be, working with patients who have just entered the health care system has many associated challenges. The PCPs interviewed in this study described

strategies that they have implemented individually and at the clinic-level that help to address some of the major challenges and increase the rewards when working with refugees. Strategies used by PCPs include; adaptations to the clinic structure, hiring members of the community as using interpreters, building trust, implementation of cultural navigators, connecting with VOLAG case managers, facilitating sharing of health records, particularly from the Public Health Department, seeing patients more frequently, enhancing collaboration among providers.

2. Adapting Clinic Structure

One clinic changed their structure completely by implementing a weekly Refugee Intake clinic. Caseworkers from local resettlement agencies are aware of the clinic and they make appointments for newly resettled refugees for this clinic. This strategy helps providers identify patients with refugee status. Though caseworkers call to make appointments, it is a walk-in clinic so that people wait to see the provider in turn when they arrive, and the problem of missed appointments is avoided. "It isn't a separate clinic, they just have long appointments, 45 minute appointments. They are called refugee intake, we also do a second follow-up, called refugee intake follow-up, because they get all these labs the first time, so we follow up with them the second time around." On site interpreters are available on that day for language groups that are expected. One provider from this clinic site said, "I didn't even realize that some of the patients we saw here were new refugees until this change was made at our clinic."

This clinic model is similar to other sites such as those described previously, in Minnesota and Colorado. It is successful in improving the ability to recognize patients as recently resettled refugees. It includes other strategies that have been described as successful such as employing members from the refugee community.

3. Hiring members of the community & using interpreters

Hiring members of the communities being served is a specific strategy used at more than one clinic. This strategy helps to address more than one of the communication challenges. In some cases, employees can become certified medical interpreters. Better communication between patients

and providers contributes to better health history and better transmission of health information. This strategy also helps with improving some knowledge gaps among providers related to history and culture of particular refugee groups. One PCP explained, "hiring people from within the community allows us to mobilize quickly. This goes back to centers of excellence. We think of transplants, heart centers, etc. Some places have developed a center for excellence around the care of people who don't reimburse. Systems and bodies of knowledge that they share with each other are unique to their population. We do something similar with immigrants and refugees and yet there is no reimbursement for it." A provider from another clinic described hiring from the communities being seen in the clinic and utilizing those interpretation skills as a cost savings since most PCPs interviewed felt that interpretation services were not adequately reimbursed from Medicaid.

The Center for International Health in Minnesota highlights their tradition of hiring an international staff comprised of individuals from similar backgrounds as the patients seen at that clinic. In a book about the history and design of the Center for International Health the value of multicultural staff was affirmed, "medical professionals now agree that the single most important factor in serving patients with limited English proficiency is the presence of an interpreter. Barriers of culture and language fall when there is a Diem or a Monorom, a Channy or a Verra [four staff members whose cultural background are similar to the patients seen there] who becomes a partner with a physician to bridge the gap in understanding medical treatment." (Young, 2008, p.182)

4. Building Trust

Employing members of the communities being served also contributes to trust building. As providers learn more about the groups they are serving, the communities and individuals within those groups learn more about the health care system. This is particularly true with groups that have lived through very similar circumstances or have come from the same community or displacement camp abroad. One PCP described their success this way, "that is one thing that is different in this clinic. We recognize that anything that you do to one patient, you have done to the whole community."

While one way to build trust is to recruit community members into the clinic setting, another way is for health care providers to visit the members outside of clinic site. One PCP describes visiting community centers and attending church services in communities where patients from that clinic attended in order to have a better understanding of other cultures and to enhance their influence among patients. As one PCP stated, "we have to get them to trust us, before they will buy into anything. A lot of times, getting them in for whatever it is they think they need or helping them get their housing, or whatever forms they need help to fill out, then they get a little bit of what they want, then we can start to get a little bit of what we are trying to get through to them. Even though we end up doing a lot of what we think is right, this really shouldn't be part of medicine, it is the only way to get them to buy into us and listen to us." Multiple studies looking at resettled refugees and health care have found that only after children and their families feel some sense of control and security with their current circumstances, including a feeling of trust toward their healthcare provider, are they ready to proceed with any recommended interventions. (Bean, Eurelings-Bontekoe, & Spinhoven, 2007), (Ehnthold & Yule, 2006)

5. Cultural navigators

Cultural navigators or cultural brokers are not utilized routinely in primary care offices, however some PCPs mentioned the idea or role as a practical strategy. One Provider proposed, "It would be a useful resource, if there was a time to sit-down with a refugee group, to explain what resources are available and how to access them. But when is the right time to do that? It is probably not in the first few weeks after they arrive. It would help to explain what we in the community can do for them and what we can't do and what they are going to need to do to move on to independence."

In fact, a new position to address just this issue was filled in King County in 2011. A position was opened for a Burmese outreach worker to act as a cultural navigator and to act as a liaison between the community of Burmese refugees in King County and the medical and social service communities. As the position evolves the effectiveness will be evaluated further. The concept of

cultural navigators can be an effective way to increase communication and trust between patients and providers.

6. Connecting with caseworkers

This study revealed that some Providers had difficulty identifying patients with refugee status. A successful strategy to improve the identification of these patients, is improved PCP collaboration with case workers in refugee resettlement agencies. The role of caseworkers was not well known to PCPs. Those who described having regular communication with caseworkers were able to easily identify refugees, and it triggered them to search for history documentation such as overseas health history and to contact the Public Health Refugee Screening Clinic for immunization records and results from screening exams. Furthermore, regular communication with caseworkers helped keep providers informed about the needs and perceptions of local refugee groups as well as information on new groups arriving in the area. One PCP, when reflecting on successful communication with caseworkers said, "I think it would be helpful to even just know who are the new refugees coming in . . . we need to be aware." Enhanced communication with caseworkers at VOLAGS was noted to improve a provider's ability to identify individuals as recently resettled refugees, as well as to enhance general knowledge about new groups or subgroups arriving in the area.

7. Obtaining Records from Public Health

Most of the providers interviewed talked about challenges with obtaining health history and particularly the results from the screening completed at the Public Health department. During the interviews, several providers inquired about ways to share health history and screening data. One PCP asked, "Is there a medical record database that we can access, like the E-HR (Electronic Health Records), especially for things like HIV testing, or other test results?" Another said, "It would help, I mean even if we had a collaborative where we could access the PH database." A standardized method of data collection was implemented in the Washington state this year, to obtain and organize baseline health data for newly arrived refugees during their initial health screening visit at Public

Health. However, this information is not accessible by health care providers.

While some providers interviewed were unaware of the screening test, immunizations, and health history collected at the Refugee Screening Clinic in the downtown Public Health department for all newly arrived refugees, others knew of the clinic but did not routinely have success in finding and reviewing records from the patient, Washington State Immunization Information System (previously Child Profile), or the health department itself. Some described success when clinic staff were specifically trained to retrieve records from the Public Health department. "We generally get them from Public Health, but it is not easy. The Medical Assistant has to call and call and call. It shouldn't be that hard. I don't know why that is."

8. Seeing Patients More Frequently

Helping to address non-medical issues, helping patients learn to navigate the health care system, building trust, and following up with referrals or lab tests given the challenge of brief appointment times is often accomplished by seeing patients more frequently. "If I know that insurance is ending I try to follow up more frequently and ensure that labs and tests are completed in a timely way. These people are similar to many other patients here who have short term plans, temporary employment, or unstable employment and who have insurance that is frequently changing or dropping," said one PCP. This common strategy was echoed by others, "We sort of adapt a system where they have to come in more frequently because they cannot absorb a lot of information all at once. With this cultural shock, with this, you know, adaptation to a new environment, we basically have to take them by the hand, and say, 'Okay Take this prescription, you need to do this.' You just have them do one or two things at a time, they you have them come back a week or two weeks later, have them bring everything in, see if they are doing things correctly, then go to the next step. You know we can't send them to specialists all at once. They aren't going to do it. Once we educate them on how the system works, because a lot of them don't know how to use the pharmacy, where is the pharmacy? And who is going to pay for it? They don't know, they can't always read."

Findings on Collaboration

“I don't know if there are other providers who see refugees at all. Are there other doctors who see patients like this around here?” This comment reflects the sense of isolation that primary care providers, particularly those in private practices can feel in the community when working with high risk or vulnerable groups. When there is information available it will be useful to bring all providers to the table, sharing information, resources, and solutions. PCPs interviewed shared their wish to connect with others working with similar populations in the area and receiving updated health information on incoming groups. There is currently not a place for concerns or strategies among providers to be collected, collated, consolidated, and shared.

Summary of Findings

This research project involved PCPs in King County and examined their self-identified challenges, needs, and strategies involved in providing care for recently resettled refugees. This project resulted in the collection and analysis of qualitative data regarding these issues and additionally included strengths of refugee patients and benefits to working with this population as described by PCPs. Finally, identified the need to promote collaboration among PCPs and social service providers working with recently resettled refugee groups. The research methodology itself engaged PCPs in the research process in order to enhance awareness, understanding, and ownership of the barriers and potential strategies along the way.

The findings show that PCPs in King County share a number of common challenges when working with recently resettled patients including difficulty obtaining health history, increased encounter time needed for clinic visits, and inadequate reimbursement rates for time and interventions.

Several strategies have been utilized individually and implemented in clinics locally and nationally. The PCPs involved in this study identified clinic wide strategies including adapting the clinic structure such that one day or time was dedicated to seeing only newly arrived refugee

patients. Other clinics hired members of the communities being served, utilized interpreters and cultural navigators, and set up standardized process' to access health records from the Public Health Department's Refugee Screening Clinic. On a clinic or an individual level, PCPs described satisfaction with successful interactions with interpreters, improved collaboration with case managers from VOLAGs, and attempts to develop and build trust among individual patients and established refugee communities. There is potential for these strategies to be useful for PCPs who are working in other settings. Improvements in the quality of care delivered were noted once strategies were implemented. These factors support the idea of creating a network of providers who regularly work with this population within King County.

Recommendations

1. Recognition of Newly Arrived Refugees

Recognition of patients who are newly arrived and have refugee status is critical. While it may not be practical or valuable to discuss the legal status of all patients, there are benefits to asking directly about a patients' social history. While some people may not be willing to disclose information due to legal implications or potential stigma, some providers in this study described success in finding a patients legal status and history by asking the patient directly as a part of the initial health and social history assessment. It may be useful to integrate several questions related to culture into the initial health assessment. Awareness of the timeline relating to resettlement is a valuable piece of information with health implications including immunization status, screening results, potential for less common illness, acculturation and understanding of the health care system, as well as emotional state ranging from hope to distress related to resettlement.

Other ways for health care providers to recognize patients with refugee status include enhanced communication with VOLAG caseworkers or modification of clinic structure such that newly arrived refugees are only seen during particular clinic days or times. The ability to recognize these patients and their unique circumstances and needs is the first step towards improving the quality of

care that can be delivered.

2. Communication with Patients

The ability to assess a brief social and medical history accurately depends on the ability to communicate with the patient. Using an interpreter is imperative. Some clinics offer training on effective and efficient methods for using interpreters in one's practice. Another recommendation for improving communication ie. increasing knowledge and understanding, and building trust, is to ensure that members from the communities being served are represented among the clinic staff. Cultural brokers are individuals who "know each culture well enough that they can translate cultural patterns for patients and clinicians; that is, they can explain to each what the cultural context is for the other" (Chrisman & Zimmer, 2000, p. 67). This strategy can be very successful, but also can be less practical in clinics with smaller offices. Recommendations also include hiring staff who are able to act as cultural brokers on alternating clinic days. An example of this may be hiring a cultural broker from the Karen speaking Burmese community on Mondays and a broker from the Oromo speaking Somali community on Tuesdays and Thursdays, etc.

3. Cross Cultural Skills

Developing cross cultural skills is critical to ensuring quality care for any patient population and particularly for some of the most vulnerable. One such skill is cultural humility. This begins with active listening with an understanding that the story told by the patient is an important part of their identity and will influence their health. Narrative medicine is a specific process to hear and integrate both the story of the patient and the provider. These components may contribute to knowing oneself and being open to differences in others, however humility and good listening skills may not be enough. Another component of narrative medicine and improved patient care in a cross-cultural setting is active self-reflection. "Reflection, self-awareness and keeping a reflective diary are all skills very essential to the practice of medicine as well as the PAR Process" (Marincowitz, 2003, p.599). Other valuable cross-cultural skills include steps to develop mutual respect and negotiation which may involve compromise (Chrisman & Zimmer, 2000). Specific techniques include utilization of

Kleinman's explanatory model interview (Kleinman, et al., 1978). Clinic level strategies may include providing training or education in cross-cultural methods and techniques.

Another strategy is to integrate an ethnomedical approach with a more traditional biomedical approach to care. "Ethnomedicine is concerned with the cultural interpretations of health, disease, and illness and also addresses the health care-seeking process and healing process" (Pieroni et al., 2005, p.1). This model could help to increase therapeutic and culturally sensitive interactions between patients and providers. Furthermore, "integration of an ethnomedical model may facilitate the extent to which patients are willing to co-operate with health advice and treatment, the degree of importance they place on the sick role and the decision making they go through to recognize disease and healing" (Alladin, 1993, p.8).

Ensuring that cross-cultural skills are obtained and practiced is the responsibility of the individual provider and the clinic in which they work. Engaging in a process of critical self-reflection is challenging, as one PAR researcher put it, "Once mastered, reflection doesn't take time, only guts" (Mash, 2007, p. 1113). Enhancing cross-cultural skills and self-reflection are extremely important in the delivery of quality health care considering the dynamic and diverse set of beliefs and behaviors among and between members of different cultural groups.

4. Support for Mental Health

Primary Care Providers find navigating mental health issues to be a complex task for a variety of reasons. Referrals for mental health providers and behavioral specialists can be difficult especially for those in private practice who need to look outside their clinic for specialists to refer patients to. Mental health providers, behavior health specialists, and counselors are not always available or qualified to meet the particular needs of refugees and access is often limited due to Medicaid reimbursement policies. In addition, the recognition of symptoms to identify and diagnosis emotional distress or mental illness is often very challenging with this population. As one researcher asserts:

The widespread utilization of the PTSD diagnosis can be seen as perpetuating the

reductionism of psychiatric categories. It sanctions the continuing neglect of refugee suffering, suffering that is associated not only with the experience of persecution and trauma, but with the stigma, isolation and rejection of being irretrievably out of phase with the host society and its values, and with one's parents' generation and the the generation of one children. Medicine and psychiatry cannot take account of or redress suffering of this magnitude, depth and complexity because they are both grounded in the assumptions of the inviolate primacy of the individual and of the necessity of treating the patient instead of the environments that constrain patients . . . Finally, because the existence of both medicine and psychiatry is predicated upon the necessity of pathology or problems, they cannot take primary account of the strengths and resilience of refugees. (Muecke, 1987, p. 520)

While there should be a concern for mental health issues among refugees, given their exposure to traumatic events and relocation, it is also important to recognize the myriad of ways that people cope with stress. Research has established that as people coming from a different culture, refugees may have "ways of understanding and responding to emotional distress that differ from the explanatory and treatment models that guide the work of Western-trained mental health professionals" (Miller & Rasco, 2004, p.30). Not only is it important to recognize how emotional distress may manifest, it is also valuable to recognize the variety of ways that refugees may cope. An intriguing approach involves the "shift of focus from refugee pathology to refugee health [in order to] provide exits from the reductionism of medicine and from the medicalization of problems of living in society. . . what medicine would declare disease may represent transition to a healthier 'assumptive world'" (Muecke, 1987, p.521).

Since it is clear that psychological and emotional distress as well as coping all manifest in a variety of sometimes unexpected ways, another recommendation is to establish a reliable method for identification of mental distress. It may mean developing improved tools or modifying existing screening methods. The Center for International Health in Minnesota has developed its own screening tool. In a recent collaboration between PH-S&KC and the resettlement organization LCSNW a new tool was developed to help screen for mental distress among newly arrived refugee

groups in King County. The Refugee Health Screener -15 (RHS-15) is being implemented as a part of the refugee screening clinic at the public health department. It is currently available in five languages: Nepali, Karen, Burmese, Russian, and Iraqi. Referral for care when needed is offered for those screened (Pathways to Wellness, 2011). This type of tool may be useful for PCPs who work with individuals from these groups.

A second priority for mental health is to develop an improved referral network. Currently several social service organizations such as LCSNW, Asian Counseling and Referral Center (ACRS), Refugee Woman's Alliance (ReWA) and a small number of independent practitioners offer culturally appropriate counseling services specific for this population. Promoting a network of mental health specialists who are up-to-date on issues related to communities being resettled who are also able to address the needs of this population in a culturally appropriate way would contribute to an improvement in the overall quality of health care delivered.

5. Inter professional Collaboration

As federal, state, and local requirements and policies change and new groups of people become displaced and enter King County as refugees, the expectations of Primary Care Providers will shift. Benefits of inter professional collaboration include a shared problem solving approach about current issues and venue to share trends and emerging health considerations about new populations. As one PCP in this study noted, "It would help us too, if she had some sort of support person, who could help, and could guide us too. To let us know what we are walking into." Increased collaboration and communication between PCPs and caseworkers from VOLAGS is one way in which information might be shared. Mutual information sharing would involve information for providers about individuals or incoming communities, and for caseworkers it may encompass health information, debunking of myths, and health system expectations. The question of how, when, and who is best positioned to provide education about the health system for newly arrived refugees is unclear. One PCP in this study contended, "that would be a useful resource for a refugee clinic, if there was a sit-down with a refugee group, of the same ethnicity to explain what resources are

available and how to access them. But when is the right time to do that? It is probably not in the first few weeks after they arrive. It would help to explain what we in the community can do for them and what we can't do and what they are going to need to do to move on to independence." Since all health and social service agencies who encounter refugees struggle with the consequences of those unaccustomed to systems and expectations, increased collaboration among these agencies could result in mutually beneficial solutions. Using a PAR model would certainly be a strong model to use for future research and action in this area. Another strategies is the use of a co-operative inquiry group (CIG) this has been described as a form of PAR in which members of a group are all committed to both action and reflection in a particular field of inquiry . . . The underlying foundation of the co-operative inquiry is a continual cycling between the research ideas and reflections on the one hand and experience on the other" (Mash & Meulenberg-Buskens, 2001, p. 1108). The CIG consists of a repetitive cycle that includes planning, action, observing, and reflecting.

An inter professional collaboration to discuss refugee health and coordination issues was initiated earlier this year in King County. The New Arrival Working Group (NAWG) meets monthly to discuss trends in resettlement, address and improve flow of patients through health care systems, and engage in interdisciplinary problem solving.

Another strategy for those not able to commit to regular meeting times might be a county wide listserv or website updated routinely with relevant information. Since some recommendations and standards come from a national level, such as the CDC guidelines, it may also be helpful to have an annual or every other year webinar or training session to cover this information. There are existing national listservs for providers on a national level, such and one called 'Clinician's Corner' out of the Minnesota Health Department (see resources section). A Community Health Grand Rounds might also be an effective way to share information and knowledge on topics such as these i.e. Strategies and barriers to refugee health in King County, WA.

Another example of an inter professional collaboration in King County involved a group of Providers, nurses, social workers, this PI(MS), and PH-S&KC, LCSNW. It resulted in a document

called, Toolkit for Primary Care Provider. This toolkit was designed to provide information about medical assessment and interventions that occur as a part of the refugee resettlement process, tips on accessing patient's medical records, suggestions on health screening priorities for PCPs, and other resources for primary care settings. It is recommended that the Toolkit for Primary Care Providers, or any document or website similar to it, be modified and updated to maintain current relevant information.

6. System-level Improvements

The recommendations to this point have focused on clinic and local level adaptations. There is also potential for system-level changes that might have a great impact on quality care for refugees. "Lack of adequate professional interpreting services presents a barrier for all non-English speaking patients, but this barrier is larger for those with psychological and emotional difficulties that can only be explored verbally. If tragic mistakes are made as a result of communication failure, does moral responsibility rest with the doctor or with a medical system which expects doctors to communicate well but fails to provide adequate resources?" (Jones & Gill, 1998, p.1445)

The creation of a position for a State Refugee Health Coordinator would help to address several gaps in the existing system. Many other states have a designated State Refugee Health Coordinators at this time. This role would best serve unmet needs if the job description were designed by members of a local coalition of invested individuals. Generally speaking, this role involves collection and standardization of health data relating to incoming refugees.

Centralized data collection at the Refugee Screening Clinic would improve and standardize epidemiological surveillance. If the data collected during this encounter were shared directly with PCPs then it would also improve and streamline the care delivered. Since one major challenge in the delivery of quality health care as described by PCPs was the difficulty in obtaining adequate health history, then an effective way to share the information that is being collected at the Refugee Screening Clinic in Public Health could greatly improve the quality of care being delivered to refugee patients seen in primary care offices.

7. Reimbursement

Providers should be reimbursed at a fair rate. This means that the state Medicaid system has a responsibility to recognize that patient encounters are more time consuming when working with non-English or limited-english speaking patients, and during initial visits for newly arrived refugees. Visits where interpreters are used should be long enough to provide the same standard of quality health care, as is provided to those who receive care in a language shared by the provider. Both the cost of the interpreter and the cost of the provider's time should be reimbursed. For example, for visits requiring interpretation the reimbursable encounter time might be increased to 30 or 45 minutes to more accurately reflect reality, to ensure that the cost for interpretation is covered in the charge for the visit, and to encourage providers to utilize interpretation services when necessary. Reimbursable encounter time for initial refugee screening visits should also be increased to 45-60 minutes to more accurately reflect the reality of the actual encounter time.

Resources

Resource	Description	Location
Ethnomed	Cultural beliefs and medical issues related to topics pertinent to the health care of immigrants.	Ethnomed.org

CDC Health Considerations for Refugees	Arrival in the United States: Process Health Status & Screening of newly arrived Refugee & Immigrants.	http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-9-health-considerations-newly-arrived/arrival-in-the-united-states-process-health-status-and-screening-of-refugees-and-immigrants.htm
CDC Refugee Health Guidelines	Overseas and domestic guidelines for medical examination for refugees.	http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html
Minnesota Refugee Health Provider Guide	Comprehensive reference document for Providers on physical exam and general questions about health care delivery for refugees.	http://www.health.state.mn.us/divs/idepc/refugee/guide/
Toolkit for PCPs	Information about medical assessment , intervention, records, and links for recently resettled refugees specific to King County.	http://ethnomed.org/clinical/refugee-health/toolkit-for-primary-care-providers-treating-refugees
RHS-15	Mental Health Screening Tool for recently resettled refugees in King County.	http://www.refugeehealthta.org/webinars/mental-health-screening-and-care/tools-and-strategies-for-refugee-mental-health-screening-introducing-the-rhs-15-2/
Center for Applied Linguistics	Information on refugee orientation, backgrounds, resettlement needs of new refugee groups	Cal.org
Clinician's Corner	A collection of resources for Providers from around the country working with refugee populations. Includes a weekly case study, relevant articles, a quick guide for initial refugee health assessment, and a listserv option.	http://www.health.state.mn.us/divs/idepc/refugee/cliniccorner/index.html
Cross-cultural continuing education for Providers	The Provider's Guide to Quality & Culture. A joint project of: the Management Sciences for Health, DHHS, HRSA, the Bureau of Primary Health Care.	http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
Cultural Competence Education	Resources in cultural competence education for health care professionals from the California Endowment.	http://www.calendow.org/uploadedFiles/resources_in_cultural_competence.pdf
Teaching cultural competence	Teaching cultural competence in health care: a review of current concepts, policies and practices.	http://minorityhealth.hhs.gov/assets/pdf/checked/em01garcia1.pdf
Community Health Workers	Expanding the scope of the health care delivery system from the National Conference of State Legislatures.	http://www.ncsl.org/print/health/chwbrief.pdf
Community Health Workers	Financing community health workers: why & how.	http://www.pscinc.com/LinkClick.asp

Ethnobiology & Ethnomedicine	Journal of Ethnobiology & Ethnomedicine is an open access, peer-reviewed, online journal that offers original interdisciplinary studies on the relationship between human cultures and nature, folk and traditional medical knowledge and relevance for public health policy.	http://www.ethnobiomed.com/
Diabetes care for Refugees	ADA, Adapting Models of Chronic Care to Provide Effective Diabetes Care for Refugees.	http://clinical.diabetesjournals.org/content/29/3/90.full
Example of Interdisciplinary Collaboration	Refugee Health and Medical Student Training. A framework for Refugee Health Night.	http://www.stfm.org/fmhub/fm2003/October/Griswold.pdf

Limitations

It would have added to the richness of the research and contributed to the increased participation and generation of ideas from within local refugee groups who have recently arrived. In fact increased participation from all sectors would enhance research findings and potential for improvements overall.

Another limitation was the maturation confound, referring to the fact that people become more experienced throughout the process of the research study (Bernard, 2006, p.114). This is a risk when using a collaborative PAR approach. This study lasted for a duration of more than two years. The ideas and suggestions from participants were integrated into the study by design. As a result of this action research technique, some PCPs changed their individual practice, learned more about the refugee experience and resettlement process, and changed their clinic structure prior to being interviewed, thus altering findings. This might affect the validity of these findings. In terms of the use of the PAR methods, the process is intensive and has the potential to affect the findings since relationship building and collaboration are a part of the process. The nature and quality of the relationships and the extent to which trust and respect are cultivated can impact the research.

Conclusions

The purpose of this research was to help identify priority areas related to clinical care for refugees, to assess the desire for more information among PCPs, and to identify common challenges

and potential strategies for providing quality health care for recently resettled refugees in King County. A qualitative research study was selected to address these issues. Despite the limitations of this research, and perhaps due to some of the action research strategies utilized, PCPs sought information on refugee health and health-care throughout this study. The findings indicated that PCPs shared many common frustrations and challenges when working with refugees newly resettled in King County. Many of the PCPs interviewed, identified clinic wide strategies to improve the quality of care provided for this population. Some strategies included adapting the clinic structure such that a particular time was dedicated to newly arrived refugee patients, hiring members from the communities being served, increasing utilization of interpreters and cultural brokers, and increasing standardization of health records collected at the Public Health Refugee Screening Clinic. PCPs also described improvements in identification and communication with refugee patients resulting from the use of certified interpreters, improved collaboration with caseworkers from VOLAGs, all contributing to the development of trust among individual patients and established refugee communities.

This research helped to identify potential areas for growth, including enhancing resources for training in cross-cultural skills, improving access and support for mental health, and strengthening the platform for inter professional collaboration. State-level priorities include implementation of a state refugee health coordinator position, improving and standardizing data collection for refugee health information, and developing improved ways of sharing of electronic health records between the health department and PCPs, and finally ensuring adequate support and reimbursement for services delivered by PCPs working with this population.

The research questions posed at the onset of this study were addressed. Overall PCPs who participated in this study were found to be knowledgeable about individual patients with refugee status and refugee groups in the community. Several knowledge gaps were also identified. In particular, gaps were noted in the identification of individuals with refugee status, their medical pathway since arrival in King County including screening and immunization status, and the expectations and clinical guidelines for recommended testing and treatment. PCPs face similar

challenges when working with this population. Some have developed strategies to adapt their individual and clinic practices to meet the needs and challenges associated with the delivery of quality care for these groups. As these providers continue to recognize new challenges associated with new groups of incoming refugees the benefits of finding a platform to share solutions will become even more valuable.

In conclusion it is clear that health care and social service providers alike are working towards improving the quality and availability of care in order to meet the unique needs of individual patients. It is also evident that the current health-care system does not provide adequate support for these providers.

At an individual level, successful strategies include the integrating of cross-cultural tools into practice. Examples are the use of cultural brokers and interpreters and the use of explanatory model interview to identify individual illness narratives. These strategies can help health care providers to illuminate the myriad of illness experiences, manifestations of sickness, and treatment modalities expressed by patients. Self-examination and self-reflection of personal views, values and perspectives is recommended. Considering a combination of biomedical and ethnomedical models may also be useful. These strategies should lead to an enhanced understanding of the variety of illness constructs and health-seeking behaviors of individual patients and contribute to improved care. Ultimately, it is the clinic structure, along with the county, and state-level policies and overall health-care system that must be designed to support and nurture the adoption and utilization of these strategies among individual PCPs. State wide reimbursement systems must not only be fair, but also flexible to allow for changes and improvements to be made at the clinic-level.

There are many benefits associated with recognizing and sharing common frustrations and challenges. Increased collaboration among PCPs and other social service providers will undoubtedly contribute to shared solutions and improved care. Individual strategies including utilization of cross-cultural tools and individual self-reflection play an important role in improving the quality of care for vulnerable groups. Therefore, enhanced support for providers at the clinic, county, and state levels

will improve the structures, policies, and methods for ensuring the delivery of culturally competent high quality care for all patients.

"Increased knowledge about the complex medical needs of refugees can help the primary care physician to care more effectively for this special population. A society's moral strength can be measured by how it treats its most vulnerable citizens." (Adams et al, 2004, p1551)

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