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**The Exploration of Historical, Cultural, and Healthcare Utilization Factors When Clinically Treating
Refugee Patients: Healthcare Providers' View**

Kandy Do, BS, 12-11-2017

Abstract

The objective of this project is to explore historical, cultural, and healthcare utilization factors that are significant to healthcare providers in their practice to clinically treat refugee patients holistically and equitably. Semi-structured interviews supported by a pre-interview questionnaire were conducted with 14 healthcare providers, who have experience in working with refugee patients. Purposive and snowball sampling method was used to recruit 14 healthcare providers. Thematic analysis was used to analyze qualitative data. Descriptive analysis was performed on the pre-interview questionnaire results. To our knowledge, there is limited research exploring historical, cultural, and healthcare utilization factors that are relevant for providing health care to refugee patients, yet the significance of it will be invaluable and beneficial to healthcare providers as more refugees call the U.S. their home. The study identified five historical, ten cultural, and eight healthcare utilization factors that can be useful for healthcare providers as a start to a framework when working with all patients, refugee or not.

Introduction

Yates Community Center is a program of Omaha Public Schools with a mission of teaching refugees, immigrants, and other community members skills that will help them be successful in the Omaha community. Yates fulfills its mission by offering classes, such as English Language Learner (ELL), citizenship, sewing, computer, and early childhood classes. Programs are free, open to everyone, and staffed with interpreters for multiple languages to accommodate students. There are countless opportunities to continue to make Yates a thriving center in the community. Ideas are not limited to inviting guest speakers, field trips, additional classes, garden programs, and external volunteering opportunities. These projects provide education to the organization, community, and other stakeholders as we continue to take care of refugees. These projects also utilize the knowledge and skills of members in the organizations to collaborate and create valuable products for the community at large and they directly impact public health. Alana Schriver, the Refugee Specialist for Omaha Public Schools and Yates

Community Center promotes some of the projects for students, such as booking Friday guest speakers for the ELL Cultural Orientation class.

The Omaha Refugee Task Force is a collaboration to address issues that refugees may face in Omaha, Nebraska. Four main issues created four sub-committees within the task force: education, employment, housing, and health. The Refugee Health Collaborative (RHC) is a sub-committee of the overall Omaha Refugee Task Force that brings healthcare organizations, refugee agencies, and refugees together to plan for a healthier refugee community. Alana Schriver is the current co-leader of the RHC, as well as the refugee specialists for Omaha Public Schools. The RHC convenes cross-sectored professionals from refugee resettlement agencies, social service providers, education, medicine, public health, and insurance to meet monthly and share resources, educate themselves about current refugee health needs, and maximizing partnerships to meet the overall goal of having healthier refugees in the community.

The RHC has four sub-committees of their own, one of which is training healthcare providers in refugee health. This sub-committee initiated the idea of creating a binder of refugee resources for healthcare providers to use as resource. In addition, with the large quantity of resources in the community, local and at large, for refugees and professionals who work with refugees, Alana Schriver and her colleagues initiated a website (www.omaharefugees.com) as a central source of information for refugees, and people who work with refugees or who want to learn about refugees. In training healthcare providers, refugee leaders are often asked to come speak at meetings and trainings. However, it is often inconvenient for refugee leaders, with a little to no compensation for their time, to educate healthcare professionals. Alana had the idea to create videos starring different refugee leaders sharing about the healthcare system back in their home country and different determinants of health that affects their refugee community that is specifically significant to healthcare providers. When working on every project, the common theme was that healthcare providers were uneducated about

refugee health and wanted to be educated, but there wasn't a strategy or a systemized framework to train healthcare providers. Therefore, the goal of my capstone project is to provide healthcare providers with some tools to use when they provide health care services for refugees.

The refugee population in Omaha, Nebraska has increased substantially over the past decade, bringing global health matters to our backyard. Seven hundred and sixty-four refugees arrived in Nebraska in 2012, and this number increased to 1,200 in 2015 (Refugee Arrival Data, 2015). However, different refugee populations from Vietnam to Sudan to Iraq have been resettling in Omaha for decades, and the health disparities still exist within the refugee population. For example, the 2015 Community Health Needs Assessment conducted in the Omaha metropolitan area, one physician reported unique barriers in health care access for refugees (Professional Research Consultants, 2015):

“There is a large refugee population in Omaha. There are huge issues with lack of appropriate translation/interpretation services, alternative clinic hours, and poor clinician/staff training to work with refugees.”

Refugees resettling to Nebraska have different factors or determinants of health compared to native Nebraskan residents (McKeary & Newbold, 2010). Healthcare providers need to understand these factors to provide equitable and quality health services. Specifically, healthcare providers need to understand the historical, cultural, and healthcare utilization contexts of the unique refugee populations to serve each distinct community justly. Acknowledging the inherent cultural influences, the personal background and circumstances, and how those factors affect healthcare utilization is vital to provide patient-centered, holistic health care, which is the type of care that efficiently and satisfactorily treats populations (Smith, et al., 2013). Understanding these factors provides clinically useful information to care the refugee populations, and is also a cost-effective approach because of the ability to explore root causes, factors, and determinants of the refugee health (Woodland, Burgner, Paxton, & Zwi, 2010).

Considering all the factors that impact health, this study explores the three factors of the refugee, including history, , culture, and healthcare utilization, to understand what healthcare providers specifically need to know about refugee patients to provide holistic and equitable care. Currently, healthcare providers are being taught about cultural competency, however the difference between being culturally competent and being culturally informed is different. Cultural competency suggests that culture is reduced to a technical skill that healthcare providers can be trained to develop expertise. However, culture is not homogenous or static and is comprised of multiple variables that can't necessarily be tested in a class or workshop (Kleinman & Benson, 2006). This study will provide valuable data to close the gap in public health knowledge about what healthcare providers need to know about refugee patients to provide holistic and equitable care.

Background

Refugees are individuals who are forced to leave their home to escape persecution, war, or violence. There is a fear of not being able to return home because of the potential persecution due to their membership of a particular social group, their race, religion, nationality, and political beliefs (UNHCR, n.d.). These experiences, events, and trauma that refugees endure may compromise their health when they arrive to the United States. When healthcare providers meet with refugee patients, they are in a position to discover diseases and conditions that patients have never been diagnosed with before. Historical information is significant to reach these hidden diagnoses (Feldman, 2006). Past events and experiences such as wars, refugee camp conditions, and traveling to refuge are examples of historical factors, which may impact refugee health. D'Andrea & et al. (2011) suggests that raising awareness about the impact of trauma on health will help healthcare providers focus on antecedent events, such as overwhelmingly stressful experiences and/or historical events. In addition, healthcare providers are often have insufficient knowledge about the significant impact of refugee patients' history or historical events on their health.

Currently, only social, family, and medical history is taken into consideration during the doctor's visit (Epstein, et al., 2008). In addition, medical history of refugees is often unknown. Studies have demonstrated that patient history provides the most information to diagnose patients (Castrejón, McCollum, Durusu Tanriover, & Pincus, 2012; Peterson, Holbrook, Hales, Smith, & Staker, 1992). Peterson & colleagues (1992) found that, out of 80 patients, 61 or 76% of patients were diagnosed based on medical history as opposed to physical examination (12%) and laboratory work (11%). It was also found that the longer the physician is in the medical field, the more they place an emphasis on history, compared to new medical students who prefer diagnostic tests (Peterson, Holbrook, Hales, Smith, & Staker, 1992). However, discrepancies exist when only utilizing the history form, due to accuracy errors, patient's changes in health or habits, misunderstandings, and not remembering (Minden & Fast, 1994).

It is currently understood that personal medical history is significant information during a healthcare visit, however other historical factors and events outside of one's personal history has not been as clearly understood as part of the patients' history. Hwang et al. (2008) suggests that factors, such as educational status, linguistic ability, refugee status, access to thriving ethnic neighborhoods in the host country, and support networks available, are some stressors before and during the refugee acculturation process that could negatively impacts health. For example, in a meta-analysis of over 80,000 refugees, a past history of torture was the strongest factor associated with the mental health condition of Post-Traumatic Stress Disorder (PTSD), followed by cumulative exposure to trauma (Shannon, Vinson, Wieling, Cook, & Letts, 2015).

In addition to historical events, cultural factors are also significant when treating refugee patients. Culture is a part of everyday life, hence it is a significant part in how individuals interact with healthcare providers. Language, religion, diet, and habits are engrained in one's culture, influence an individual's perception, and play a role in an individual's health and illness. Identifying cultural factors is

not a technical skill, but it becomes a part of the provider's clinical resource to orient a holistic, patient-centered treatment (Kleinman & Benson, 2006). Although studies frequently refer culture as a factor in health disparities, the specific individual cultural factors that influence health outcomes have not clarified in the field of refugee health (Hruschka, 2009).

In addition, it has been found that refugees do not utilize health services as often as native-born Americans because of various reasons, such as lack of understanding the U.S. healthcare system and language barriers (O'Mahony & Truong Donnelly, 2007). Culture influences health care choices, including healthcare utilization. For healthcare providers to fully grasp a refugee patient's health status and condition, they need to know healthcare utilization patterns of certain refugee communities (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Refugee healthcare utilization trends can provide healthcare providers with information to identify the gaps in health services use, and the reason for promoting specific healthcare services in a culturally competent manner. However, previous health service utilization was not adequately considered when treating refugee patients.

With the specific historical, cultural, and healthcare utilization factors not been explored robustly, there is a gap in knowledge that is crucial to the public's health. Understanding a refugee patient's culture, historical experiences or events, and healthcare utilization can provide clinically useful information to the refugee's treatment (Woodland, Burgner, Paxton, & Zwi, 2010). Healthcare providers, who are informed about specific refugee population's cultural practices and preferences, relevant historical events, and past healthcare utilization, may be able to treat the patient holistically and in a patient-centered manner. This knowledge enables healthcare providers to treat the refugee population better, and therefore, reduce health disparities within the refugee population.

Literature Review

Refugees had to go through unacceptable living conditions, such as malnutrition, insanitary housing, and insecurity in their home country and in refugee camps. Many refugees experienced

stresses and traumas that are accompanied by immediate and long-term health consequences when they resettle to a refuge country, such as the United States. Newly arrived refugees have only 90 days with a resettlement agency to receive initial assistances such as housing, employment, cultural orientation, and health screenings in some states. Refugees that come to the U.S. have been screened at their refugee camp country, which is focused only on communicable diseases, thus may have other hidden diseases or health conditions (US Department of State, 2017).

Refugees settled in Nebraska originated from many different areas of the world. From 2012 to 2015, the top countries of origins were Bhutan, Burma, Iraq, Somalia, Republic of South Sudan, Sudan, and Iran (Office of Refugee Resettlement, 2015). There are also refugees who secondarily migrate to Nebraska as well, after having initially been resettled in a different state. Refugees from different countries may have different health needs due to differences in living conditions, burden of diseases, as well as the reasons that have compelled refugees to leave their native countries.

Historical Factors

Refugees have experienced historical events, such as wars or personal events that relates to their refugee life (e.g., personally experienced violence and trauma). Epstein's (2008) book on clinical examination found that over 80% of diagnoses are made from the history that is obtained from the patient alone and proposes the theory that the patient will show the provider the diagnosis through their history (Epstein, et al., 2008). The historical trauma theory is a concept novel to the field of public health and it proposes that populations who have been historically exposed to long-term war, genocide, mass trauma-colonialism, and slavery have a high prevalence of disease (Sotero, 2006). Even generations that come after the original trauma have a high prevalence of disease. Sotero (2006) suggests that it is significant to understand how historical trauma influences the health of racial and ethnic populations in the United States and how that can provide insights for eliminating health disparities.

This suggestion derives from three building blocks 1) the link of disease to physical and psychological stress from the social environment 2) political and economic structures being determinants of health 3) socio-ecological systems that recognizes the multifaceted, dynamic, and interdependence of present and past life course factors in causing diseases. All three building blocks are embedded in historical events or personal historical experiences that impacts health. For example, Post-Traumatic Stress Disorder (PTSD) and chronic stress are high in refugees and may derive from their pre-arrival to their refugee country. These conditions are linked to damage of the nervous system, the hypothalamic–pituitary–adrenal (HPA) axis, and cardiovascular, metabolic, and immune systems. The damages of the nervous system contribute to chronic diseases like diabetes, hypertension, and cardiovascular disease (Sotero, 2006). Jankowski (2016) said that there is a correlation between PTSD and poorer physical health and that stressors from trauma impairs physical and mental health significantly. Direct physical harm and experiences that many refugees encounter may have lasting health impacts as well. Physical harm could include beating, forced stressed positions, and sexual assault. Some physical harm may have an effect on other health conditions, such as musculoskeletal pain from beatings may be compounded by extreme deficiency of vitamin D. In other cases, signs of physical harm might disappear after acute injuries are healed (Sondra, 2013).

In addition, the recognition of unequal exposure to stressful experiences may lead to inequalities, such as racial-ethnic inequalities in physical and mental health. Refugees might see and experience discrimination stress which damages mental health and that stress extends over the life course and across generations (Thoits, 2010). It is important to understand the historical context of refugee patients because refugees have endured mass trauma of deliberate persecution, thus have different responses compared to individuals with other trauma caused by accidents or nature. Deliberate intent of trauma may yield an overwhelming sense of shock, alienation, invulnerability, panic, and injustice (Hwanga, Myers, Abe-Kim, & Ting, 2008). We also know that trauma, before, during, and

after the migratory process affects the physical, cognition, psychological, and neurological health of an individual (Center for Substance Abuse Treatment, 2014). Not only historical events, but significant historical personal experience, such as resettling or living in the refugee camp plays an important role in refugee health. Acculturation for newly resettled refugees presents a major difficulty in refugee health where resettlement agencies have identified mental health as the number one priority health issues in the refugee population.

Cultural Factors

The second domain is culture, a broad term for “a process through which ordinary activities and conditions take on an emotional tone and a moral meaning for participants. Culture is inseparable from economic, political, religious, psychological, and biological conditions” (Kleinman & Benson, 2006). Culture affects how one copes with health, one’s beliefs regarding treatment, disease etiology, human physiology, symptoms, emotions, and the provider-patient relationship (Shaw, Huebner, Armin, & Orzech, 2009). Culture can be a barrier and a protective factor to health (Hruschka, 2009). Refugees bring their healthcare traditions, beliefs, and practices from their homeland, primary care providers are challenged daily by the effects of cultural differences, which affect disease outcomes and compliance from patients (Shaw, Huebner, Armin, & Orzech, 2009). For example, some refugee patients believe in fatalism and accepts the circumstances and believe that medicine cannot change the course of events. Many refugee cultures stigmatize mental health and seeing a mental health provider would mean a person is “crazy”. There are also many refugee cultures that view being overweight as being associated with being wealthy and healthy because they have the ability purchase food to eat. Tolerance for pain can also be expressed culturally and should be considered when treating patients (Mayhew, 2016).

Kleinman & Benson (2006) stated that culture influences diagnosis, treatment, and care. Culture shapes lifestyle and diet, and other human behavior that all play a vital role in one’s health, such as disease management or understanding the symptoms and behaviors that are culturally normal to a

diagnosis (Shaw, Huebner, Armin, & Orzech, 2009; Hwanga, Myers, Abe-Kim, & Ting, 2008). Other cultural influences to health include somatization and the development of psychiatric disorders (Hwanga, Myers, Abe-Kim, & Ting, 2008). Religious and spiritual values can influence how one identifies, defines, and interprets health issues as well as how they use it to cope with health (Smith, et al., 2013; Hwanga, Myers, Abe-Kim, & Ting, 2008). Cultural influences also impact how one experiences trauma. Language, as a part of culture, can also be a barrier that affects disease management, treatment adherence, and overall, worsen the health status of refugees (Understanding the Impact of Trauma, 2014; Shaw, Huebner, Armin, & Orzech, 2009).

The cultural differences, such as social stigma, spiritual beliefs, and unfamiliarity to Western biomedicine can create difficulties to access health services. To understand the refugee's health care behavior, there is a need to understand their conceptualizations of health, illness, and disease, as well as how their cultural values and knowledge may shape their healthcare experience. This is vital in recognizing the different views of health and illness brought into the U.S. health care field (O'Mahony & Truong Donnelly, 2007).

Health Utilization Factors

HealthyPeople 2020 considers access to health services as one of the determinants of health (Healthy People 2020, 2010). Access to health services critically affects one's health status. Studies have found that medical services are less utilized by those that are less privileged and who are 'most in need' of health care (Correa-Velez et al. 2007). Studies about specific healthcare utilization trends within different populations are scarce. Health care providers understanding the health services that are being utilized or underutilized by specific refugee communities have the ability to recognize the significant gaps in health services. Closing this knowledge gap in healthcare utilization helps allow an increase in referrals and recommendations for refugees to use the U.S. healthcare system. This is especially important because there are barriers to accessing health services include lack of awareness, language,

lack of insurance coverage, and cost. These barriers can lead to delayed care, inability to reach preventive services and other healthcare services, preventable hospitalizations, and unmet health needs (Healthy People 2020, 2010).

Culture and health services are inseparable because of the influence on one another (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). For example, one study demonstrated that Asian Americans underutilize mental health services because of cultural and language barriers (O'Mahony & Truong Donnelly, 2007). Another study showed how important healthcare utilization is with promoting children's health - if current health service interventions were being utilized, two-thirds of child deaths could be prevented in low to middle income countries (Adekanmbia, Adedokunb, Uthman, & Clarke, 2017). Another study by DesMueles et al. (2004) found a pattern that within the first year, refugees visiting a doctor increased up until the 5th month and then there was a steep decrease in physician visitation. However, refugee health did not improve after the first five months. Another study reported that Asian Americans used mental health services less than White Americans with similar conditions due to a reluctance to seek services. In addition, Asian Americans visited a physician less frequently than White Americans (Zhang, Snowden, & Sue, 1998). Healthcare providers knowing these trends can be useful to health promotion efforts for patients, as well as refer refugee patients to necessary services.

Overall, there are multiple and compounding influencers that impact refugee health. Numerous examples demonstrate the weight of the contextual domains outside of the medical information that needs to be understood about a refugee patient. However, a trend exists where there is a knowledge gap in the identification of specific factors in domains that influence refugee health. According to the literature, these specific factors affect refugee health in various ways, but understanding the extent of significance has not been identified.

Methods

Research Question

What are specific historical, cultural, and healthcare utilization factors do healthcare providers need to identify about refugee patients to clinically treat them holistically and equitably?

Study Design

This study was a qualitative study that used semi-structured interviews. A pre-interview questionnaire was conducted to obtain participant demographic information.

Study Sample

The study sample included participants that were identified as refugee-experienced healthcare providers in Omaha, Nebraska. "Healthcare provider" refers to anyone who provide medical and health services and has been paid for their health services in the normal course of business (Jones III, Hartley, & Williams, 2017). A few examples include primary care physicians, nurses, physician assistants, and mental health providers. "Refugee-experienced" signifies individuals who consider themselves or was recommended by someone else to be knowledgeable about refugee health because of their high refugee patient caseload, their amount of time working with refugee patients, and/or they are a refugee themselves.

Sampling approach

Purposeful sampling is commonly used in qualitative research for the identification and selection of information-rich cases when there are limited resources. This involves identifying and selecting individuals that are especially knowledgeable about or experienced with the topic of interest (Palinkas et al., 2015). Purposive sampling was used to identify and select individuals in the sample because of limited refugee-experience healthcare providers in the community, but still allows for rich information to be obtained. Utilizing purposeful sampling, 13 refugee-experienced healthcare providers were initially identified. With a limited participant population, snowball sampling was also utilized to recruit additional participants and to ensure culturally appropriate efforts in recruitment (Sadler, Lee, Seung-Hwan, & Fullerton, 2010).

Data Collection

The interview guide and pre-interview questionnaire were developed with the assistance of the faculty committee chair (See Appendix A & B). A sample interview question is “What do you think another provider needs to know about the experiences of a refugee, experiences that they face?” Eligible participants were sent an interview invitation individually via email or phone that explained the parameters of the study and interview process. Utilizing purposeful and snowball sampling, semi-structured interviews were conducted with 14 healthcare providers. A pre-interview questionnaire was sent to each participant to obtain demographic information. A verbal consent narrative was provided to participants and continuing with the interview signified consent. Participants were identified and recruited with the assistance of the refugee coordinator for Omaha Public Schools. Interviews lasted approximately 20 minutes to 45 minutes. Interviews were recorded using an audio recorder and transcribed verbatim by the principle investigator.

Analytical Methods

Analysis of the interviews were performed by identifying significant and common themes. As an exploratory study, the research did not attempt to test existing theories. Instead, a grounded theory approach was used during the coding process to facilitate understanding. Common themes were identified through the coding process for relevance and significance through the “cutting & sorting” technique. Pre-interview questionnaire responses were analyzed through Microsoft Excel for descriptive results.

Ethics

This project does not involve the review of identifiable private information. Participant interviews did not present any potential risk to the participant. A verbal consent narrative was provided during the interview to provide information regarding the goals, objectives, and confidentiality of the study, as well as collect consent. Interview recordings were deleted immediately after transcription. Interviews were conducted in a private location the principle investigator and participant agreed upon to offer privacy

and comfort. Study data was only available to the research team. No financial or conflict of interest lies within this study. The Institutional Review Board approved of this study on September 19, 2017, IRB# 563-17-EX.

Results

Participant Demographics

Ten out of 14 participants filled out the pre-interview questionnaire. There is diversity in the type of organization participants are employed with a majority being employed by a Federally Qualified Health Center (FQHC). This can be predicted due to the barriers of cost and language. FQHCs provide means to alleviate those barriers for refugees. There is a wide range of services participants' specific department or clinic provides, for example family medicine, mental health, and women's health were the top three services. Occupations varied from physician assistants, mental health providers, and dentists, with nurses being the occupation with the highest mode. Services provided and occupation can briefly demonstrate the types of services that are available to refugees and that there are experienced healthcare providers with refugee health experience in these fields. In terms of years of practice, there was an even distribution between time spent in their current practice. Most providers work in small or medium sized clinics or departments. An average patient caseload was medium (11-20 patients per day) with 44.44% of participants reported 26-50% of their patient caseload being refugee patients. Refugee patients from Sudan and Burma were the most common among participants, followed by Somalia, Bhutan, and South Sudan (Table 1).

Table 1. Participant Demographics

Variables	Frequency (n)
Type of Organization	
Federally Qualified Health Center	4
Large Health System	3
Privately-owned Clinic	2
Services Provided in Department/Clinic	
Dental	3
Family Medicine	6
Internal Medicine	2
Mental Health	4
Pediatrics	3
Women's Health	4
Other (nutrition, social, preventive, midwifery)	3
Occupation	
Dentist	1
Dental Hygienist	1
Midwife	1
Physician	1
Physician Assistant	1
Psychologist	1
Registered Nurse	3
Years of Practice	
Less than 5	3
5-10	3
More than 10	3
Total Number Physicians Employed in Dept./Clinic	
Under 10	4
11-50	5
Over 50	0
Average Daily Patient Caseload	
0-10	2
11-20	5
21-30	2
Refugee Patient Caseload Estimate	
0-25%	3
26-50%	4
51-75%	0

76-100%	2
Refugee Patients' Country of Origin	
Afghanistan	4
Bhutan	7
Burma	9
Burundi	4
Democratic Republic of Congo	4
Iraq	2
Somalia	8
Sudan	9
South Sudan	6
Syria	5

Qualitative Data

Qualitatively exploring the significance and specific historical, cultural, and healthcare utilization factors that impact refugee health, there was variation on the opinion of the significance of these three domains. In addition, there were many factors that merit great value to refugee healthcare, and ultimately, population healthcare. Table 2-4 describes what participants reported during interviews as factors that are significant to know, research about, or appropriately ask refugee patients to obtain the necessary information to provide holistic and equitable care.

Table 2. Historical Factors

HISTORICAL FACTORS	DEFINITION
TRAUMA HISTORY	Past traumatic events i.e. war, violence, stressful conditions
FAMILIAL CONTEXT	Family background and dynamics
OCCUPATIONAL HISTORY	Past occupation(s) and their implications
HEALTHCARE UTILIZATION HISTORY	Past medical treatments and health services used, or lack thereof
REFUGEE CAMP CONTEXT	The refugee camp experience, condition, and context

Table 3. Cultural Factors

CULTURAL FACTORS	DEFINITION
AUTONOMY	Decision making preferences
COUNTRY OF ORIGIN	Country(s) where the refugee identifies as their past home(s)
LANGUAGE	Language preference
RELIGION	Religious affiliation
VALUES	Understanding what the refugee patient values
HEALTHCARE PRACTICES & TRADITIONS	Traditional medical treatments used and healthcare practices
VIEW OF HEALTHCARE PROVIDERS	Cultural perspective of healthcare providers
RELATIONSHIP NORMS	Cultural customs regarding gender and every person involved with the patient: family, interpreter, healthcare provider
DIET	Daily foods eaten
SOCIAL BEHAVIOR	Social environment preferences and habits formed by culture, i.e. betel nut chewing, alcohol use

Table 4. Healthcare Utilization Factors

HEALTHCARE UTILIZATION FACTORS	DEFINITION
HEALTHCARE UTILIZATION TRENDS AND PREFERENCES	Trends noticed about under- and over- utilization of healthcare services and the preferences that motivate these trends
PAST HEALTHCARE SERVICES UTILIZATION	Past medical treatments and appointments
COMPLIANCE	Compliance to treatments and appointments
HEALTH LITERACY	Comprehension of navigating the healthcare system
LANGUAGE	Barriers that exist when utilizing healthcare with another language that's not English
TIME	Preferences related to time when utilizing healthcare
COST	Barriers in cost to utilizing healthcare
DAILY LOGISTICS	Barriers in daily logistics, i.e. transportation, childcare, that impact healthcare utilization

Historical Factors

When participants were asked if understanding the historical background of a refugee patient was significant, two main answers were conveyed. Approximately half of participants advocated that understanding historical background was important and even a priority because of the diversity within refugee experiences and it has an impact on refugee health. Participant 14 stated:

“Absolutely, it gives us a better idea of where they’re coming from. Just what they’re encountering because it has a huge impact on their care.”

The other half of the participants suggested that it is significant to find out and understand the historical background, especially backgrounds of trauma because how trauma impacts health, but if it takes asking the patient for the information, the significance is now dependent on each individual patient.

Participants were concerned with the potential retraumatizing of refugee patients. Participant 11 shared:

"I think it depends on the patient's complaint and it also depends on the patient, individually. Some of them, they want to, willing to share their story, background. Some of them, they don't want to go back feel the same trauma they have been through so it depends and depends on their illness and depends on the patient."

Despite there being two main answers, it was unanimous that historical information is significant when treating refugee patients. Participants reported specific historical factors that impact refugee health for healthcare providers should know or ask about. These historical factors included trauma history, familial context, occupational history, healthcare utilization history, and the refugee camp context.

One historical factor that majority of participants conveyed in magnitude and quantity was past traumatic events like war, violence, and other stressful conditions refugee patients have endured.

Knowing the general trauma history of a refugee population, such as women being raped or civil wars, allowed participants to have an understanding of potential influences or causes of the patient's health complaint. Participant 8 illustrated:

"One preventative health screening for women, the pap smears. It's helpful for me as a provider to know that there's a higher likelihood that this is a patient who's come from an area where rape was used as a means of suppression among the population. Just for any patient to know, obviously we try to take the same care for dignity but there may be additional trauma that is provoked by that and it's helpful to be aware of that beforehand to talk that through and maybe this needs to take place over a series of appointments as oppose to one appointment to make it less traumatic for the patient. So that information is helpful."

Some refugees don't identify as having trauma even though, overall refugees experience trauma a minimum of three separate times, 1) during the time in the country they fled from 2) the refugee camp or other refuge process 3) relocating to a new country, can also aid healthcare providers to identify pressing mental health issues in refugee patients. Participant 2 supported and expressed:

"First and foremost, all refugees have trauma. Whether they know they have trauma or not, that's up to research. But most of them don't identify as having trauma because they don't know that it's trauma and so it's up to us, as professionals to help them figure that piece out and then there's also so much stigma with the refugee population."

Participants also found it significant to know about the refugee camp culture and environment (if they went to a refugee camp) to put patient medical and health details into context. Healthcare providers can recognize what refugee patients were potentially exposed to, the conditions, diseases, and healthcare structure. Recognition of refugee camp conditions can allow healthcare providers to determine potential root causes or influences patient conditions. Participant 5 explained:

“There’s a lot of exposure to different kinds of diseases and by the time they get here though, most of them have been treated. But you still have to pay attention because they could get treated and they go back to the refugee camp before they come here, they already drinking out of the same water from the refugee camp while using the same cup in the refugee camp. They get reinfected. So there’s a lot of problems with the stomach, stomach problem among the refugee population and part of that is the food. They not use to the food here. And then the other one is, some of them come with some parasites and you have to take care of that. So you have to make sure how long they’ve been here? Have they been treated? Do they have diarrhea? Do they have this?”

Participants also stated the importance of understanding past healthcare utilization to further understand the medical history of refugee patients and what healthcare services refugee patients have not utilized. An issue that came up during four different participants interviews was the reoccurring issue of refugees who have had the BCG vaccine, the vaccine for tuberculosis, and PPD skin tests that come back positive. Refugees are then put on the extensive tuberculosis treatment when many do not have active tuberculosis.

“And also, immunization history. That’s also a big one. Like we use to have BCG immunization in Asia and in Africa also, I think. So those people who come from Asia, we have like a mark here. So it’s one of the difference. They still are confusing. They said they did get a shot from prevent TB back when they were young but why they still have to take the medication even though they don’t have the disease. Because when we come here, they check the skin test, so if they found that they have some. So depend on the site of the swelling, they gave the medication but some people think that “oh, they got a shot, they got a shot when they were young and they are not even sick, even in the x-ray it’s fine but why they have to take medication for 9 months, for no reason. People have been asking me “Why we have to get a flu shot all the time, every year, even though we’re not sick.” And some of the other people told me that “when we got the flu shot every year, we still get sick, runny nose, flu-like symptoms.” So at the time, I have to explain to them again that there are different kinds of strains in the flu virus so it doesn’t cover all the strains of the flu virus. Like those are the examples that I see, especially in the community.”

Another historical factor participants articulated as being significant for healthcare providers to find out about is the familiar context. Most refugees come from collective societies where familial relationships are very tight. Participants wanted to ask refugee patients about their current and past family dynamics, if they are willing to share, and where certain family members are currently residing to quickly assess the familial context and any potential stress.

"I want to know where their elders are in their family. I want to know if they're back in their country of origin. It makes a huge difference if all of the family has gotten here safely. It's just like a blessing. Like women will say to me, they have been burned severely, they've seen all of this death, but so and so have made it, you know, which has given them strength, they can start a family again here."

Lastly, occupational history was a factor that participants felt should not be left out. This information informs healthcare providers about potential past hazards and exposure that have implications on one's current health.

"Occupational history is a good one. You can ask what did they do back in Burma. There's a lot of like diseases still related to like occupations."

Cultural Factors

There is a wealth of cultures and factors that are influenced by culture that it is impractical to learn everything about every culture that patients identify with. Participants offered eight different cultural factors that could provide a framework of factors to observe for, perform additional research, and appropriately ask. In addition, every participant agreed that cultural factors are significant in providing equitable and holistic healthcare to refugee patients. Cultural factors are significant due to the cultural differences within the refugee population, how culture is tied directly and indirectly into medicine, and can start the trust between the patient and provider. Participant 5 described:

"So if I know the country they are coming from, I probably know most of the cultures there. Whatever they believe in and things like that. So you want to know what their religion is, what cultural beliefs they do, because it's all tied to medicine you know. Because if you don't know what their beliefs are back home, their traditions, you might miss something. You know, like people coming from Bhutan or Nepal or Philippines, Somalis, South Sudan. I mean, all these people have different beliefs and different traditions and so you have to pay attention to that in order to take care of it...listen and pay attention to their cultural background because somebody coming from Bhutan is

different from coming from Somalia. They're totally different. Description of medical conditions can be totally different and we have to pay attention to not labeling patients being psychotic or something like that because they describe something like seeing something or feeling something that's not there, you know. These are pretty typical things in Africa or other parts of the world, people use."

The eight cultural factors that participants reported as significant for healthcare providers to understand were autonomy, country of origin, language, religion, values, view of healthcare providers, and relationship norms. Patient autonomy refers to the independence patients have regarding decision making. Participant 6 suggested the importance of understanding the implications of collective societies (which most refugees are from), medical treatment preferences, and decision making. Implications of patient autonomy preferences include legal implications and responding to a situation where autonomy and different cultures are not congruent:

"So one of the things that are sometimes challenging is sometimes, some societies have healthcare decisions that are made by group decision, not an individual person's decision. That does not intersect well with the American legal society. So there has to be one encounter per one patient and that patient gets billed for it and then we have HIPAA, which is healthcare privacy, which is fine, but the situation that will sometimes come up is, in a society that makes decisions by group, grandma is the patient and she gets some terminal illness or something and we're asking what her wishes are. So I would be asking what are your wishes surrounding this and culturally she might defer to the 50ish year old or 40ish year old adult child that is making the decision. Which everyone is allowed to defer any decision they want but it has to be clear, you know, Respecting patient autonomy, in a way that sometimes is uncomfortable for the patient's family unit. You have to say these things so...so that's a difficult intersection. If there is any cultural understanding of autonomy versus not...unautonomy or group decision making, that would be helpful to know. Whether or not, generally speaking, every patient is different, if groups want to generally know diagnosis or the degree to which they want to know diagnosis, if we have some understanding of that."

When patient autonomy preferences are not met or understood, other implications include lack of follow up because autonomy preference was not respected, whether intentionally or not. Participant 13 speaks to how they notice a healthcare provider seeks to understand the cultural factor like religion and how that affects patient autonomy preferences, it allows patients to be comfortable and ultimately continue to return to the healthcare facility for healthcare services.

“Also that we are communicating with the proper person who get to make the decision in the family. Sometimes, I know with some of our Muslim families, the decision isn’t necessarily made by the mom, and maybe the dad has to make that decision or we involve more than one person in the family so it’s very difficult sometimes to know that if mom brings child, is the mom the one that gets to make that decision. Or do we need...and we have to ask. Do we need to talk to somebody else? Do we need to invite an elder? However, this family, their culture makes their decisions. Those are things that we kind of have learned to make the hard way because we will have set up a treatment plan and a treatment schedule and nobody shows up and nobody shows up because somebody outside of our circle that we were speaking with says no and we don’t know that.”

With the diversity of refugee patients, it’s significant to know the country of origin refugee patients are from. This information could provide cues to historical factors, other culture factors, such as language and diet, and past healthcare utilization factors, which all impacts health. Participant 5 said:

“Listen and pay attention to their cultural background because somebody coming from Bhutan is different from coming from Somalia. They’re totally different.”

Understanding country of origin can be a predictor of understanding of the language preference refugee patients have. Language being a major barrier in receiving healthcare, participants needed to know refugee patients’ language preference(s) to serve them appropriately.

Participant 7 describes the process of communicating with refugee patients and how the first task is to understand their language level:

“First of all, we try to find out their grasp of English. And then if they don’t speak English or they don’t speak it well and they need an interpreter. First you have to be able to communicate and then if we can’t find an interpreter and they can speak a little English, then they have to go into health literacy mode and be able to say in the simplest terms what you’re trying to get across to the family and then you basically go into nursing. “tell me what I told you” and some people would be offended. “well, I understand” I said “no, I just want to make sure because this is important stuff, especially when you’re talking to diabetics or people with hypertension” I say, because you know you are fortunate because you can speak your language and a little English. I can only speak English.”

Majority of participants referenced religion as an important cultural factor to know or ask because it could provide insight to other patient preferences, like diet, traditional practices, and gender norms. One participants recommended keeping the conversation about religion as neutral as possible.

Participant 1, 4, and 8 respectively and differently stated how being aware of refugee patients' religious background impacts their healthcare.

"Sometime, I'll ask their preferred religious background or if they have ...sometimes I'll keep it really just neutral and like 'do you have a religious background or do you come from a religious background'"

"Religion is important as far as how that affects their health because some people definitely believe the healer is what's going to help them as oppose to medicine, so obviously that plays in."

"Religion because especially after Muslim babies are born, the dad needs to be the first voice the baby hears. He usually sings a song, a blessing. And if its, you know some Asian babies, they don't want you to touch their head, you know. That's very important things. So these things will need to be known. The interpreters will sometime help but you need to directly ask. Is there a special plan that you have, especially around childbirth?"

With each culture, different values are instilled. Participants recommended healthcare providers understanding the values their refugee patients hold to better grasp how they ultimately influence patient health goals, which affects patient compliance to recommendations and treatment, as suggested by participant 6, 9, and 4 respectively:

"The first thing to know is what exactly do people think so with each different group that we work with, everyone has a different set of priorities and goals and motivators. Every individual person has their own but also it's in the subtext of the culture and society that the patient is finding themselves in. So kind of get at some of that information. Sometimes, I've worked with groups enough that I have a little bit of a feel but sometimes I don't, so I try to ask what things are important to you."

"So, yeah, we also have to understand we didn't have the same emphasis on routine dental care that we did so just really trying to educate about good home care, brushing every night and understand that they're not going to turn, flip the light switch and "oh, I'm going start brushing every single day" no. We have to sensitive to that. Where they came from is different, different values."

"And just not believing in pills are the right way...asking them what their beliefs are in our system because obviously, if they don't believe pills are the right way, then giving them four pills in a visit, one, that's already hard on Americans, isn't the right answer because then they're not going to take them. And then that's not going to help anything."

Participants also understood that there are healthcare practices and traditions that are important to refugee patients and it's trying to either incorporate their practices and traditions (i.e. traditional

medicines), understanding the complexity of practices and traditions that should or should not be compromised (i.e. betel nut chewing), and educating patients on when practices and traditions have to be compromised (i.e. female mutilation). Participants 8 and 9 spoke to these humbling, yet difficult positions:

“Incorporating medications in a way that really can also honor their life long use of herbs and traditional healing and some of their traditional healing is quite effective. So, I’ll go into the store and ask, I want to see what’s going on. You know, I need to understand about the cupping. I need to understand about some of the things with respect...Well, you know because of gentile mutilation, that’s a big one for me as a nurse midwife. I just really try to be so good about never creating another cut or tear getting those babies out of those circumcsions. And most of the ones that I see are grade 2 or 3 which are really severe circumcsions. And that talk has to happen then again to them, that we don’t circumcise children, girl children here. Most of the immigrants and refugees I work with don’t circumcise their boys either which is really an easy thing. You can just say we don’t circumcise our children. But that topic has to be addressed and you never know until you do that first pelvic exam, you know when you’re doing that initial pregnancy exam.”

“So I’m sure you’ve heard about the beetle nut chewing. So that is obviously...we do not recommend that because it creates a terrible stain that we have to clean off and we have to spend so long cleaning off because it’s super tenacious. I would say behavior. I think it’s kind of like a tobacco chew as I understand it. It kind of makes them kind of ...I don’t know, it’s like euphoric or something. Anyway, so that would be obviously trying to be sensitive to that and we won’t ...it’s more so even than smoking. We always advise not to smoke but I don’t as much in the refugee population because I know that they have had like a different experience and I don’t know how ...it’s hard for me to understand how important it is in their culture versus like, I know I grew up here. I know that smoking, I know how that is in our culture. I don’t know how it is in their culture so that I try and leave alone. Yeah, I don’t know whether that’s good or bad. I mean sometimes we’ll even see like the kids with the beetle nut stain and it’s just like, how is that even like ok. I don’t know! Because here, smoking is, 18 or whatever you can buy cigarettes, kids, little kids, like five or six years old, it’s like obviously, hopefully, you won’t see them smoking but in their culture, it’s just something that they just do.”

Refugees coming from a different culture compared to the Western culture, their perception of healthcare providers are different as well. Healthcare providers are generally regarded very highly by refugee patients. Participants have noticed the immense gratefulness and respect, however, with refugee patients’ timidity, their willingness to agree with everything healthcare providers say or ask should concern healthcare providers. Provider 9 speaks to the concern:

“So it’s just very, very different and as I understand, in their culture, they are very like... people who have education are sometimes more highly regarded. So I feel like

sometimes they might not feel like we're the same, on the same level but really we are. We're all God's people, we're all the same. So I feel like, and obviously they've never shared this with me but I feel like they just respect me like... I just feel like they would have a hard time imagining that we're the same. But they've never shared that. I would just kind of feel that from the way they respect me and talk to me and it's really, really nice, but I want them to feel like we are the same. I am the same as them. So, I don't know, I just feel like, yeah, because of where we come from... I was born and raised here and I have had this much education and they've had a completely different experience in their life so we just have very different backgrounds. For them to think like "oh, I'm going to connect with this lady who's telling me that I need all of this treatment so I don't know but like I said, they seem to be very, very respectful. And that's really nice. Kind of whatever I say is really ok with them, whether that be good or bad. I try to present all sides of the coin to them to help them decide but sometimes they're just like 'oh, whatever, whatever you think is best!'"

Participants reported significant cultural norms regarding relationships that are significant to know, ask, understand, and be accommodating as possible. For example, gender norms between the patient, provider, and interpreter and physical touch need to be considered when working with refugee patients. Participant 10 and 13, respectively provided supporting evidence:

"And if they're female, most prefer female providers that are female. If they're male, they like a male provider. Especially older women, older men. You know, even American older women and men."

"I think it's learning, we learn the hard way some things that are taboo. Touching women, touching a man in a different culture, shaking hands. Just reaching out and shaking hands with someone or as a woman, me shaking hands with some of the men, some of the fathers that come in. They will not touch and most of the time, it's because we are friendly and we touch people and those types of things are, I am more well aware of those things too. Those are kind of a little bit, not big picture items as far as healthcare but I think when you get through some of those initial social norms, how to have a conversation. Do they look you in the eye when they talk to you? That doesn't mean they're not listening. You know, so learning those things."

All participants reported the significance of asking about refugee patients' diet during a patient visit to understand what certain foods might affect their health conditions and how to work with their diets to treat health conditions. Participants suggest that nutrition is probably the most important cultural factor to refugee health. Healthcare providers should find understanding in refugee patients' current diet and cooperate with it when working with treatment plans to ensure compliance. Participant 1 and 8 provide more insight on how different diets influences refugee health.

“So just kind of finding ways to reset or recalibrate your own expectations maybe, going in to a setting and then you know, learning about foods they typically... refugees especially typically eat the foods that they ate for forever and ever so if you understand that, that helps you with diabetic management and helps you...they’re not going to go eat fruits and vegetables if they don’t eat fruits and vegetables in their predominate culture.”

“Well, nutritionally, you really do have to get into diet and understanding what people are doing, especially these moms who are use to not eating because they’re feeding their kids first. They feed the men first, kids, and themselves. Especially with hypertension, I have to really have a jaded eye out looking at these really skinny, fit women, women who are fit with this severe hypertension. And one thing I’ve discovered is in Haiti, and in Africa, the very same thing, they use these magic cubes for seasoning that has tons of sodium so that’s sort of, we have to switch around herbs and spices on that and they know spices so that’s good. But women put under their tongue a grain of salt to assuage hunger. And if you don’t ask and kind of figure out that habit, you’re going to miss something that attributes to their hypertension that could be a long-learned habit because of hunger, poverty and hunger.”

Participants also reported witnessing a paradox among refugees, where they come from poor conditions and diet but when they come to a developed western country and accustom themselves to the western diet, it leaves refugees with poorer health. Healthcare providers should be aware of this paradox and ensure they discuss with their refugee patients about their diet to understand additional context of their health. Participant 7 uncovered:

“Well, there are basic things that you should ask every patient, but it’s important with refugees. Diet is one. There’s some people especially the Sudanese and some the Karen were pretty healthy until they came here and they started eating McDonalds and then I’ll ask them about their diet but then I’ll also have to ask them ‘What is that? What is that made of?’ There are some that basically who had like a vegetarian diet. They got here and started eating red meat and they’re talking about gout and things like that.”

Lastly, participants stated social behaviors as a cultural factor that was significant to caring for refugee patients. Asking about cultural social habits and preferences can provide insight into health conditions. Participant 11 shares some examples of social history and habits that need to be asked:

“I think social history is a good one, like their drinking habits, smoking habits, betel chewing habits. They are good ones.”

Healthcare Utilization Factors

All participants agreed that there is significance in understanding past healthcare utilization factors of refugee patients. Participants were experienced working with refugees, they were able to notice how

refugee patients utilize healthcare and realize the considerable impact that has their refugee patients' health. Participant 6 explains how helpful healthcare utilization information is to them, especially to start the conversation with the patient appropriately:

"It's helpful for me. If I know, for instance, when I, it helps the in-room time if I know somebody is coming from kind of a first world type model care like Syrian refugees. Syria is a first world country and they're going to be well versed, generally speaking, in colonoscopy, preventative medicine, things like that. So I know going into it, if somebody was raised in that environment, I can expect some degree of health literacy. All though, that should be assessed on an individual basis versus when I get camp records. This particular group has come from this camp, where they've only had access to camp medical care for 20 years, if I have an 18 year old patient, then I can speculate they were born in the camp and probably have never had any access or understanding of preventative medicine whatsoever. They only have acute care, which is basically just illnesses so and not chronic illnesses either. Knowing that sort of background is helpful before I go into kind of start the conversation."

Participants reported eight different healthcare utilization factors, which included many barriers that should be considered when treating refugee patients. These factors include compliance, past healthcare services utilization, health literacy, healthcare utilization trends and preferences, language, time, cost, and daily logistics. Many of these factors root from cultural factors. Participants also observed the lack of understanding refugee patients have with the healthcare system. Having minimal health literacy knowledge leads refugee patients to not have full comprehension of their initial eight months of Medicaid coverage and other healthcare services too, especially preventative services. This also leads refugee patients not taking advantage of the resources appropriately and utilizing healthcare services.

Participants 1 and 6 discussed about the health literacy concern:

"The utilization is really sparse, I guess is a good word, just because there's not good ways to access it or good ways to get there. And maybe not an understanding of the importance of it or how their Medicaid works or Medicare. Whatever it is that they're on for those months. It's really difficult for them to figure that out kind of quickly."

"Some refugee groups also don't have a good understanding of when to see primary care versus when to see the ER. Appointments, I go see primary care but if I don't have an appointment, then I go to the ER, but they're not understanding that's for higher acuity care so they're utilizing the healthcare system in not in the best way for that reason. Also, some refugee groups don't have a good understanding of preventative medicine so they underutilize or take less advantage of it even after explaining. Sometime the explanation, depending on their health literacy level, is difficult to assess"

whether they're understanding. But they tend to underutilize preventative medicine compared to other groups too, so all for a number of factors."

Participants reported a dichotomy of healthcare utilization trends and preferences in refugee patients: underutilization and the overutilization. Underutilization may be caused by different barriers, such as cost and the undervalue of healthcare, especially preventative care. Participants 4 and 10 talked about the underutilization trend they noticed in their refugee patients.

"I've seen most refugees come in for acute illnesses, not preventative, because I don't think, you know, they're not use to that. Basically, they don't have that push for preventing."

"In general, they just don't like going to the doctors unless something becomes so serious, they really do not care for it."

Participants also observed high utilization or overutilization of healthcare services, which may stem from having healthcare be more accessible now compared to where refugee patients came from. Participants 5 and 14 spoke to this effect:

"Well, you know, you have to remember that refugees come from countries that are really impoverished so medical care is like a luxury. And so they're not use to that. A lot of them are not use to it. They will either overuse it because every little thing that they get, they will just run to the doctor. Every little thing they just run to the doctor because now they have access to the doctor."

*"They'll take any vaccine you'll give them because in their home countries, they don't have that available. 'You telling me I need a flu shot?' *finger snap* they're getting it right away. Tell them they need a vaccine, they're here immediately."*

Understanding past medical treatments and appointments can provide important details to what type of healthcare services refugee patients have utilized, what healthcare services they do not utilize, and how healthcare providers can play a role in assisting refugee patients utilize healthcare services appropriately. Participants 8 and 9 found understanding past healthcare services utilization to be critical to their practice:

"The important things that I want to hear about, I want to see their immigration paperwork that a TB tine has been done, some of the basic testings because I don't want to ever redo any of that. And I want to know, I want to get for women especially a detailed obstetric history because it will give you an idea of how many babies they've had, how many babies they've lost and what their abilities have been to keep children

alive in these x-rated. When I see a woman who has 5 or 6 pregnancies and all of her children are alive, it's like how did you do that?"

"So it's always important to know kind of, from a dental perspective, like where the patient has come from dentally. Whether they have been to the dentist, whether they've never been to the dentist, whether they've had oral hygiene instruction, whether they haven't had that. I understand some of the intake when they come here, we have a little bit of like personal grooming lessons for them. And maybe they might learn how to brush their teeth, but other than that, basically, I just want to know what type of homecare they're doing at home and whether they have been, you know, ever had a full dental checkup. And that goes for every patient too but it's more important in a refugee population."

Examining compliance as a factor, participants reported a contrasting dyad: 1) there is a lack of compliance from refugee patients and 2) refugee patients are the most compliant patients. Participant 9 observed how value influences low compliance in refugees utilizing healthcare, specifically in dental and that education plays a big role when values become critical barriers.

"So I would say less compliance. I think that they don't have, in my experience, we have a perception of dental health care. You know, we want really white, bright smile, beautiful teeth and I find that that's not always the case there. I think they are probably more likely to see treatment when they're in pain rather than routine care. It just wasn't something was prevalent in where they came from. They probably didn't have access to it so yes, I would say less compliance and I find a lot of time if you recommend something like even if it's like a really small cavity. "Oh, I recommend a filling for this tooth" and then they'll be, oh can I just pull the tooth?" So it's like a big jump. It's like your tooth is really healthy, it just have a small cavity and it's happened a couple different times "can you just take the tooth". Frequently, they'll say, "I'm going to leave it alone because it's bothers me" So until it bothers, it's not something that they jump into. The second thing is "can we just take the tooth out." And so it's just like maybe not valuing the teeth as much as we do here in our culture? Which has been interesting. I've had to catch myself a couple times, "oh, you just had a really, really small filling" "Well, can you just take it out because I don't want the filling." Then maybe they don't understand what the filling is or maybe really, they just don't want to have the filling. Maybe they just want the tooth out. There's lots of patient education in working with the refugee population."

Other participants detect that noncompliance to utilizing healthcare services stems from barriers and a lack of understanding and education that does not allow them to be compliant patients. Participants 1 and 14 respectively reported:

"With refugees in particular, I feel like, they generally are noncompliant but most of the time it's because they don't understand well enough what is happening. Like somebody

just gave them some pills and was like, 'hey, take these.' And maybe didn't take time to explain them or help them understand why it's important to take them."

"Nobody wants to be noncompliant with a chronic disease or any type of illness. Because we have latent TB, diabetes, hypertension, and maybe they'll only do a couple months of latent TB therapy and that's it and come back and maybe try to do a couple more. I always try to train my physicians to be... why and caution them, especially with latent TB therapies. What's preventing them from getting here. You know, so they can start teasing through that. Same with chronic diseases as far as if they're uncontrolled, and very, very uncontrolled, there is a reason. I also force my physicians to ask the question, why is it. Is it transportation? Is it the affordability of medication? Did they lose their insurance? Those are huge pieces to why people are not compliant. I really try to train our physicians, nobody's noncompliant. I mean, nobody wants to be noncompliant. There's always some factor backing that so here we do, not that we're great, we do try to do a better job of asking the questions as to help tease through some of that uncontrolled problem."

Participants who noticed high compliance deduced it being from the cultural high respect and trust refugee patients have in healthcare providers. Participant 7 and 13 respectively, saw this in their practice:

"I do know that once they commit, I can't even think of one that's never missed a follow up appointment. And then they're very grateful, bringing us little things from their countries or food and stuff. Of course, again, we don't charge and so "I've got to give you something" It's a sense of "I don't want you to give me something for free and so they're very grateful. Probably more grateful than the people in the community."

"The amazing thing I've found about the refugee population is they are very trusting of medical professionals so they ...we don't get a lot of push back as far as the treatment we would like...What I notice, especially with the refugees who come from the Burma area, those patients that we've had are very compliant with, we get our Medicaid and we need to go to the dentist. That's just kind of boom, boom. I'm just kind of utterly amazed on how they find ways to get to see us. We have a very low appointment fail rate with the refugees from the Burma, Thailand area. It's amazing to me. By nature, our clinic, we have a very high Medicaid population and by nature, the Medicaid population, we tend to have a high appointment fail rate. That's just kind of the nature of that situation."

Participants described language as a factor in refugee patients utilizing healthcare. For example, the serious implications from language barriers such as misdiagnoses, refugee patients not seeking healthcare services in a timely manner, and healthcare providers not being able to explain diagnoses directly. Participant 5 describe how language is a factor for refugee patients utilizing healthcare:

“Well, I think the first thing is language. A lot of them have difficulty with language. But even if...with the language, the way they describe things is a little bit different. You know, you have to pay close attention. Don’t go by what an American or European would tell you about a medical condition because they are not going to describe it the same way. For example, somebody who...let’s say a woman in menopause might describe hot flashes as blood running from her head to the toe. She feels like this blood running all over. And so if you don’t pay attention, I have had a lot of refugees here labeled as depressed or having psychotic delusions and things like that because they’d describe certain things and then those things would be misinterpreted as “you know what, it looks like they’re crazy” but it’s not craziness and then they get put on anti-psychotics or antidepressants and then they even get worse.

Time was another factor participants reported that affects refugee patients utilizing healthcare is time.

Refugee patients need more time in an appointment in order to build trust, work with the interpreters, and culturally, so they don’t feel rushed and undervalued. Participant 12 explains:

“And I think a big part of other cultures is that you spend a little bit of time to just talking. Just “how are you?” you know, “what’s going on in your life?” Or whatever it might be, just to get a little bit of back and forth conversation going and not talking about anything serious in the beginning but just setting the tone of let’s just get to know each other a little bit. That’s hard to do in our healthcare system because every minute counts. For insurance at times and all of that but as much as possible, I feel like that is so important because that’s what they’re use to. That’s what they feel. That’s what a lot of them have come from. Where if they go to seek medical help, it’s expected it’s going to take awhile. And so for us to be in a hurry to get right to the serious stuff is very foreign to them and could seem very rude and very unexpected and that could cause them to shut up and to shut down. So I think just taking that time to just shoot the breeze, you know. It seems so foreign to us but so important to them.”

Cost was another factor participants reflected to be a significant factor that impacts refugee patients utilizing healthcare. Refugee patients come to their refuge home with no income and are presented with many barriers to increase their socioeconomic status. Participant 10 explain how cost and their low paying jobs prevent refugee patients from utilizing healthcare, even when it is needed most:

“There are refugee patients who have died of heart attack but never wanted to go to the hospital because he thought if he went, they’re going to ask for health insurance. They’re going to ask for money, which is not something they’re use to back in the country. He has gone to the hospital before and he had to pay for it and didn’t have the money.”

Lastly, participants stressed the idea of respecting the daily barriers that arise as refugees accommodate in a new home. Participants 4 and 13 describe how these daily logistics that can be taken for granted are

very unfamiliar to refugees as they try to utilize healthcare but manage work commitments, childcare, and transportation at the same time.

“Or really, in this case, we’re making them wait for very long periods of time. And they have other obligations. They have kids. They have, you know, a ride that they had to get and so I think all of that, transportation. You know, respecting what they’re doing in their everyday life. Maybe they’re missing work in order to see you and so if you don’t...so that’s just another thing.”

“Really understanding other barriers besides language. The transportation, work schedules. A lot of...I’ve noticed our refugees are...the patients that we serve, the parents, one person works one shift, the other person works another shift, so it’s to avoid having to do daycare and it’s difficult if someone is either sleeping or working, as one or the other, to try and find when can someone come to the doctor’s office or for a dental appointment. We’ve found that a lot of times, God love them, they come anyway. Whether they’re tired...they’ll sleep in the waiting room while their child is back for their appointment or whatever.”

Discussion

Historical, cultural, and healthcare utilization factors were found to all be interconnected and influenced by one another. Factors may not be observed independently, but instead together as a cohesive framework. From this study, healthcare providers can have an understanding of the significance of specifically historical, cultural, and healthcare utilization factors that impact refugee health as well as educate themselves on the specific factors within historical, cultural, and healthcare utilization factors.

In addition, through this study two main overarching motifs presented itself: 1) the need for healthcare providers to continuously be educated on the populations they serve and 2) most of these factors can be and should be applied to all patients. The need for healthcare to continuously be educated on the populations they serve lends itself to the theme of *“you don’t know what you don’t know.”* The factors that were found in this study can be used as part of a framework to understand the cues and questions to observe and ask when working with patients. In addition, multiple times, participants stated that the factors that were uncovered through this study should be relevant to every

patient healthcare providers care for. The applicability of this framework part can potentially be generalized all patients.

Recommendations

1. Listen and ask:

According to a medical school book "Principles of Internal Medicine, Kasper and colleagues (2014) suggest that any event related by a patient, however trivial or seemingly irrelevant, may provide the key to solving the medical problem. In addition, generally only patients who feel comfortable with the physician will offer complete information; thus putting the patient at ease to the greatest extent possible contributes substantially to obtaining an adequate history.

"I'm asking all types of questions to figure out where they're at so I will, gosh, I ask all types of questions. I don't have a particular list, I just kind of do the interview and based on that interview, kind of where that leads me."

"Ask them, "what do you do in a situation like this at home? Where you come from, how would you address this?" Then they will tell you how they will address it. How they can address that issue and then you tie it into medicine."

2. Build trust:

The act of asking about the different factors provides the healthcare provider with an opportunity to establish an ideal patient-physician relationship. This process helps the healthcare provider develop an appreciation of the patient's view of the illness, the patient's expectations, and the different implications of the illness for the patient.

"I think the main thing, and I do this with all my clients, is connect with my client. I want a connection. I want to know if you have brothers, sisters. I want to know what is that between us that we can connect. You can tell me you have two brothers and a sister and I can tell you the same thing. I have two brothers and a sister and this is my favorite dish. Just connect. Think of things that bring connection between you and your client."

3. Be respectful of the experiences refugee patients have endured and are enduring:

Recognizing the refugee journey and how it does not stop once refugees resettle, but affects their everyday lives can allow healthcare providers to be more effective in working with refugee patients.

“Be accommodating because a lot of them have issues, transportation issues. They don’t have that much money so it’s very tough for them. Whenever you get the chance to come and try to get their things get taken care of.”

“I always tell the staff and volunteers that come here is that we have to be nonjudgmental and not a glorified rescuer.”

4. Have a team and community based approach to alleviate barriers:

Create a team to meet the various unique needs refugee patients may face. Resist duplicating resources that already exist and utilize current community resources to assuage public health barriers.

“The interpretation piece adds so much to the time frame they’re able to see patients so that is also hard when you have 15-20 minute time frame to see a patient and you have to get out and you have six patients down the way. So another thing that we do here is if a physician is working with a patient and sees diabetes, noncompliant, uncontrolled, is what I’ll get. So they’ll often send us, nurse care coordinators in and then we work through.”

“Programs in the community are great if you can refer. Making sure you understand that you’ll never be able to get anything done and utilizing the resources that are out there and trying to partner has a huge thing too.”

5. Utilize tangible tools:

Tangible tools such as an immunization card can assist healthcare providers to track past medical history and healthcare utilization to prevent redoing healthcare services. Tangible tools such as maps to ask about patients’ background can provide insight to the refugee patient’s level of literacy and start a connection with the patient by getting to know the patient.

“Initially when they arrive to the United States, they have to have a card or something like that. Something that all the things that are being done to them can be recorded and saying “here, you carry this with you wherever you go.” So that way, the doctors will know because they don’t know how to keep records. We don’t have medical records in Africa. We don’t keep that. So they don’t have time to keep track of who they... sometimes they don’t even remember who their doctor is. So yeah, it’s really important to know what has been done to them.”

“I use a map because it shows that I really want to hear and know and it also gives me an idea of their educational background and preparation. So if they have no idea at all where on the map they’re from, then you have an idea of how I need to redirect a little bit of my teaching.”

6. Utilize teach-back method:

Utilizing teach-back method among refugee patients in order to make sure communication has been effective, especially with language barriers and timidity that leads to mindless agreement.

“You basically go into nursing. “tell me what I told you” and some people would be offended. “well, I understand” I said “no, I just want to make sure because this is important stuff, especially when you’re talking to diabetics or people with hypertension” I say, because you know you are fortunate because you can speak your language and a little English. I can only speak English.”

7. Utilize in-person interpreters as cultural liaisons:

Utilizing interpreters as more than their word-for-word interpreting skills but as cultural liaisons.

Healthcare providers providing interpreters with that permission could provide invaluable information.

Even asking the interpreter what their thoughts are on the patient to provide cultural factors that might influence refugee patients’ health, or having the interpreters do training to learn about their culture.

“I think listening to the interpreters. Talking with the interpreters. Not necessarily specifically about the patient but about their culture because they obviously...they’re interpreting for their culture people, their culture for the most part but they’re also intermixed enough with us Americans that they see things in appointments and so what has gotten to me before in clinics is that interpreters are only there to interpret the word and nothing else. But there’s a lot of information interpreters can give us that I think it’s important to listen to. Really, it’s important to listen to everybody’s opinion because somebody might say something that may trigger you to ask something else. And so I don’t know that there’s ...because yeah, there’s a lot of very reserve cultures and even if you ask vague questions, they wouldn’t answer them. And so there’s really no way to know with those people. But interpreters who are use to talking with us and they see what we ask, they have so much to give, much more than just interpreting the words but interpreting the culture as well.”

Future Directions

1. Interview refugee patients to understand what historical, cultural, and healthcare utilization factors are important to them. Being able to compare both the refugee patient and healthcare providers’ point of view can create a more comprehensive and inclusive framework.
2. Research on patient intake forms and healthcare providers notes form to explore how comprehensive and inclusive they are to include historical, cultural, and healthcare utilization factors that healthcare providers reported as important. This could provide a revised framework for healthcare providers to use on every patient to capture significant patient information that would impact their health.

3. Quantitative research on identified factors and their weight of significance of each factor.

Limitation

Considering the limited population of this study and the wide breadth of this study, saturation was not necessarily reached. Also, because of time constraints of the project, it limits the ability to collect a larger sample size, even with a limited population of refugee-experienced healthcare providers to interview. In addition, only the principle investigator analyzed the qualitative data.

Conclusions

In summary, participants agreed historical factors to be significant but have to consider the potential retraumatizing possibility. Five factors were identified: trauma history, refugee camp context, healthcare utilization history, familial context, and occupational history. Participants agreed cultural factors were significant and identified ten impacting factors: autonomy, country of origin, language, religion, values, healthcare practices and traditions, relationship norms, diet, and social behavior. Participant also agreed healthcare utilization factors are important if it can be uncovered. Eight factors were identified: healthcare utilization trends and preferences, past healthcare services, utilization, compliance, health literacy, language, time, cost, and daily logistics. Participants provided many recommendations to treat refugee patients equitably and holistically and future directions to further validate the study and address current barriers and issues.

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Service Learning/Capstone Experience Reflection

I wanted my Service Learning/Capstone Experience (SL/CE) to take a community-needs approach and that the research would lead itself to be translational for practical implementation. When I first met with my preceptor to discuss potential service learning projects, one project was to create a survey to administer to medical residents to see if the refugee healthcare binder would be useful. After reaching out to multiple contacts and people, only a handful responded, however, from that survey, yielded my research question. One survey question asked “In your opinion, what historical, cultural, and service level information would be helpful when specifically assessing a refugee patient?” Receiving minimal survey responses and finding interest and value in this question, I decided to look into closing this gap of knowledge through my SL/CE.

The refugee health binder for healthcare providers is a project I work closely with another student in the MD/MPH program. He developed a draft of the one-pager of information for a refugee patient from the Democratic Republic of Congo. It contained historical information like wars, priority health conditions, views of western medicine, cultural beliefs, and resources. He had informally asked his medical preceptors about the draft and had positive feedback that he was on the right track and that it would be something very useful. When I came onto the project, there were nine other main country of origins left to do research to develop these one-pagers of information. Researching the information was quite overwhelming as there as a significant amount of material and trying to critically decide which materials were significant. We are currently adding more materials after an initial draft was looked at from my preceptor and we’re going to verify the information with refugees from the community next.

During conversations with my participants, they were excited about the binder and thought it would be useful. There was a suggestion of turning it into an app. Another suggestion was including it in the hospital cultural competency orientation training. Overall, there was positive feedback for the binder. This project allowed me to learn new resources and information about the main refugee

communities living in Nebraska. I learned to work a multilevel and -disciplinary project, how to be discretionary on information to include, and how to write concise information for the one-pagers.

Yates Community Center is a very special place that not many cities have a place for adults to continue learning. Since OPS does not support adult education, Yates is an approach where Omaha can reach adults from the aspect of when we educate the parent, the student can have a better chance of success in school. I have learned and enjoyed the lower-bureaucratic style Yates exhibits. It allows projects to move quicker and according to the relevant time of the community needs compared to research or academia where there may be many administrative steps and barriers that when working with community partners to help them reach their needs, the time line is too slow for them and once results are collected, they are no longer relevant. For example, my preceptor saw a need of creating videos of refugees talking about the healthcare system from their perspective. She told me her idea and the next day we started working on it. This project may have had to go through many more hoops in a different organization. Yates may operate this way because meeting the needs of their students is more significant than being completely systematic, especially because when working with refugees and their culture, it requires flexibility, patience, and being understanding of the experiences refugees endure.

Working at Yates Community Center, I had the opportunity to set up guest speakers for their Friday Cultural Orientation class. Before the summer ended, a meeting was conducted between me, Alana, Veronica (the lead teacher at Yates), and Joe (the new social worker at Yates), to ensure we were all on the same page for the goal of the semester and how we'd reach our goal through our guest speakers. We wanted to focus on health and law issues that have been identified as pertinent issues through the cases Joe and Alana would get called to assist on. Topics were settled on child welfare, positive police interactions, scams, mental health, and winter care to name a few. It was inspiring reaching out to different community partners such as the Omaha Police Department, Better Homes and Gardens Real Estate, Charles Drew Health Center, how open and willing they were to speak and present

to Yates students. The presentation was very well attended and students have been very receptive of the speakers. They ask questions and show emotions and engagement. It seems like Yates is providing good information during Cultural Orientation class. The speakers that we have come present were strategically planned time-wise and topic-wise according to the needs the teachers saw of their students. I believe this is what has made Cultural Orientation class successful and students continue to attend week after week.

During Friday sessions, I would meet the guest speaker, assist the guest speaker to set up, assure classes were taking their breaks, ensuring interpreters were there and available, introducing the speaker, monitoring the room for logistical needs, such as chairs, and asked critical questions of the speaker. Cultural orientation class is an option for Yates students, however, Alana mentioned that this year, the cultural orientation class has been the largest yet, as she's seen it. The students seem to be really engaged and interested in the topics and ask very important questions so it has been rewarding to see the students appreciate the weekly presentations, in hopes that they are informative and impactful.

Having worked on another refugee health literacy project previously, I also had the opportunity to utilize my past research and input it into the website project. Finding materials for the website exciting because I was able to identify, convene, and populate the information in a centralized area. This is exciting because having a library of information available for refugees and people who work with refugees can close so many barriers. Logistical barriers of lack of time and too much effort and impact barriers of education and awareness. Though it was exciting, the overload of information did also get exhausting to sort through and manage on the website. As we are working on the website, there were some technical issues with the formatting of the site. Through a previous project, I had worked with Do Space, a local digital library and was able to make an appointment to meet with a mentor to provide me with some new tools to troubleshoot the website.

In training healthcare providers, refugee leaders are often asked to come speak at meetings and trainings in high demand. However, it is often inconvenient for refugee leaders, as well as little to no compensation for their time to educate healthcare professionals. Alana had the idea to create videos, which will be accessible through the website, starring different refugee leaders sharing about the healthcare system back in their home country and different determinants of health that affects their refugee community specifically that is significant to share to healthcare providers. I also had the opportunity to perform some administrative duties for the Refugee Health Collaborative. I set up meeting rooms, email reminders, help set up monthly speakers, assist to put together the agenda, etc. I also had the opportunity to do a strategic planning session with the collaborative to re-examine our mission and goals, determine our vision, and find our strengths, weaknesses, opportunities, and challenges. We are still working with the entire RHC to gain more input into the strategic plan, but I was happy to see our mission, vision, and goals be revised to reflect the work we do and will inspire to continue future work.

In regards to the Refugee Health Collaborative, I've learned how appropriate the ecological model is and having everyone represented at the collaborative meetings is important. I learned that even though the RHC is voluntary for the members, the members are so passionate about serving refugees, they take the time out of their jobs to be a part of the RHC and in sub-committees. The RHC being not a part of any specific organization, there is a lot of freedom in the organization in some areas. As mentioned earlier, my new refugee video project is something my preceptor thought of and we have the freedom to just do it. The RHC not being part of any specific organization has its barriers, such as no streamline of funding unless it is applied for through the RHC, and the work the RHC does is all unpaid work, so the passion is there to get the work done, however, the work can be easily pushed aside as it is not anyone's main priority. For example, one expectation I had was that I would have a completed refugee healthcare binder by the end of the semester. However, when working as a team in a voluntary

committee, sometimes other things takes priorities and rightfully so. I plan on learning how to use Adobe Illustrator to finish the refugee health binder.

Something that I also didn't expect was all the different project ideas my preceptor, which was great, however it was also challenging. As someone who has learned how to multitask at a very young age, multitasking multiple projects from one organization was very difficult. Usually, I tackle the easiest task first and I have to finish it through before starting on the next easiest task. However, during my SL/CS, projects had overlapping timelines and had similar levels of difficulty that it's been challenging than have one project during the same amount of time. To overcome this challenge, I've accepted that my time and effort can only provide so much output and I've told my preceptor that I plan to continue to work on all my projects after graduation to see them through completion.

Another challenge that I faced was filtering through the abundance of qualitative data and then coding and analyzing the data. Having previously worked with qualitative data informally and not having been formally educated on the subject matter, the amount of data and work ahead was daunting and overwhelming. To overcome this challenge, I had the assistance of my committee chair and faculty committee member to provide some recommendations, as well as articles and lectures that could inform me on analyzing qualitative data appropriately.

A significant unknown for me during my SL/CE was how many participants I would recruit from the limited population of refugee-experience healthcare providers. From the original 13 participants that were identified, after inviting them for interviews, ten accepted and four were a result of the snowball sampling, to obtain a final total of 14 participants. During my time interviewing the participants, I tried my best to never lead on my participants. However, many participants told me that they had wished they had the interview questions before the interview to think answers. I responded that I had questions that that succeeding questions that could lead on participants to answer in a biased

manner. In addition, I also wanted to know the answer participants were thinking right on top of their heads for the most relevant and significant answers.

There were many resources, relationships, and skill that enabled the activities to grow in fruition. The teachers as Yates were cultural liaisons. They spoke multiple languages, taught English classes, and interpreted for the Friday Cultural Orientation classes. The teachers made the students feel comfortable during the Friday speakers to ask questions and engage with the presentation. Another resource that was used and will continue to be used is Do Space, the Omaha digital library. I used their mentoring services to receive assistance with working with Word Press for the refugee website. I learned what I need to learn as well as some additional coding tricks. In addition, my preceptor's relationships with refugee-experienced healthcare providers permitted my project to be successful as it was with more than the target sample size we originally estimated for.

My views of public health practice since starting my SL/CE has widen to understand some of the barriers why public health outcomes are difficult to reach. However, I've also learned that there are a plethora of ideas that are waiting to be implementing and put into public health practice. Overall, on all the multiple projects I've had the opportunity to contribute and lead, they required me to be resourceful and a continual learner, which I think adheres to the unknown for the future of public health. I'm so grateful for where all the different projects led me to learn how public health practice can be creative but also involve research. I like to call it creative research.

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Thank you to the healthcare providers that took time and effort to share their invaluable insights. The data gathered from their input is what drives future projections and recommendations for equitable and holistic care for refugees. This project would also not be possible without the valuable time, commitment, and insights from my committee chair, Jungyoon (JY) Kim, my committee faculty, Shannon Maloney, and my preceptor, Alana Schriver. Each member of my committee contributed such unique and significant qualities to this project. JY and her study design and critical thinking skills to push me to analyze my research. Shannon and her expertise in qualitative studies and analysis that aided in the development of the study materials. Alana and her passion and wisdom about refugees and the resources to coordinate refugee health projects and programs provided me the opportunity to be involved in innumerable projects. I look forward to continue them.

Appendices

Main Focus	Probe For
1. In order to provide holistic care, what kind of information do you need to know about a patient?	Historical, cultural, healthcare utilization
2. Describe how it might be different if the patient was a refugee? What do you need to know about a refugee patient in addition?	Historical, cultural, healthcare utilization
3. Tell me more about some of the things that make it challenging for a patient to connect to a healthcare provider?	Historical, cultural factors
4. What would be different if the patient was a refugee?	Specific factors within the 3 domains
5. Can you tell me about the differences refugee experiences with using healthcare/how they use healthcare? Explain.	health care utilization
6. Tell me about your experiences in working with refugee patients.	-3 domains -Are they a refugee themselves -Clarify what refugee population they work with most -how much do the provider understand about their patient's background
6b (back-up question). Can you tell me a specific story or challenge that you faced and how did you manage that when working with a refugee patient?	The 3 domains and specific factors
7. In general, what do you think are the most relevant factors that a provider needs to know about the experiences of a refugee or the experiences they face?	Historical, cultural, healthcare utilization
7b (back-up question). In your opinion, what impacts refugee health?	The 3 domains and specific factors
7c (back-up question). Based on what you know about the refugee journey on how they leave and how they got here, in your opinion, what impacts refugee health?	Historical

Appendix A: Interview guide

Appendix B: Pre-interview Questionnaire

Thank you for participating in this important study! Your responses will provide such valuable information to assist the healthcare system and our refugee population.

1. What type of organization do you currently provide healthcare services for?
 - a. Federally Qualified Health Center
 - b. Large Health System
 - c. Privately-owned Clinic
 - d. Other (please specify)

2. What services are provided in the department/clinic you currently work in? (Select all that apply)
 - a. Dental
 - b. Family Medicine
 - c. Internal Medicine
 - d. Mental Health
 - e. Pediatrics
 - f. Urgent care
 - g. Women's Health
 - h. Other (please specify)

3. What is your occupation?
 - a. Advanced Practice Registered Nurse
 - b. Dental Hygienist
 - c. Licensed Practical Nurse
 - d. Mental Health Counselor
 - e. Midwife
 - f. Psychiatrist
 - g. Physician
 - h. Physician's Assistant
 - i. Psychologist
 - j. Registered Nurse
 - k. Therapist
 - l. Other (please specify)

4. How many years have you been practicing in your current occupation?
 - a. less than 5
 - b. 5-10
 - c. more than 10

5. What is the total number of physicians employed in your department/clinic?
 - a. under 10
 - b. 11-50
 - c. over 50
6. What is your average daily patient caseload?
 - a. 0-10
 - b. 11-20
 - c. 21-30
 - d. 31-40
 - e. 41-50
 - f. 51-60
 - g. 61 or more
7. Estimate the percentage of the patient caseload whom you know are refugees accessing your department/clinic in the past 12 months.
 - a. 0-25%
 - b. 26-50%
 - c. 51-75%
 - d. 76-100%
8. What countries are the refugee patients you work with from? (Select all that apply)
 - a. Afghanistan
 - b. Bhutan
 - c. Burma
 - d. Burundi
 - e. Democratic Republic of Congo
 - f. Iraq
 - g. Somalia
 - h. Sudan
 - i. South Sudan
 - j. Syria
 - k. Other (please specify)