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Culturally Effective Care for Refugee Populations: Interprofessional, Interactive Case Studies

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Abstract

Introduction: Within health sciences education literature, the majority of reported student experiences with refugee populations are limited to traditional, professionally independent, elective courses and extracurricular volunteer opportunities. A simulated patient exercise is a learning opportunity that helps participants engage with material in real time in a realistic environment, demanding higher levels of learning. This session utilized a simulated patient facilitator in interprofessional small groups to explore common health needs and barriers to care among refugee populations. **Methods:** Health professions students from nine degree programs participated in a refugee health session in interprofessional teams of nine to 10 students to explore patient cases. The session concluded with a debriefing discussing the outcomes of the student-patient interaction, best practices, and exemplary practice models as takeaways. The simulated patient facilitators completed an Observation Checklist to assess students' grasp of learning objectives. **Results:** Five hundred twenty-four students participated in the refugee session, divided into 61 groups. Observation Checklists were completed for 58 groups (95%). Assessment of student engagement focused on general health needs common to refugee populations: barriers to health care, team and individual roles, bias, consequences of nontreatment, and social determinants of health. Most of the groups (95%) reported engagement between the simulated patient facilitator and the group of student providers. Qualitative data indicated student groups were knowledgeable in each of the overarching learning objectives. **Discussion:** This session allowed health sciences students to focus on culturally effective patient care for refugee populations as a part of an interprofessional team.

Keywords

Interprofessional, Cultural Competency, Interprofessional Relations, Culturally Competent Care, Refugee Health, Simulation Based

Appendices

- CECS Refugee Simulated Patient Facilitator Guide .docx
- CECS Facilitator Training Postsurvey and Results .docx
- Breakout Session Flowchart.xlsx
- Refugee Summative Presentation.pptx
- Breakout Session Observation Checklist.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this session, learners will be able to:

- Discuss common health needs among refugee populations.
- Recognize the influence of social determinants of health on the health of refugee individuals and populations.
- Identify barriers to health care in refugee populations.
- Discuss professional roles in refugee patient/client care.
- Demonstrate interprofessional engagement.

Introduction

Across the globe, homogeneous populations rarely exist, while the presence of refugee and migrant populations is ubiquitous. Global international migration is projected to double to more than 400 million by 2050.¹ Inherent in those populations are unique health needs. An international Delphi consensus was developed and utilized an extensive survey to prioritize the needs and challenges for building responsive systems for refugees, migrants, and groups affected by migration. Survey participants uncovered the

following priority indicators: health inequities, system discrimination, health data, and considerations for disadvantaged nonmigrant populations and migrant subgroups.² As globalization broadens its reach across the world, addressing health care needs for all is a concern for human rights, public health, and the professional social responsibility of health care providers. Human rights standards declare that “all people have an equal right to the highest attainable standard of physical and mental health, which includes access not only to health care, but to the underlying determinants of good health.”³

The future health care workforce should be trained in culturally effective care to best serve the needs of refugee populations and ameliorate barriers to care.⁴ The American Academy of Pediatrics has defined culturally effective care as “the delivery of care within the context of appropriate physician knowledge, and an understanding and appreciation of cultural distinctions leading to optimal health outcomes.”⁵ Practicing culturally effective care includes an understanding of the social determinants of health (i.e., economic stability, education, social and community context, health and health care, and neighborhood and built environment)⁶ for the populations providers serve. Within the medical education literature, the majority of reported student experiences with refugee populations are limited to elective courses and extracurricular volunteer opportunities.^{4,7-10} Therefore, additional emphasis needs to be placed into the required curriculum for health professionals, in alignment with barriers, factors, and contributors to health outside of physical health.

Pedagogical Framework

Simulated exercises, as alternatives to lecture-based, instructor-centric training models, are learning opportunities that help participants engage with material in real time and in a realistic environment, demanding higher levels of learning.¹¹ This pedagogical framework utilizes both social cognitive and constructivist learning theories in order to achieve learning objectives. Bandura defined social cognitive theory as people learning “vicariously through observing the experiences of others.”¹² Through observation, constructivism builds knowledge structures into a set of rules and norms based on the behavior and environment experienced in a social setting.^{11,12} This set of rules then guides future actions and becomes learned behavior.¹²

Across the literature, social cognitive theory and constructivism support more progressive efforts in learning and are especially salient when focusing on the topics of cultural competency and diversity. This is important as these topics may engender conflict in groups where there is an imbalance of heterogeneity.¹³ Heterogeneity of thought is emphasized in constructivism, as participants engage in social and cultural interpretation, exploring participant identities, and developing knowledge processes along the way.¹⁴ However, without social interaction, the opportunity to explore diversity and conflict resolution is at a disadvantage. Respectfully exploring relationships, cultural norms, and the facing of adversity is difficult to accomplish with the traditional instructivist, lecture-based approach.¹¹ The interactive refugee session described here utilizes concepts of constructivism and social cognitive theory.

Culturally Effective Care Symposium

Each year, the University of Louisville Health Sciences Center Office of Diversity and Inclusion (HSCODI) provides a campus-wide symposium focused on culturally effective care. The symposium is composed of learners from multiple degree programs, including DMD, MD, AuD, BS Nursing, BS Dental Hygiene, PharmD, MS Nursing, MPH, and MS Social Work. The goal of the symposium is to provide instruction and interprofessional foundational experiences in culturally effective care to equip future health professionals in achieving optimal patient care. During the symposium, interprofessional student teams rotate through two distinct breakout sessions focused on lesbian, gay, bisexual, and transgender (LGBT) health equity¹⁵ and refugee health.

In addition to providing cultural competency training for the care of refugee populations, this session is conducted in an interprofessional manner, meeting multiple educational requirements of professional accreditation bodies. The Interprofessional Education Collaborative¹⁶ and other accreditation bodies have called on health profession programs to provide students with interprofessional education experiences. Large, case-based, educational forums are a feasible method for introducing interprofessional education.¹⁷

While there are existing interprofessional educational initiatives addressing refugee health in the clinical environment^{18,19} and elective courses,²⁰ this session serves as a foundational experience that can be implemented in the preclinical years. The purpose of this session is to use simulated patient facilitators in small groups to explore various health professional roles and identify common health needs and barriers to care among refugee populations.

Methods

Session Development

This session was developed through the Culturally Effective Care Symposium (CECS) programming subcommittee, consisting of faculty and staff from multiple health science disciplines, in spring 2016. Learning objectives were developed to lead the content, and specific focus was placed on an interactive learning experience using simulated patient cases. To accomplish this, facilitators were recruited from the university and the community to support the session, which simulated patient cases based on refugee populations in the U.S. The facilitators' role-playing of identities that they did not hold could have posed risks to those represented, including reinforcing stereotypes, upholding incorrect assumptions, and generalizing single cases across entire populations. In an effort to address this risk, the session was introduced by a short presentation and disclosure about respecting the integrity and dignity of the populations represented, which stated that the facilitators were not intended to portray, generalize, or stereotype a certain population but rather to represent a patient case study with an interactive component.

The HSCODI works with University of Louisville health sciences schools to reflect and put into action tools to achieve health equity by reenvisioning their educational framework, exploring a more complete research agenda, enriching the clinical experience, and deepening community-involvement opportunities for students, staff, and faculty. Over the past 4 years, the HSCODI has worked with university and community partners to establish new health equity curricular initiatives within each of the four health sciences schools. The School of Medicine Global Health Program, a project partner, operates the Refugee Health and Immunization program, providing patient-centered care for refugees. Services include health screenings and assessments, vaccines, and health education tailored to the unique cultural and linguistic needs of refugees. Thus, these two organizations were uniquely positioned not only to develop and implement this content but also to recruit and train university and community partners to serve as small-group facilitators.

Session Logistics

Two identical morning and afternoon sessions were offered for this refugee health seminar in order to serve the large number of student attendees. Each session contained 31 interprofessional student teams of nine to 10 students, approximately 300 students total. This was necessary due to facility limitations and facilitator availability. The other half of the group attended a session focused on LGBT health. Prior to the breakouts, all students went through an orientation session that covered safe zone building and group norms to use throughout the day. One simulated patient facilitator was assigned to each team. Four weeks prior to the symposium, the students were randomly preassigned to interprofessional teams. Students were distributed in teams based on their percentage of representation in the entire group (i.e., if 20% of participants were medical students, then two medical students were assigned to each team).

A flowchart (Appendix C) outlines the sequence of this 1.5-hour session and the time allotted to each section. The session began with a presentation (10 minutes) by a community member who shared his/her individual journey as a refugee. The session was guided by a PowerPoint presentation (Appendix D), which included a short presentation (15 minutes) by a local health care professional, a basic overview of culturally and linguistically appropriate services,²¹ the expectations of the breakout session, and the case introductions. Although directions were minimal, students were instructed to "explore the health and social history, share your role in the U.S. health care system and how you can serve this patient, and counsel the patient on their concerns with their health and barriers to accessing care" (Appendix D, slide 11). The presentation also provided brief descriptions of the two cases: a Cuban male refugee recently diagnosed

with HIV and an Iraqi female refugee recently arrived with her two sons from Baghdad who was experiencing mental distress (Appendix D, slide 11). Limiting the information provided to the students prior to this exercise was intended to facilitate dialogue and prevent making every step explicitly clear. This approach followed social constructivism and social cognitive theory, where knowledge is created from the collective experience of the group, without prior instruction.^{11,12}

The students engaged with their simulated patient facilitator to explore the patient's medical and social history and identify their role in the patient's care. The students were able to connect to others in the treatment team network and explore health disparities, social determinants of health, and systems barriers that refugees may face. If the students were unable to start the conversation independently, the simulated patient facilitator would ask them probing questions to catalyze discussion.

The session concluded with a debriefing (30 minutes) that discussed the outcomes of the student-patient interaction and included best practices and exemplary care models as takeaways. During the large-group feedback portion of the seminar, three questions were posed to the groups:

- What was the main challenge for this patient?
- What assumptions were made about this patient?
- What barriers were you able to resolve?

The large-group debrief was a synthesis of social constructivism, where students harnessed prior knowledge within the group to create new knowledge from the interactive experience. Providing this feedback is considered across the literature to be most valued in interactive, simulated learning activities.²²⁻²⁴ This debriefing session is where the learning experience results in knowledge and skill acquisition from the group, instead of only the individual.²⁵ Apart from the large-group debriefing, several small groups also had the opportunity to debrief among themselves as time permitted. Reference materials, including terminology and exemplary practice models presented in this session, were made available for use online after the symposium and via QR scans posted around the conference area.

Simulated Patient Facilitators

The purpose of the facilitator was to both simulate a refugee patient case and lead small interprofessional groups of nine to 10 students in exploring the patient's health and social history. The student participants examined professional roles in the U.S. health care system and counseled the patients on their health concerns and barriers of access to care. With the facilitators simulating the patient cases, there was a personal aspect added to the case study, and the students were able to interact and engage with a human story in the first person.

The simulated patient facilitators consisted of those who had significant experience with refugees and/or were experienced health care providers in the community. Facilitators were recruited as volunteers with the following self-appraised parameters: ability to manage and facilitate small-group discussions in critical thinking, comfort in facilitating difficult conversations, working knowledge of issues related to health equity (i.e., social determinants of health), and experience working in interprofessional health care teams. Working together, the HSCODI and the School of Medicine Global Health Program were able to recruit 31 facilitators from the university and the community to support this session. For the session, the facilitators represented various professional backgrounds, with five representatives from refugee resettlement agencies, four from a local managed care organization, two from community organizations, and 20 faculty from the schools of medicine, dentistry, nursing, pharmacy, and social work.

The programming subcommittee also made facilitator training a priority in order to improve student engagement and achieve learning and knowledge objectives. A mandatory 2-hour simulated patient facilitator training was held 1 week prior to the symposium. Simulated patient facilitators were provided with a comprehensive training guide (Appendix A) that included a summary of health disparities and social determinants of health, case blueprints, and the Observation Checklist. This guide calibrated the facilitator to simulate the patient case, ask probing questions, and debrief.²² The guide was an important tool during the training, and facilitators were encouraged to review content and study the patient cases after the

session. In order for the facilitator to simulate the patient case studies, the patient profiles were emphasized in the training. This aspect put a face on the refugee patient, which many students had not engaged with at this point in their professional career. This simulated patient design provided an interactive learning opportunity and was exercised in both the facilitator training and the small-group seminar.²³ To ensure proper training of facilitators and to gather feedback, a posttraining survey was administered (Appendix B). For successful implementation, logistics of the learning event needed to be clear, organized, and communicated to facilitators during the training session. Without proper explanation of the learning theories and sequencing, it was difficult to achieve buy-in.

Data Collection

During each session, the facilitators completed the breakout session Observation Checklist (Appendix E). Specific items on the checklist were designed to measure the learning objectives. Facilitators were asked to identify those students in attendance by indicating the number of students per category at the beginning of the session and, at the end, to identify the number of students who remained engaged throughout the session. Some disciplines had more students attend than others, and the facilitators were trained to indicate the number of students by discipline, which was easily identified on the student name tags.

Data Analysis

The quantitative data analysis consisted of a frequency count of binary yes/no answers, with the option of selecting N/A. This was supported by the qualitative comment areas available for each question. The level of engagement was also measured by calculating the difference between the numbers indicated on the first and last questions on the Observation Checklist, which asked first which students were physically present and last which students remained engaged throughout the session. The qualitative content analysis of the written comments was conducted by a single coder using peer debriefers to enhance reliability and ensure validity. Preassigned codes were based on the learning objectives to guide the content analysis. The written responses were coded and quantified by categorical frequency.

Results

Participant Fields

The 2016 symposium included learners from nine health sciences degree programs (DMD, MD, AuD, BS Nursing, BS Dental Hygiene, PharmD, MS Nursing, MPH, and MS Social Work), for a total of 524 participants. A breakdown of participants is presented in [Table 1](#). The majority of participants were in the first year and semester of their respective degree programs. For BS Nursing and BS Dental Hygiene students, the third year was actually the first year of their major curriculum. All students were required to attend the symposium as part of their curriculum with the exception of MS Social Work and MPH students. As these students attended on a voluntary basis, year in their programs varied.

Table 1. 2016 Session Participants (N = 524) by Program

Program	No. of Participants	Academic Year	Required Curriculum?
MD	162	1	Yes
DMD	120	1	Yes
BS Dental Hygiene	30	3	Yes
AuD	10	1	Yes
MS Nursing	11	1	Yes
PharmD	86	1	Yes
BS Nursing	89	3	Yes
MS Social Work	9	varied	No
MPH	7	varied	No

Observation Checklist

Fifty-eight Observation Checklists (95%) were returned out of 61 groups for the refugee sessions. [Table 2](#) illustrates what knowledge the small groups were able to produce in the 40-minute active time between the patient and the group of providers. The Observation Checklists reported overall engagement at 95%.

Table 2. Performance of Student Groups (N = 58) as Rated Using the Observation Checklist

Item	No. (%)		
	Yes	No	N/A
The students discussed general health needs common to refugee populations.	45 (79)	10 (18)	2 (4)
The students identified barriers to accessing care for this patient.	58 (100)	0 (0)	0 (0)
The students were able to work together to break down barriers to accessing care.	52 (91)	4 (7)	1 (2)
All students discussed their role as a health care professional in this patient's care.	52 (91)	6 (10)	0 (0)
Students identified bias or assumptions in their exploration of this patient's case.	43 (75)	10 (18)	4 (7)
Students were able to discuss the consequences of not treating this patient as a health care team.	36 (65)	10 (18)	9 (16)
Students articulated health disparities or social determinants of health for this patient (i.e., health, social, environmental conditions that affect overall well-being).	48 (86)	6 (11)	2 (4)
Total	334 (84)	46 (12)	18 (5)

Analysis of the written Observation Checklist comments revealed main categorical themes of social determinants of health, health care, techniques, and engagement. Each main theme contained specific subcategories. Twenty-nine percent of all comments related to the social determinants of health, with subcategories of social support, adjustment, transportation, language, culture, health beliefs, literacy, education, insurance and cost, stress, and barriers. The theme of health care represented 28% of all comments, with subcategories consisting of health systems, provider roles, nutrition, patient needs, public health concern, and preventive care. Twenty-three percent of comments focused on techniques, with subcategories of appointments, resources, referrals, trust and rapport, listening, coordinating care, patient communication, social support resources, family integrated care, legal, and social work. Engagement was found in 20% of all comments, with subcategories of teamwork and participation. The top three themes, social determinants of health, health care, and techniques, constituted 80% of the comments, indicating that the students engaged with the overarching learning objectives for the session. Furthermore, a wide range of topics was discussed among the groups, as indicated by the variety of subcategories.

Discussion

The learning objectives focused on health disparities, social determinants of health, barriers, and techniques for serving refugee populations. The themes and content as evidenced by the Observation Checklist demonstrated that the refugee breakout session met the learning objectives. Students were able to discuss a variety of contributions to their patient's overall health. The small groups covered a variety of topics related to the patient cases in a short amount of time. Students were able to interact with the exercise to the extent of meeting learning objectives. Finally, they maintained a 95% engagement rate, which met the programming committee's primary goal. This measure demonstrated the effectiveness of the interactive CECS refugee breakout session using simulated patients.

The most impactful quantitative measure was the engagement factor. As the tool measured the difference between which students were present at the beginning and which students were engaged throughout the session, facilitators were able to measure student participation in their small groups. The 95% engagement rate is a positive indication that this simulation-based approach achieved its objective in student engagement.

The trained facilitators were able to engage their students on the difficult subject of refugee health and worked together through collective experience to access prior knowledge and problem-solve for the patient. This exercise utilized social cognitive theory to pull experience out of a group and social constructivism to create new knowledge from the collective intelligence of the group.^{11,12} The facilitators were able to simulate refugee patients, the students connected with the patients to dive deeper into their needs, and the small groups were able to debrief with the large group about challenges, assumptions, and barriers that refugees face in the U.S. health care system. In essence, the simulated patient facilitators brought the refugee patient cases to life for the small groups, implementing social constructivism and social cognitive theory and thereby stimulating critical thinking for the benefit of the patients.

Conclusion

Refugee health care manifests in complex medical needs, complex health care systems, and complex cultural challenges, all of which require culturally effective interprofessional care. This learning solution

benefited the students as future health care providers, as well as their future patients, by placing the students in a realistic experience to use in practice. Developing a better trained health care workforce that understands patient needs as well as the systems involved is a small step in promoting refugee health equity. Interpersonal engagement was applicable in the refugee health cases, as the patient case studies were not about merely diagnosing a medical issue but rather connecting with a patient on a personal level. Constructivism and social cognitive learning theories are particularly useful in interpersonal, nontechnical scenarios, which require interaction in order to achieve learning objectives.¹³ This approach was specifically designed into the seminar by training facilitators to simulate patient cases. Because of the social component of these sessions, social determinants of health, as well as cultural, environmental, and social contexts, were influential on the learning outcomes. Students in the small groups interacted directly with both the patient case and their colleagues and explored various implications of providing culturally effective care for refugee populations.

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Ethical Approval

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