The Refugee Health Partnership: A Longitudinal Experiential Medical Student Curriculum in Refugee/Asylee Health

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Abstract

Problem
In 2017, there were 25.4 million refugees worldwide, of whom 33,400 were resettled in the United States. In fiscal year 2016, 20,455 individuals were granted permanent asylum status in the United Sates. Both in the United States and overseas, refugees/asylees face significant disparities in accessing needed medical, mental health, and social support.

Approach
The Refugee Health Partnership (RHP) was developed by Johns Hopkins University School of Medicine students and colleagues at a local refugee resettlement agency in 2011. The program pairs teams of preclinical medical students with recently resettled refugees/asylees who have special health care needs. After receiving training, students conducted monthly home visits and accompanied patients to appointments to assist them in navigating the health care system over one year. Students participated in monthly reflection exercises to process experiences and attended monthly seminars facilitated by expert faculty and guests.

Outcomes
From 2012 to 2016, the RHP served 20 refugee families and engaged 60 students across four cohorts. Refugee participant retention was 20/22 (90.9%), and student retention was 57/60 (95.0%). In surveys completed at the end of their programs, students reported improvement in all measures, including understanding of different patient perspectives as well as comfort in communicating with patients across cultures and language barriers.

Next Steps
The authors plan to integrate more objective measures of students' progress into the evaluations. They are scaling this model up both locally and beyond and plan to gather data from refugee/asylee participants to more accurately assess how they benefit from the program.

Problem

The United Nations defines a refugee as a person who is forced to flee and/or is unable to return to their country of nationality owing to a well-founded fear of persecution.[1] In 2017, there were 25.4 million refugees worldwide.[1] Refugees who cannot return to their home country or remain in the country where they first sought safety may apply for resettlement in a third country. In 2017, only 102,800 (< 1%) refugees were resettled; of these resettled refugees, 33,400 (32.5%) entered the United States.[1] Further, 20,455 individuals were granted permanent asylum status in the United Sates in fiscal year 2016[2]; these individuals came to the United States of their own accord but sought legal asylum after arrival (granted under the same criteria as refugee status).

Refugees/asylees face significant disparities in accessing needed medical, mental health, and social support both overseas and in the United States upon resettlement. Socioeconomic adversity, limited English proficiency, limited provider understanding of their unique needs and of the prevalence of trauma among refugees/asylees, and challenges with communicating across languages and cultures contribute to these disparities.[3,4] In Baltimore, for example, health care providers frequently complained that they were unable to provide interpretation services for refugee/asylee patients despite the federal unfunded mandate requiring them to do so.

The Association of American Medical Colleges' (AAMC's) Core Entrustable Professional Activities for Entering Residency (Core EPAs) include demonstrating sensitivity and responsiveness to socially and culturally diverse patient populations, empowering patients to participate in their care, assessing the impact of psychosocial-cultural influences on health, and advocating for quality patient care systems.[5] Prior to the implementation of the program described below, Johns Hopkins University School of Medicine (JHUSOM) primarily addressed such competencies through a weeklong didactic course on health care disparities at the beginning of the preclinical curriculum. Longitudinal patient partnerships have been proposed as an alternative method of learning, which may cultivate such skills more effectively.[6] Such programs, which allow students to follow individual patients across diverse settings over time, have fostered insight into the social conditions through which patients experience illness, as well as greater knowledge retention.[7–9] Because newly resettled refugees/asylees often require significant assistance with health care navigation, they are well suited to mutually beneficial longitudinal patient partnerships.

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In this Innovation Report, we describe the design and preliminary outcomes from the first five years of a student-driven, faculty-supported longitudinal patient experience and curriculum in refugee/asylee health at JHUSOM, the Refugee Health Partnership (RHP).

Approach

Development of the RHP

We established the RHP in 2011 as a service-based, faculty-supported student group in partnership with a secular, nonprofit local refugee resettlement agency to address unmet needs for additional health advocacy among refugees/asylees in Baltimore and to improve the capacity of medical students to engage in cross-cultural and patient-centered care.

The RHP evolved out of an exploratory conversation between a medical student who had volunteered at the resettlement agency and agency health staff, whose burgeoning caseloads had made providing personalized attention for high-risk clients increasingly difficult. Additional students and agency staff became involved and participated in an iterative, collaborative program design process from June to December 2011. Grant funding was obtained from several sources, and the program was approved by administrators at both the resettlement agency and JHUSOM.

Overview of the RHP program

An executive board—composed of student leaders (new student leaders are chosen each March by the executive board), affiliated faculty, and agency staff—selected cohorts of preclinical medical students each year (mean of 15 students per year for 2012–2016) through a competitive process, in which applicants shared interests and skills that would make them effective advocates for patient partners. The executive board then matched teams of 2 to 4 students to refugee/asylee partner families with special health care needs who agreed to participate in the program. Teams were established based on students' access to transportation, prior experiences, language competency, and refugees'/asylees' gender preferences when applicable. Students participated in the program between January of their first year and December of their second year; the first cohort began in January 2012. The program was completely voluntary and not for credit, though students were asked to commit to a full year of service.

Agency staff provided students with an initial daylong orientation in January, which included an overview of the refugee resettlement process and asylum application process, as well as modules on the use of medical interpreters, cross-cultural communication, and specific health challenges faced by refugees/asylees. For the duration of the program, student teams conducted monthly home visits—during which they focused on relationship building, health literacy, and health system navigation, accompanying patients to health care appointments when possible—and participated in a complementary formal curriculum that included monthly reflection sessions and seminars facilitated by expert faculty and guests (Figure 1). The home visits were initially facilitated by agency staff. Two faculty advisers were available to students via telephone during home visits as needed, as was a care coordinator at the resettlement agency who served as the case manager for the agency's medically complex clients. Refugee/asylee participants were told at the beginning of the program that their relationships would be limited to a year, and this was reinforced by the agency staff before the students' final visit.

Through a literature review, we outlined four major objectives for students at the start of the program, which we have used to organize an overview of our program's design below. An additional objective was to provide refugee/asylee patient partners with health education, mentoring, and advocacy to improve their ability to navigate the U.S. health care system independently. This objective was defined by the resettlement agency and is not formally evaluated in this Innovation Report, which focuses on student outcomes.

Building skills communicating across cultures and languages. As part of their monthly curriculum, students received instruction in the use of interpreters, cross-cultural communication, and refugee/asylee mental health (including trauma-informed care). Students had ample opportunity to practice interpreter-assisted communication during interactions with refugee/asylee families, with interpreters available via telephone or in person. They also observed how interpreters were used during health care appointments and were encouraged to provide constructive feedback to providers directly when appropriate. Beyond reflecting on these interactions in group sessions, students submitted monthly reports to the resettlement agency documenting any concerning interactions observed, which were shared with trusted individuals at the medical centers where the interactions occurred.

Adopting a patient-centered approach to treatment and understanding barriers to care. Refugee/asylee families and students developed joint health literacy goals that they worked to achieve during their monthly visits, adjusting those goals throughout the year on the basis of refugee/asylee family feedback. Students then compared their own experiences with refugee/asylee partners when in their partners' homes versus their observations of their partners' interactions with health care providers in medical centers. In many cases, students assisted their partners in traveling to appointments (e.g., accompanying them on the bus) to help their partners navigate the complex health system. An example case detailing the longitudinal experience between one student team and one refugee partner is available in Supplemental Digital Appendix 1 (at http://links.lww.com/ACADMED/A622). This core experience was supplemented by formal curricular topics, such as seminars on Medicaid, refugee/asylee health policy, and refugee/asylee primary care.

Incorporating narrative medicine. Recognizing the power of narrative medicine—the use of stories to promote healing—in responding to refugee/asylee patients,[10] we aimed to provide students with exposure to refugee/asylee narratives, as well as opportunities to share their own narrative responses to their experiences within the program. In addition to the exchange of personal stories between students and refugee/asylee partners (of note, students were trained not to solicit trauma narratives), students were exposed to an annual refugee speaker, a professional creative writing workshop, a documentary on the stories of refugee/asylee patients, and books on refugee/asylee resilience. Students shared their reactions at

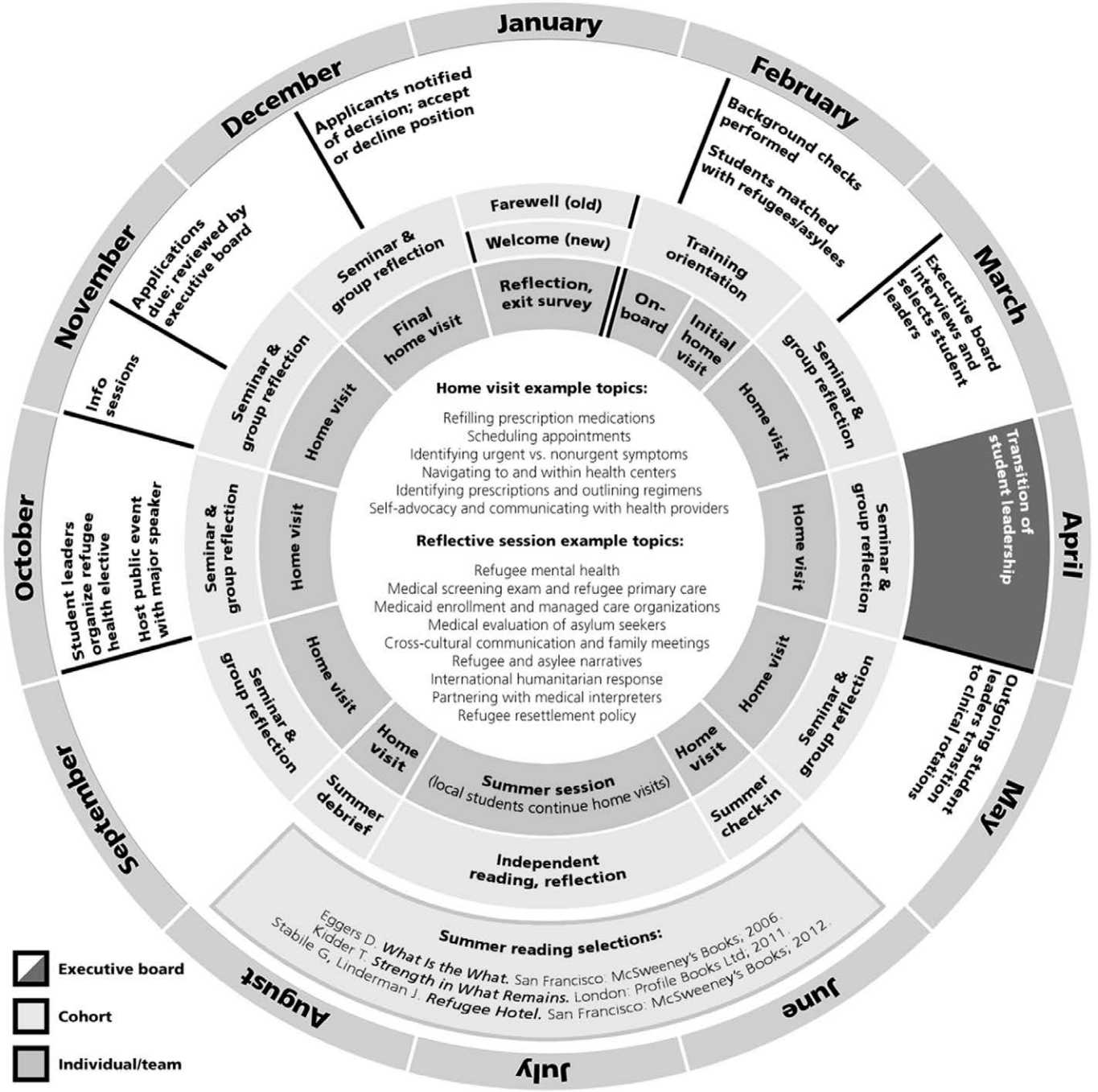

Figure 1 Graphical overview of a typical cohort's progression through the Refugee Health Partnership (RHP) program at Johns Hopkins University School of Medicine, including executive board, cohort, and team or individual student activities. Students participated in the RHP between January of their first year and December of their second year; the first cohort began in January 2012.

monthly reflective sessions and provided written reflections at the end of each semester.

Communicating best practices in treating refugee/asylee patients. Students engaged in two major initiatives to define and communicate best practices in refugee/asylee health each year. Second-year RHP student leaders organized a brief elective course on refugee/asylee health for first-year students at JHUSOM (prior to the selection of the incoming RHP cohort), which focused on the ethical challenges of delivering health care to refugee/asylee patients. Additionally, RHP students collaborated with agency staff to design, publish, and distribute a guide for health care professionals on how to effectively communicate and work with newly resettled refugee/asylee patients. The guide targeted JHUSOM clinicians and medical students and was disseminated by RHP students at clinical practices across Johns Hopkins Medicine.

Evaluating student outcomes

We assessed students' outcomes using anonymous web-based, nonincentivized surveys at the end of their RHP year. In these surveys, students were asked to retrospectively assess their comfort with

a variety of skills at the beginning versus the end of the program (Kirkpatrick level 2a). Self-reported comfort was rated on a five-point Likert scale (where 1 = not at all comfortable and 5 = very comfortable). Students were also asked to what degree their participation in the RHP impacted those skills (Kirkpatrick level 1), using a five-point Likert scale (where 1 = not significantly and 5 = very significantly). Students were further asked to reply to a few open-ended prompts about their experience and how to improve the program.

This study was reviewed by the Johns Hopkins Medicine institutional review board and classified as exempt.

Outcomes

Participant data

From 2012 to 2016, the JHUSOM RHP served 20 families from 15 countries of origin; this number excludes 2 families who began but then moved during the program. Sudan and Bhutan were the most represented countries of origin. The majority of families (17; 85.0%) were from either Africa or the Middle East. Only 1 (5.0%) family had asylee status, with the remainder being refugees (19; 95.0%). Refugee/asylee participant retention was 20/22 (90.9%); if families moved during the program, their student partners were paired with different families.

Sixty students were enrolled in four cohorts from 2012 to 2016; this represented an acceptance rate into the program of 60/70 (85.7%). Students came from a variety of backgrounds, with 10/60 (16.7%) being underrepresented minorities (this included students identifying as black, African American, or Latino) compared with 61/599 (10.2%) underrepresented minorities for a representative student population at JHUSOM (Table 1). The student retention rate was 57/60 (95.0%), and the overall response rate on the postprogram student surveys was 44/60 (73.3%).

Quantitative survey data

Students' self-reported comfort in skills related to refugee/asylee health care provision is described in Supplemental Digital Appendix 2 (at http://links.lww.com/ACADMED/A623). Notably, mean pre- versus postprogram scores improved for all reported measures, including comfort in communicating with patients across cultures (mean increase of 1.11), comfort in communicating with patients across language barriers (mean increase of 1.82), and understanding of different patient perspectives (mean increase of 1.21). Students felt that RHP participation had factored significantly into their subjective improvement in these skills (data shown in Supplemental Digital Appendix 2 at http://links.lww.com/ACADMED/A623).

Table 1

Demographic Profiles of RHP Students From 2012 to 2016 in Comparison With a Representative JHUSOM Student Population (2017–2018)[a] and National Medical Student Populations (2013–2015)

Characteristic	RHP cohorts, 2012–2016	JHUSOM student population, 2017–2018	National average as reported by the AAMC, 2013–2015[b]
Total enrolled students, no.	60[c]	599	61,029
Male, no. (%)	24 (40.0)		31,979 (52.4)[d]
Female, no. (%)	36 (60.0)		29,046 (47.6)[d]
White, no. (%)	24 (40.0)	247 (41.2)	34,977 (57.3)
Black or African American, no. (%)	7 (11.7)	43 (7.2)	3,800 (6.2)
Latino, no. (%)	3 (5.0)	18 (3.0)	5,373 (8.8)
Middle Eastern, no. (%)	6 (10.0)		
Asian or Pacific Islander, no. (%)	20 (33.3)	192 (32.0)	13,305 (21.8)
Underrepresented minorities, no. (%)[e]	10 (16.7)	61 (10.0)	9,173 (15.0)

Abbreviations: RHP indicates Refugee Health Partnership; JHUSOM, Johns Hopkins University School of Medicine; AAMC, Association of American Medical Colleges.
[a]The representative JHUSOM student population included the entire student population across all years of study for one specific year at JHUSOM.
[b]Data for 2012 were not reported.
[c]By year: 2012–2013 (n = 15), 2013–2014 (n = 13), 2014–2015 (n = 14), 2015–2016 (n = 18).
[d]Source: Association of American Medical Colleges. Table A-7.2: Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. Medical Schools by Sex, 2009-2010 through 2018-2019. https://www.aamc.org/download/492954/data/factstablea7_2.pdf. Accessed February 14, 2019.
[e]Underrepresented minorities included individuals identifying as black, African American, or Latino.

Qualitative survey data

Each year, the survey included the following two open-ended prompts: (1) "Please describe how your communication skills have been impacted by the RHP program," and (2) "Please describe how your sense of cultural humility has been impacted by the RHP program." Eight major themes, which are included in Table 2 along with representative quotations, emerged through iterative analysis of the responses to these prompts.

In our 2016 survey, we also solicited suggestions for program improvement. Broadly, suggestions centered around increasing structural guidance and mentorship from faculty, particularly regarding the tumultuous political climate surrounding refugees/asylees, and around improving the program's integration with other services that refugees/asylees are receiving.

Next Steps

We present the RHP as a model of a longitudinal experiential medical student curriculum that shows promise for fostering competency within several AAMC-identified Core EPAs while also providing health education and advocacy to a vulnerable population. Despite being a voluntary, student-driven, not-for-credit pilot program operating on a grant-supported budget, we were able to consistently attract and retain a diverse student group with high engagement, as reflected in students' qualitative feedback. Students reported gains in their comfort communicating across language barriers and cultures, as well as understanding of different patient perspectives, and attributed these to participation in the program.

Although encouraging, our preliminary analysis had several major limitations. First, we assessed both pre- and postprogram skills at the same time (after completion of the program) to ensure the anonymity of participants, but this

Table 2

Emerging Themes and Representative Quotations From Students' Responses to Open-Ended Prompts,[a] Refugee Health Partnership (RHP; First Cohort Began in January 2012), Johns Hopkins University School of Medicine

Theme	Representative quotation (participant ID)[b]
Using clear and precise language	"I gained practice learning to speak with a limited-English proficiency patient, which entailed speaking more slowly, avoiding idioms, figuring out alternative ways to express thoughts, and checking for understanding." (Cohort 3-1805)
Listening actively and seeking to understand	"I have seen how important it is to make eye contact with patients when talking to them, to talk about one topic at a time, to take time to try to understand what a patient is talking about, especially when it seems unconnected to what the provider has asked (it is usually not)." (Cohort 2-0858)
Communicating effectively via interpreters	"Adjusting for communication through an interpreter has made me more aware of the efficiency of my communication—challenged to try and communicate more with fewer words." (Cohort 4-1055)
Appreciating the cultural lenses through which patients experience illness	"I realize that my understanding of what is 'good' for the patient is contextual and based on my cultural context. RHP helped me understand that each encounter involves both the provider and the patient bringing their cultures and biases to the table and that we can work together." (Cohort 1-1643)
Emphasizing physicians' responsibility in patient follow-up	"I am better able to understand how to follow up with patients about what we may have communicated about to ensure that there are no miscommunications." (Cohort 2-0101)
Connecting across language barriers	"RHP has been my most longitudinal patient experience thus far. It has shown me how a health care provider can develop a relationship that extends beyond just caring for one's health … and has taken me from being completely uncomfortable working through a translator to feeling quite comfortable with it." (Cohort 3-1354)
Understanding socioeconomic barriers to care	"It made me recognize just how much of patients' lives we don't see as doctors. I would say 95% of the things our family worried about weren't brought into the clinic. I saw how difficult it was to simply get to an appointment, and how much of a difference consolidating appointments can make. I don't think the doctor treating my family knew their full background and just how much the family had gone through to get where they are today." (Cohort 4-1121)
Valuing patient-centered exposure to the complexity of the U.S. health care system	"RHP opened my eyes to how difficult it is to navigate the U.S. health care system as a refugee. It made me more aware of challenges my patients may face as they seek medical care." (Cohort 4-1251)

[a]The open-ended prompts were "Please describe how your communication skills have been impacted by the RHP program" and "Please describe how your sense of cultural humility has been impacted by the RHP program."

[b]Participant IDs comprise participants' cohort number (cohort 1 = 2012–2013, cohort 2 = 2013–2014, etc.) and the time stamp of their response.

may have created recall bias. Second, there was no control group providing a counterfactual to represent how students' skills may have improved without such a program. Third, our data are based on students' self-reported learning, which may or may not reflect objective measurements—in the future, we plan to integrate more objective measures of students' progress (e.g., performance on standardized patient exams) into our evaluations. Fourth, although our resettlement agency colleagues conducted a set of semistructured interviews with a selection of the refugee/asylee participants for internal program evaluation purposes, it was an ad hoc sample whose data we were unable to include in our analysis because of ethical considerations; thus, the refugee/asylee perspective is not included in this Innovation Report. In future iterations of this program, we plan to build on this innovation by documenting feedback from our refugee/asylee partners through focus groups, individual interviews, and participant surveys that would be translatable across cultures and languages to more accurately assess how they benefit from the program.

We have begun to scale this model up both locally and beyond. For example, our program structure was used to inform an experimental "pathways" program at JHUSOM, through which students were able to design similar interventions with other underserved populations. More recently, students at the Boston University School of Medicine have incorporated elements of our model into the design of a similar program.

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Previous presentations: Pilot results from this program were presented in a poster format at the 4th Annual Osler Center Day, Baltimore, Maryland, April 20, 2012, and in an oral presentation format at the North American Refugee Health Conference, Rochester, New York, June 21, 2014.

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