Promoting Quality Care for Recently Resettled Populations: Curriculum Development for Internal Medicine Residents

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Abstract

Background Residents report they lack preparation for caring for an increasingly diverse US population. In response, a variety of curricula have been developed to integrate cultural competency into medical training programs. To date, none of these curricula has specifically addressed members of recently resettled populations.

Methods A preliminary assessment was conducted among internal medicine (IM) residents at 1 program (N = 147). Based on 2 conceptual frameworks and the survey results, a pilot curriculum was developed and integrated into the interns' ambulatory block education within the general IM track (n = 9). It included (1) online information made available to all hospital staff; (2) 4 interactive didactic sessions; and (3) increased exposure to newly arrived patients. The curriculum was qualitatively evaluated through 2 focus groups.

Results The preliminary assessment was completed by 101 of 147 residents (69%), with 61% of respondents indicating they felt that they received less than adequate education in this area. Eight of the 9 interns exposed to the new curriculum participated in the focus groups. Overall, respondents reported they thought patient care had improved for recently resettled populations and across their patient panels after exposure to the curriculum.

Conclusions This study demonstrated that an intervention that included didactics and enhanced exposure to a diverse population improved IM interns' perceptions of care for all patients, including recently settled individuals.

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Funding: This study was supported in part by grants from the Rhode Island Hospital Graduate Medical Education Committee and the Community Health Department of Brown University.

Conflict of interest: The authors declare they have no competing interests.

Some components of this work were presented as a poster at the American Academy of Family Medicine Global Health Annual Workshop, San Diego, CA, October 13, 2011, and as an oral presentation at the 2012 Northeast Group on Educational Affairs Annual Retreat in Boston, MA, March 23, 2012.

The authors would like to thank Denise Tyler, PhD, Department of Public Health, Health Services Policy and Practice, for guidance and assistance with the qualitative portion of this study; the general Internal Medicine interns for their gracious participation throughout this project; and Matt McLaren, International Institute Refugee Resettlement Program.

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Received May 7, 2013; revisions received October 30, 2013, and December 16, 2013; accepted January 1, 2014.

DOI: http://dx.doi.org/10.4300/JGME-D-13-00170.1

Editor's Note: The online version of this article contains resource sheets used in the study.

Introduction

Approximately 21% of the US population over the age of 5 speaks a language other than English at home.[1] This increasing linguistic and cultural diversity has implications for a health care system already facing significant disparities.[2] For recently resettled populations, defined as those who arrived in the US within the previous 12 months, linguistic and cultural barriers to effective communication between provider and patient appear to be especially pronounced.

Although residents feel qualified to manage the technical aspects of patient care, insufficient formal training and/or lack of strong role models may leave residents poorly prepared to address less tangible aspects of cross-cultural care.[3,4] Thus, residents may struggle to achieve cultural competency, defined by the United States Office of Minority Health as "a set of congruent behaviors [and] attitudes that come together . . . [in order to enable] effective work in cross-cultural situations."[5] Consequences include poor patient satisfaction, longer office visits,

patient nonadherence, delays in obtaining consent, unnecessary testing, and lower quality of care.[2,3,6–8]

In response, some providers have called for integration of cultural competency curricula in medical education.[2,9] Despite the variety of existing curricula,[9] to our knowledge, few target residents, and none target resident preparedness to work with recently resettled populations. Furthermore, many existing articles address the assessment of competency rather than the acquisition of competency.[10,11]

With the goal of improving health care for recently resettled populations in Rhode Island, we (1) assessed internal medicine (IM) residents' preparedness to provide quality care to recently resettled populations; (2) developed a curriculum that addresses Accreditation Council for Graduate Medical Education competencies of professionalism and interpersonal and communication skills; and (3) evaluated this curriculum.

What was known

Residents lack preparation for caring for a diverse US population, including recently resettled patients.

What is new

A pilot curriculum in the general internal medicine interns' ambulatory block encompassed online information about cultural competence, interactive didactics, and enhanced exposure to newly settled populations.

Limitations

Single site and small sample limit generalizability; assessment was limited to perceptions.

Bottom line

The curriculum increased residents' perceived confidence for caring for resettled populations, with the exception of dealing with previous trauma. The curriculum could be readily replicated in other programs.

Methods

There were a total of 147 residents in the IM program during this time, including 27 in the general internal medicine (GIM) track. Although all 147 residents were invited to participate in the initial assessment, the curriculum was piloted and evaluated among the GIM interns only (n = 9). Participation was voluntary, and we obtained written consent.

Assessment Survey Prior to Curriculum Development

We conducted a baseline assessment to better understand provider perceptions of and preparedness for providing care to recently resettled populations. The survey design drew from a literature review and interviews with expert faculty and community members. The survey was initially piloted among 10 IM junior attending physicians and revised accordingly. The final instrument consisted of 17 questions using either the Likert scale or multiple-choice format that related to perceived barriers to care for recently resettled patients; use and effectiveness of 5 modes of interpretation; overall comfort level in working with this population; level of preparedness in conducting 10 population-specific patient care tasks[3]; and previous experiences with preparation for working with recently resettled populations.

Conceptual Framework for Curriculum Development

Cultural competency is a dynamic and controversial concept, and to avoid perpetuating stereotypes and conflating concepts such as culture, race, and patient advocacy,[12] we drew from 2 conceptual frameworks. The first is the notion of cultural humility, in which effective communication necessitates that providers have insight into their own culture rather than simply identifying that of the patients as "other."[13] The second is that of transnational competence, in which competence represents aptitude in 5 distinct skill sets: analytical, emotional, creative, communicative, and functional.[14]

Curriculum Development

Using our survey findings and solicited GIM faculty input, we applied the 2 conceptual frameworks to gaps identified in the survey. We developed a 5-themed curriculum: context, communication, analytical thinking, experience, and advocacy (TABLE 1). Thematic content was delivered through 1 of 3 instructional approaches: (1) online information sheets for providers, (2) didactic sessions, and (3) increased clinical time with recently resettled patients. GIM interns could opt out of the curriculum; all 9 participated.

We designed online resource sheets that provided information about some of the most recent immigrant groups in Rhode Island (provided as online supplemental material). Resource sheets addressed the sociopolitical context of the country of origin; pertinent clinical considerations; relevant local community resources, including places of worship; and a list of books and/or films offering an alternative introduction to the specific community or country. These resources, posted to the hospital intranet site, were available to all hospital staff.

Second, we integrated 3 pilot sessions, each 2 to 3 hours long, into the 36 hours of GIM intern mandatory education on psychosocial medicine. A fourth session, which focused on addressing patients with a history of trauma, was not mandatory. Brief, relevant readings were provided by e-mail before each session. Facilitators included at least 1 GIM faculty member, 1 medical student, and relevant outside speakers.

Finally, a collaborative effort with the Refugee Resettlement Program of the International Institute of Rhode

TABLE 1 **Pilot Curriculum to Prepare General Internal Medicine Residents to Care for Recently Resettled Populations**

Theme (5)	Instructional Approach (3)	Learning Objectives and Curricular Resources
Context	Seminar session 1; faculty plus student facilitators with the IIRI's health care coordinator	1. To become familiar with the design and expectations of the new curriculum 2. To learn more about specific newly resettled populations in Rhode Island 3. To acquire and integrate knowledge of cultural practices that impact clinical care Resources used: ■ See the online version of this article for information sheets
	Development of online information sheets	1. To provide information on sociopolitical context of Rhode Island's immigrant populations
Communication	Seminar session 2; faculty plus student facilitator with 3 professional interpreters	1. To review the interpreter's role and training 2. To use the literature to discuss advantages/disadvantages of different interpreter types 3. To improve the clinical experience with recently resettled patients by learning how to effectively use interpreters and other professional interpreting services Resources used: ■ Schenker Y, et al. Navigating language barriers under difficult circumstances. *Ann Intern Med*. 2008;149(4):264–269. ■ Teal and Street. Critical elements of culturally competent communication in the medical encounter: a review and model. *Soc Sci Med*. 2009;68(3):533–543.
Analytical Thinking	Seminar session 3; faculty plus student facilitator	1. To reflect on the definition of culture, including the culture of medicine, culture as dynamic 2. To discuss the dynamic nature of culture and those experiences that impact one's culture 3. To strengthen awareness about personal culture Resources used: ■ Goldman et al. Cultural self-awareness: a component of culturally responsive patient care. *Ann Behav Sci Med Educ*. 1996;3(1):37–46.
Experience	Increased clinical interaction with recently resettled patients	1. To assign residents incoming refugees in longitudinal clinic, including the initial visit in the United States
Advocacy	Seminar session 1; faculty plus student facilitator and IIRI's health care coordinator	1. To understand the transnational experience and the context with which many people emigrate to the United States (eg, refugee versus undocumented/documented immigrant) Resources used: ■ Lavall J. *Home Across Lands*. Devlo Media; 2009.
	(Optional) Seminar session 4; outside expert speaker	1. To learn basic strategies for addressing previous history of trauma in patients Resources used: ■ Mollica RF. "The Call to Health." In: *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Nashville, TN: Vanderbilt University Press; 2008:188–213. ■ Mollica RF. "Society as Healer." In: *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Nashville, TN: Vanderbilt University Press; 2008.214–240.
	Development of online information sheets	1. To become familiar with local clinical and sociocultural resources (eg, grocery stores, spiritual centers, and others)

Abbreviation: IIRI, International Institute of Rhode Island/Refugee Resettlement Program.

Island (IIRI) generated increased clinical exposure to recently resettled patients. IIRI's health care coordinator worked with a GIM faculty member to schedule newly arriving refugees initial health appointments with a GIM intern who would then follow patients in their longitudinal clinic.

Curriculum Evaluation

Due to the small number of participants, this pilot curriculum was evaluated through 2 semistructured, hour-long focus groups conducted by 2 facilitators not involved in curriculum development or implementation. Sessions were recorded and transcribed by a professional transcription service, omitting identifying information. The template analysis method was used to code transcripts independently by 2 of the authors (S.A. and M.M.).[15] The authors separately reviewed and organized the data, using an initial template that represented the 4 core questions of our evaluation: highlights of the curriculum, areas for improvement, implications for patient care, and future directions. Findings were compared and codes were refined until all discrepancies were resolved.

This study was conducted in 1 IM residency program between January 2011 and June 2012. The institutional review boards of the Warren Alpert Medical School of Brown University and Lifespan, the health care system overseeing the hospitals where the study was conducted, approved the study.

Results

Assessment Survey

The response rate was 69% (101 of 147), with a similar demographic breakdown of the overall residency program. Program years had equal representation.

TABLE 2 **Resident Perceptions of Barriers to Outpatient Care Among Recently Resettled Patient Populations**

Respondents "Agreed" or "Strongly Agreed" With the Following Perceived Barriers to Care	No. of Respondents (%)[a]
Appropriate management of patient's previous trauma	91 (90)
Provider awareness of patient's social norms	90 (89)
Patient's ability to navigate the health care system	88 (87)
Patient's biomedical understanding of illness	84 (83)
Integration of traditional healing practices	81 (80)
Patient adoption of preventive health care practices	75 (74)
Establishment of a long-term provider-patient relationship	74 (73)
Access to professional medical interpreters	70 (69)
Regular patient follow-up	69 (68)
Medication adherence	68 (67)
Insurance coverage for medical care	67 (66)
Transportation to medical facilities	54 (53)

[a] n = 101.

Sixty percent of respondents perceived their training in residency to work with these populations to be only somewhat adequate or not at all adequate, and 30% reported feeling "minimally comfortable" working with recently resettled populations, whereas only 8% felt "very comfortable." TABLE 2 shows residents' perceptions of barriers to care for recently resettled populations, and TABLE 3 shows residents' self-reported preparedness level with various patient care tasks.

Qualitative Curriculum Evaluation

Participants in the 2 voluntary focus groups included 8 of the 9 GIM interns. Three primary themes emerged: (1) perception of overall improved care for recently resettled populations, (2) positive implications for care for all patients, and (3) continued discomfort addressing patients' history of trauma.

In addition, participants emphasized the value of the medical interpreter panel. One offered, "learning from [the

TABLE 3 **Resident Perceptions of Their Ability to Care for Recently Resettled Patients[a]**

Respondents Reported Feeling "Not At All" or "Minimally Prepared" to Conduct the Following Tasks	No. of Respondents (%)[a]
Deliver services effectively through a medical interpreter	8 (8)
Determine how to communicate with an LEP patient	15 (15)
Negotiate key aspects of the treatment plan	16 (16)
Assess a patient's understanding of the cause of his or her illness	20 (20)
Identify how a patient involves his or her family in medical decision making	39 (39)
Identify whether a patient is mistrustful of the health care system	43 (43)
Identify how well a patient can read and write English	65 (64)
Identify cultural customs that might affect clinical care	69 (68)
Address different religious beliefs that may impact health care decision making	78 (77)
Discuss the role of traditional healing techniques in patient care	79 (78)

Abbreviation: LEP, limited English proficiency.

[a] n = 101.

interpreters] changed my practice the most in terms of how I approach a new refugee visit,'' and another commented on the importance of understanding the patient's perspective.

Residents also believed the curriculum positively affected all of their care of their patients by enhancing the focus on communication, how comments may be perceived, and the importance of learning ''what their lives are like really.''

Finally, while several participants remarked on being more aware of a likely history of trauma among their resettled patients, several also expressed feeling they were inadequately prepared to address this. Residents commented that although they were less surprised to hear that patients had endured trauma, they were unsure how to proceed: ''I don't know if I should explore more, ask them more, or if I should just let it be.''

Discussion

A pilot curriculum designed to prepare IM residents to provide quality care to recently resettled populations appears to improve care beyond the target population. This may be due to increased awareness of the potentially far-reaching effects of miscommunication.

This curriculum could be replicated without significant expense. One interested residency faculty member would be required to assist with the design and implementation of a similar intervention, including facilitating the didactic sessions (8 to 10 academic hours). Formal training in cultural competence is not required. Additional contributing members could include local community agency representatives and medical students with an interest in promoting improved care for recently resettled patient populations.

Our preliminary assessment suggests that few residents feel prepared to provide quality care to recently resettled immigrant populations and reflects the findings of larger studies that examined resident preparedness for cross-cultural care more broadly.[3,4] Furthermore, our findings corroborate other research demonstrating positive effects of ''cultural competence'' training on provider attitudes.[16]

Limitations of our study include its single institution and small sample size, which reduce generalizability. Additionally, we examined perceptions, and cannot speak to the curriculum's impact on actual behavior or outcomes. Future evaluations of this curriculum should address outcomes and behavior directly.[16–18]

The positive response to the curriculum and its potentially far-reaching effects on patient care bolsters our intention to expand the curriculum to additional residents, including our categorical IM residents. Logistical challenges include how to prioritize this curriculum among competing medical and psychosocial topics. However, our intervention could be scaled back to meet the time constraints of a particular group or program.

Conclusion

Our study demonstrated that an intervention that included didactics and enhanced exposure to patients improved IM interns' perceptions of care for all patients, including members of recently settled populations.

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