

# An Exploration of Barriers and Strategies for Effective Delivery of Point-of-Care Patient Education in the Refugee Population

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## **Introduction**

Health education is one of many factors that influences a person's ability to manage their health.<sup>1,2</sup> For many refugees, multiple co-existing barriers to health education result in a reduced number of opportunities to learn how they can improve their health and manage the diseases affecting them. While most of these barriers are not specific to the refugee population, many individuals find themselves having to navigate a multitude of obstacles at the same time. Language barriers, cultural barriers, limited literacy, and limited access to health education materials are some of the common obstacles that refugees might need to navigate in their quest for better health.

One potential platform for refugees to receive health education is at the healthcare clinic. Unfortunately, the same barriers that reduce the number of opportunities for health education also make it difficult for healthcare teams to deliver point-of-care health education, especially in the setting of time constraints.

In this paper we will explore several common barriers that make it difficult to tap into the opportunity for health education in clinic, and discuss strategies and resources that healthcare teams can use to help their refugee patients bridge the health knowledge gap necessary for them to better manage their health.

## **Barriers to and importance of health education in the refugee population**

It is important to note that there is tremendous variety in the extent to which these barriers affect different individuals, both within and between refugee groups. As such, healthcare teams should always strive for an individualized approach to care that involves meeting individuals at their level of understanding, and leveraging their learning strengths to improve the knowledge and management of their health.

### *Language Barrier*

Limited English Proficiency (LEP), which is defined as a limited ability to read, write, speak, or understand English, is one barrier to health education that is prevalent among the refugee population.<sup>3</sup> LEP results in a language barrier that has been shown in the hospital setting to result in greater risk of patients experiencing an adverse event, experiencing an adverse event that is harmful, and they have a greater percentage of adverse events that happen as a result of errors in communication.<sup>4</sup> Another study showed that patients with limited English proficiency are more likely to have problems understanding a medical situation and report bad medication reactions than English-proficient individuals, suggesting that health education is especially important when language barriers exist.<sup>5</sup> Language

barriers also make it more difficult for patients to fill prescriptions and take medicine correctly.

#### *Limited literacy*

Literacy levels are associated with both levels of health knowledge and health outcomes.<sup>6</sup> English literacy is low for most refugees. This alone vastly decreases the number of effective educational resources for refugees. Native language literacy also varies between individuals and groups. Among the refugee groups that are more commonly resettled to Virginia, recently resettled Somali and Bhutanese refugees self-reported native language literacy rates of 25% and 38%, respectively, compared to rates of 88% among Iranian refugees.<sup>3,7</sup> As a result of differences in educational opportunities, women are also less likely than men to have native language literacy, a disparity that is more pronounced among older generations.<sup>8</sup>

#### *Limited Time for education during the visit*

While inclusion of certified medical interpreters is a crucial part of high-quality care to mitigate the effects of the language barrier for non-English speaking patients,<sup>9</sup> using a medical interpreter also increases the time of a clinic visit.<sup>10</sup> Because patient education usually takes place later in the patient-provider interaction, providers may also feel a time crunch during what is otherwise the best time for patient education. This time crunch serves as a barrier to both delivery of patient health education during a visit and sharing of translated material for patients to learn from after a visit.<sup>11</sup>

#### *Limited Knowledge of health management and cultural perceptions of disease*

If the goal of patient education is to equip patients with the knowledge and tools necessary to be able to properly manage their health within the context of the health system, then it stands to reason that patients who have less knowledge of their health condition and less knowledge of how to navigate the health system need to acquire more information and skills to be able to manage their condition. Based on a survey of healthcare team members who have worked closely with refugees, many refugees are not familiar with the purpose of prevention or screening of chronic diseases and cancers.<sup>12</sup> They also are generally less familiar with the concept of follow-up appointments and the value of following-up after a first visit for a medical problem, functioning under the perspective that the purpose of their healthcare is to cure rather than manage their disease.<sup>13</sup> There are also many examples where people who ascribe to certain cultural practices and beliefs will develop their own understanding of the cause of a disease or action of a medicine, which can make it less likely for them to adhere to the treatment suggested by their provider.<sup>14</sup> The presence of these health knowledge gaps in the context of an unfamiliar and difficult-to-navigate health system makes it especially important for healthcare teams to educate patients on the nature of chronic diseases and importance of following up on those diseases in the long-term.

### *Limited health education materials*

While there is a rather sizable collection of written translated health education materials on the internet, many of the translated resources are outdated, and not all resources have been translated by qualified translators. Consequently, many of the available resources may be inaccurate, outdated, and/or not culturally suitable. There is also significant variation between languages in terms of what is available. For example, the Influenza Vaccine Information Statement (VIS), which healthcare teams are required to provide to parents or guardians of children before vaccine administration, is updated in only 17 of 47 language options on the Immunization Action Coalition Website.<sup>15</sup> The limited pool of updated resources, concerns regarding which translated resources are accurate and culturally suitable, and inconsistency in which resources are available for different languages all make it difficult for providers to find quality, updated health education material that they can share with patients during appointments.

### **Low-cost, Easy-to-access Strategies for Health Education**

There are several ways that healthcare teams can overcome these barriers and effectively deliver health education both in-clinic and out-of-clinic. Given the importance of a multidisciplinary approach in the care of refugees, these resources can be applied by all members of the care team to successfully embody a team-based approach to health education.

### **In-clinic resources**

Despite the various barriers to delivering effective health education for many refugee individuals, there are low-cost, easy-to-access in-office health education strategies that providers can add to their toolbox and that work for patients with any level of literacy.

#### *Teach-back method*

The teach-back method, also called the “show me” method or “closing the loop,” involves the provider asking the patient or their caregiver to explain the key parts of the plan back to the provider in their own words. The approach can be used for patients with any level of literacy and requires no extra materials. The Agency for Healthcare Research and Quality (AHRQ), which is part of the Department of Health and Human Services, recommends the use of teach-back for patients with limited English proficiency, and the teach-back method is encouraged as a standard of care by several major organizations, including the AAFP and The Joint Commission.<sup>16,17</sup>

Although data are sparse on the efficacy of the teach-back method for refugees, the approach has been explored in low health literacy populations. One randomized controlled study done in the Emergency Department setting showed that when the teach-back method was used for patients with limited health literacy, they had better understanding of their post-ED care instructions than when the teach-back method was not used.<sup>18</sup> Another direct observational study showed that in a population with low functional health literacy, patients of providers who used a form of the teach-back method when

making a medication change or introducing a new concept were more likely to have lower HgbA1C levels, although the method was used only 12% of the time when discussing a new concept.<sup>19</sup>

While providers may be hesitant to use the teach-back method with patients because of perceived time constraints or concern about offending the patients, in reality the teach-back method takes very little extra time, and patients prefer the “teach-back” method to a simple “yes-no” assessment of understanding.<sup>20</sup> It is also better for the healthcare team to find out that a patient does not understand how to take a medicine or manage their disease before they leave the clinic than to find out later.

There are a few important considerations when it comes to proper execution of the teach-back method. First, providers should always convey that the purpose of the teach-back is not just a test of the patient’s knowledge, but rather a check to see how well the provider conveyed the material. In one study examining patient’s preferences in how a provider asks for a patient’s understanding of blood clots and their treatment, researchers found that using a statement of “I’ve given you a lot of information. It would be helpful to me to hear your understanding about your clot and its treatment.” is preferred to “It’s really important that you do this exactly the way that I explained. What do you understand?”<sup>20</sup>

The teach-back method should also be a dynamic process, such that if the patient initially shows a lack of understanding or misunderstanding in their initial “teach-back”, after working with the

patient to eliminate the misunderstanding, the provider should again ask the patient to “teach back” their understanding of the plan.

### *LEARN Framework*

Based on their experiences working with immigrant groups in California, two family practice providers developed a framework for approaching interactions with patients with cultural practices different from those of providers.<sup>21</sup> The LEARN framework lays out step-by-step guidelines that providers can use as a supplement to their history taking, and involves:

**L:** *Listen with sympathy and understanding to the patient’s perception of the problem,* by asking questions such as “What do you feel may be causing your problem?”

**E:** *Explain your perceptions of the problem.*

**A:** *Acknowledge and discuss the similarities and differences.* Point out areas of agreement between you and your patient’s explanatory models, and potential points of conflict. Identify when the patient’s explanatory model might pose a therapeutic dilemma and strive to bridge the conceptual gaps between the two belief systems.

**R:** *Recommend a treatment.* When developing a treatment plan, keep the treatment plan within the constraints of the patient and provider’s explanatory models.

**N:** *Negotiate Treatment.* With the knowledge of both the patient and provider’s explanatory models, come to an agreement about the treatment plan through shared decision-making.

This approach can help providers to overcome several barriers to effective delivery of health education by providing a platform for patients to share their understanding of what is going on, and give providers the opportunity to determine whether and how they can build off the patient's preexisting framework of understanding to communicate a plan to the patient.

*Building on the LEARN model: The GREAT Approach to Communication of the Treatment Plan*

Building on the LEARN model and taking into account common misunderstandings of patients before they leave the clinic, providers may consider employing the GREAT approach when communicating the treatment plan with patients. The GREAT approach is designed to help providers cover key components when it comes to communication of the treatment plan and can be valuable in bridging the gap between a patient's current understanding and the understanding necessary for them to better manage their health. The GREAT approach is comprised of:

**Give a Reason:** Give a reason for why you are suggesting an approach to management of a care plan.

**Expectations:** Set expectations for treatment and follow-up. Based on interviews with medical interpreters, case managers, and pharmacists regarding challenges of refugee health care which suggest that refugee patients are not familiar with the purpose and importance of follow-up appointments, as well as unfamiliarity with the concept of management of chronic diseases, providers

should explicitly communicate to patients when the goals of treatment is to manage vs. cure, as well as expectations for following up.

**Ask** what questions the patient/caregiver has.

**Teach-back:** Use an open approach that conveys the benevolent motivations behind asking about the patient's understanding of the treatment plan, such as "I've given you a lot of information. It would be helpful to me to hear your understanding about your (condition) and its treatment".

## **Resources for patient use outside of clinic**

### **For patients with literacy in non-English language**

#### *MedlinePlus*

There is a centralized database of culturally and linguistically appropriate health information housed by MedlinePlus through the United States National Library of Medicine.<sup>22</sup> The initiative began in 2002 thanks to the efforts of a few state refugee health coordinators who identified a need for both more translated health materials and centralization of those resources. All of the materials are free to access, and every resource that has been translated to a non-English language is both reviewed for accuracy and available in English so that providers can always know what they are sharing. The website also has a simple interface, as healthcare team members can search for materials by language. Multilingual resources available on

MedlinePlus include physical rehabilitation exercises, general disease information sheets, and advice on health promotion.

#### *Immunization Action Coalition*

Another helpful written translated health information resource is coordinated by the Immunization Action Coalition funded by the CDC, and contains Vaccine Information Statements that have been translated into a number of languages. These Vaccine Information Statements are available at <https://www.immunize.org/vis/>. Healthcare team members can navigate the website in two ways. By using the Language Index tab, they can see which Vaccine Information Statements are available for a specific language. Clicking on the Vaccine Index tab allows providers to see which languages have updated Vaccine Information Statements for each vaccine. A list of languages with updated Influenza Inactivated Vaccine Information Statements is shown in Appendix A.

#### **For patients with limited/no literacy**

##### *HealthReach*

There are far fewer health education resources available for individuals who are not able to benefit from written translated material due to poor literacy. HealthReach, the organization responsible for the MedlinePlus database of translated material, is a centralized source that contains some health education material in video format that anyone can access free of charge.<sup>23</sup> The easy-to-use search bar allows users to filter by language and format to quickly identify which topics are covered.

Note: Beginning October 1, 2020, HealthReach will no longer function as a stand-alone website as much of the information on HealthReach is also on MedlinePlus. Unfortunately, many of the videos available on HealthReach are not available in MedlinePlus, and it remains to be seen what will become of these videos after October 1<sup>st</sup>. MedlinePlus also does not have an easy way for providers to filter the format of the health education material, which increase the barriers providers face to sharing health education materials to refugee patients with limited/no literacy.

#### **Group Visits as an Alternative Model of Care**

##### *Group visits*

Group visits, also called shared medical appointments, involve a group of patients who have a health feature in common participating in a clinic session that has two components: 1) a group educational session with discussion, and 2) a brief one-on-one visit with the provider. Group visits allow providers to overcome several barriers to health education in the refugee population, particularly limitations of time and literacy, and cultural barriers to understanding of health and disease management. Group visits have commonly been used for things like diabetes, prenatal care, and chronic pain, and may be applied to a great variety of health topics/conditions.<sup>24-26</sup> Several studies have shown that health outcomes are equal to or better than outcomes of traditional one-on-one visits, with increased satisfaction among both providers and patients.<sup>27</sup>

Group visits present an ideal opportunity for interested refugee patients from similar cultural backgrounds to receive disease-specific education while leveraging the collective experiences of others to better manage their health. Group visits also give providers the opportunity to expand their perspective on how a culture's beliefs and practices affect the management of their health.

### **Multidisciplinary Approach to Health Education**

A multidisciplinary approach to health education that involves all members of the care team can make a big difference in a patient's experience. Nurses, care coordinators, clinical pharmacists, and providers can all use the tools discussed above to optimize patients' learning. Healthcare teams may also consider a clinic workflow that alleviates the common time constraints for providers by having much of the health education and teach-back take place after a patient's appointment with the provider.<sup>28</sup>

### **Conclusion**

While there are many reasons why it is important to deliver patient education for all clinic visits, the combination of several co-existing barriers make health education particularly important for refugees. Given the heterogeneity within and between groups of refugees, an individualized approach that involves meeting patients at their level of understanding and making use of their learning strengths would be the ideal approach in all clinic visits; however, the reality is that limited time often makes that ideal difficult to achieve. Using brief and

easy-to-access educational interventions such as the teach-back method and connecting patients with resources they can explore outside of the clinic can go a long way in equipping refugee patients with the knowledge and understanding necessary to improve their health. These challenges also invite innovation and an opportunity to employ alternative models of care such as group visits.

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#### Appendix A. Languages of Inactivated Influenza Vaccine Information Statements

Arabic	Hmong
Armenian	Korean
Burmese	Punjabi
Cambodian (Khmer)	Russian
Chinese – Simplified	Somali
Chinese – Traditional	Spanish
Farsi	Tagalog
French	Vietnamese
Hebrew	