



Original Research

A Physician-Community Partnership's Approach to Addressing Health Needs of Local Refugees: Participants' Perspectives and Recommendations for Developing New Partnerships

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Abstract

Community-academic partnerships have demonstrated how collaboration can provide academic healthcare workers and non-medical community providers such as educators and social services with a comprehensive view of issues affecting refugee populations. [1] The ICIH (Interagency Council on Immigrant Health) is a physician-community partnership consisting of healthcare professionals, non-medical educators, social workers, early childhood services and other community agencies. It was formed to address the well-being of a local immigrant population, strengthen bonds between the community and healthcare system, and educate and empower pediatricians to provide culturally aware services. The collaboration has been very successful as demonstrated by the production of multiple collaborative products in a very short time period with minimal funding. This article explores the experiences of community and physician members in order to share insights and recommendations for others working in small cities who wish to start such a collaborative. We collected data from 17 of 30 ICIH members through focus groups, interviews, and a survey and conducted a qualitative analysis using transcripts from these sessions. From our analysis, the following themes emerged: 1) increased awareness of challenges faced by refugee families, 2) making connections and collaborating with a diverse group of agencies, 3) improvement of care for the population using knowledge learned through the ICIH, 4) expanding perspectives through the sharing of information between agencies, 5) the importance of education for providers and community members about the refugee population, and 6) relational support gained through interaction with other service providers struggling to overcome similar obstacles. Results support the ideals of a productive community-academic partnership. [1] With this information, we present recommendations for others working to establish similar community-academic collaboration efforts.

Introduction

A child's early years are a time of great growth and development. For refugee families, circumstances necessitating fleeing their home countries, the process of seeking refugee status, and life in a new country can be very traumatic. Early childhood education and care providers can play an important role in addressing trauma. [2] The Migration Policy Institute recommends increased collaboration between early childhood programs, health services, and organizations working with young children in order to address this trauma.

One way of increasing collaboration is through developing partnerships between universities and their local community organizations for the purpose of education and research. [3,1] Community-academic partnerships (CAPs) have demonstrated how collaboration can provide academic healthcare workers and non-medical community providers such as educators and social services with a comprehensive view of issues affecting refugee populations. [1] It is difficult to gain cultural competence through classroom teaching alone and important to know about these cultures within your own community. [4] One such collaborative, the Refugee-Centered Medical home, adopts a holistic approach to the care of their patients, recognizing the unfamiliar cultural landscape refugee families must navigate during resettlement and the difficulty this brings when attempting to

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re-establish one's physical, mental, and spiritual wellbeing. [5]

Unfortunately, studies have shown that people living in poverty feel that physicians ignore their realities and are unaware of topics such as health coverage and social security. [6] Partnerships linking community members and health-care providers are an important way to combat this lack of knowledge. These collaborations are very useful in identifying persistent needs of the local immigrant, noncitizen, and refugee community. [7] These partnerships help physicians and community service partners to address social determinants of health that in the past have been considered outside the scope of a physician's role such as education, employment, housing, and economic arrangements. Clinicians benefit by greater appreciation of challenges, and communities benefit by increased access and better understanding of resources available. [8] Knowledge about other organizations leads to improved utilization of resources when interacting with a refugee family struggling through a combination of social, personal, and medical issues.

Midwestern states have lower numbers of immigrants and refugees, meaning that some of the smaller towns and cities in which they settle may have fewer refugee specific services. Health and social service providers in these areas may have had fewer opportunities to interact with immigrant families. In addition, refugee specific organizations have experienced significant federal funding cuts over the past couple of years which may have prompted refugees and immigrants to seek other services. One small midwestern city of about 120,000 developed an interagency council to address the healthcare needs of the refugee and immigrant community. The county has about 11,000 immigrants with the city experiencing an increase in immigrants from 2017 to 2018 despite the overall state receiving far fewer refugees in 2018. [9]

Although this council was initially started to improve refugee care by providing community-based education for pediatric resident physicians, it was soon recognized that all members felt the benefit of attending. The program proved to be very successful as demonstrated by the production of multiple collaborative products in a very short time period with minimal funding. This article explores the experiences of community and physician members in order to share insights and recommendations for others working in small cities who wish to start such a collaborative.

Background

The Interagency Council on Immigrant and Refugee Health (ICIH) is a collaboration between physicians practicing at academic medical centers and community partners, formed to address the well-being of immigrant and refugee children in the city. The partnership strives to strengthen bonds between the community, health-care system, and resident physicians in order to educate and empower members to proactively address needs and to provide culturally aware healthcare services for our refugee and immigrant population. In 2016, a Pediatrics resident at the Academic Health Center had an interest in immigrant and refugee health and began reaching out to local agencies serving this population. From here, interest in a broader coalition developed. ICIH was created as a collaborative of community stakeholders to address the developmental and socioemotional needs of the growing refugee population in our community.

The ICIH is unique in that it combines resident education with community partnership—the council, co-led by resident and attending physicians, brings together diverse community partners (medical and non-medical) in order to brainstorm and implement solutions to current barriers faced by the area's refugee and immigrant population. The partnership allows members a chance to hear about multiple sides of refugee experiences. Not only are collaborators able to learn from and share with each other about challenges faced by refugee and immigrant families, they are also given the opportunity to gain perspective on the daily lives and the personal struggles these families face. The hope is that with improved understanding of the diverse cultures from which local refugee and immigrant families originate, social workers, educators, physicians, and other community partners can tailor their services to better fit the populations they serve.

The ICIH holds quarterly meetings to support ongoing collaboration between its members. Anyone present can share new experiences and present ideas for future projects. The agendas for these meetings remain open and flexible to permit such discussion and are not exclusively set by the physicians facilitating them. This flexibility allows the group to tackle challenges they are facing in meeting a child's or family's need and to brainstorm solutions and share resources.

Although the council was originally organized with the idea of developing a free healthcare clinic, a community needs assessment revealed a need for focused attention on developmental and socioemotional needs. The group discovered that most refugee families and children in the area did not have tools, such as books, toys, and games that could aid in the appropriate development and building of resiliency skills. In response, the group worked with Refugee and Immigration Services to identify specific families, visit homes to deliver developmentally appropriate toys, and connect them with in-home services. By the end of 2018, ninety-nine bags were delivered to local families. In 2019, an additional

100 bags were created and are being delivered by partner organizations as needed. This is one of many collaborative initiatives that have resulted since ICIH's inception. Other projects include multilingual and culturally sensitive videos on local healthcare access and healthcare text messages that include topics such as positive parenting messages, preventative care reminders, and safety education (**Figure 1**).

Collaborative Projects

The group produced several products to benefit the community. The pride in these accomplishments came out in discussing what is working well.

Health Texts
Educational texts for parents focus on the socioemotional needs of their children and accessing appropriate preventative services, partners with public school district.

Health Videos
Video series developed for refugee and immigrant families to learn about accessing healthcare. Partnership with school district, refugee services, and School of Health Literacy.

Toy Bags
Partners filled bags with developmentally appropriate toys and books and partnered with early childhood services on home visits and toy bag delivery.





Figure 1. Collaborative projects completed by the ICIH.

ICIH is unique in that it allows for a fluid partnership between a large variety of community members, healthcare workers, resident physicians, educators, and social service providers. This also includes intermittent participation by the local resettlement agency which works directly with incoming refugees. Though started with a pediatric focus, this organization recognizes the need to help solve issues facing the parents and guardians, which ultimately helps their children. ICIH members participated in this research not only as subjects but also as active contributors in planning the focus of the research including development of the focus group questions.

The purpose of this study was to learn about individuals' experiences of participating in the ICIH quarterly meetings including aspects that participants found particularly helpful and if participation changed the way members approach their work in the immigrant community. With this information we would like to present a framework and recommendations for other community-academic collaboration efforts.

Methods

Focus groups, interviews, and surveys were conducted to learn more about the experiences of ICIH participants. We use a phenomenological approach with an emphasis on interpretive understanding of participants' meaning of their experience. [10] The methods and procedures of this study were approved by the University of Missouri Institutional Review Board May 15, 2018 (#2009559).

Participants

Anyone who attended at least one ICIH meeting was invited to participate in focus groups via an email invitation. Thirty individuals were invited and ten agreed to participate.

Table 1. Focus group participant characteristics

Number	Occupation	Nature of Work with Refugees	Sector	University Affiliation
1	Physician	TB	Public Health	Y
2	Social Services	Pregnancy	FQHC	N
3	Teacher	English Language Learners	Public School	N
4	Social Services	Home Visits	Early Childhood	N
5	Social Services	Food Support	Food Pantry	N
6	Social Services	Home Visits	Early Childhood	N
7	Physician	Child Health	Child Health	Y
8	Educator	Health Literacy	University	Y
9	Social Services	Parent Education	Parent Education	N
10	Social Services	Families	Developmental Disabilities	N

An additional seven members completed surveys based on the analysis of the focus groups and interviews. Participants' occupations from both focus groups and surveys included physicians, social service providers, early childhood service providers, and non-medical educators (**Table 1**). In total, four practicing physicians and 13 non-healthcare providers participated. Five of the seventeen participants, including all physicians, were affiliated with the university.

Table 2. Participation level by data collection type

	Meetings Attended		
	0-2	3-4	5+
Survey	4	1	2
Focus Groups			10
Total	4	1	12

Seventy percent of all participants were regular attendees (5+ meetings in 18 months). All the focus group attendees were regular attendees (5+ meetings in 18 months) with nine being members since the formation of the council. Three of the seven survey respondents attended three or more meetings. The remaining four attended two or fewer meetings (**Table 2**).

Procedures

We provided participants with written study information via an online survey before focus group meetings and written and verbal study information at the focus group or interview. All the participants provided informed consent to participate in a manner that was approved by our Institutional Review Board. Participants were provided a \$25 gift card for their involvement.

We conducted two focus groups with each group lasting about 1 hour. There were four participants in each group which is consistent with recommended sizes and availability of the participants. [11] Focus groups were conducted by a Ph.D. researcher with ten years of experience in qualitative research (MWG) and a second-year medical student (NT). One (MWG) facilitated the group discussion and a second individual made notes and monitored process. [12] We also conducted two individual interviews for people unable to attend a focus group. For the individual interviews, one researcher (MWG) was present. All focus groups and interviews were conducted at the University's Child Health administrative offices. A semi-structured approach was used which included open-ended questions to spark discussion among all the participants (Appendix A). Questions were developed in collaboration with ICIH members. Broad topics included what went well during ICIH meetings, things learned through participation, benefits to the participant and those they serve, and what could be changed to improve the experience. All interviews and focus groups were audio-recorded. Survey questions were developed based on the analysis of the focus groups and interviews (Appendix B).

Data Analyses

To inductively derive themes from the data, de-identified transcripts of the audio recordings were used to conduct a content analysis using coding software QDA Miner version 4.1.31. Although the aim of this study is not to produce grounded theory, we used the technique of constant comparison to identify emerging themes in focus groups and interviews. [13] The coding procedure involved two researchers (MWG, NT) independently open coding one focus group transcript then debriefing to agree upon the preliminary codes. The remaining transcripts were independently coded with a meeting afterward to discuss any disagreements in coding. New codes were added, as needed. Similar codes were refined and grouped into subcategories before gathering codes into larger, broader themes. Results were sent to all participants who were given the opportunity to provide feedback and were also presented and discussed at two ICIH meetings. Feedback indicated that results were consistent with participants’ experiences.

Results

From our analysis, the following themes emerged: 1) increased awareness of challenges faced by refugee families, 2) making connections and collaborating with a diverse group of agencies, 3) improvement of care for the population using knowledge learned through ICIH, 4) expanding perspectives through the sharing of information between agencies about their own services and their experience with refugee communities, 5) importance of education of providers and community members in properly serving refugee population, and 6) relational support gained through interaction with others struggling to overcome similar obstacles (**Figure 2**). Representative quotes from focus groups and interviews follow a description of each theme.

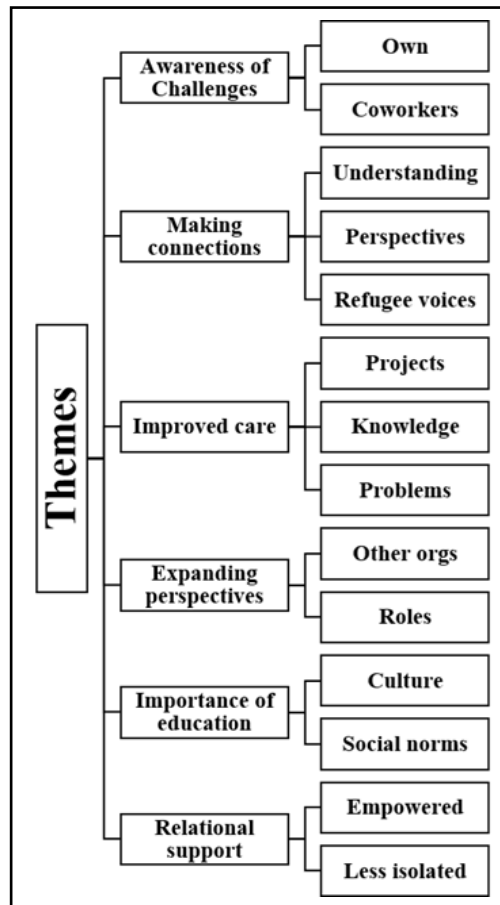


Figure 2. Themes and subthemes

Increased Awareness of Challenges

Most participants discussed learning about challenges faced by the refugee community through membership on the council. They mentioned deepening their own understanding through the experience of another's perspective. Participants also talked about specific challenges that they had encountered while working with refugees such as attending doctor's appointments, not getting apartment deposits back due to unintentional property damage, undergoing financial strains, and being unsure what to do with a prescription.

"They didn't know that you couldn't just take a pan off the stove. They were used to just sitting it on the ground. It was really a financial strain for them not to get that security deposit back. . . I think that's been really helpful just to bring light to some of those things that we often overlook."

"That's a story that came out of these meetings. That they don't know what to do with a prescription. They don't know to get it refilled or even to take all of the medicine or whatever it is."

"How transportation is an issue all around in our lives. So, like they were able to get jobs. A lot of them work factory work out north, and they live south, so trying to find jobs, or rides through the opposite side of town, and then they had to take whatever shift was available, so if you work three to 11, people aren't so kind to be like, 'Sure I'll pick you up at 11,' you know? And then, getting their kids in activities. So, if they wanted their kids involved in soccer or something like that, how would they get their kids involved?"

"(I learned for) many refugee families, past trauma exists, but (there) may be the hesitancy to seek out mental health services. I mean I guess I knew that that makes sense, but I learned that that really could be a huge barrier to one, even engaging with agencies like ours, all of ours, and then too, if they are enrolled, participating and engaging. So that was a huge thing for me, like the importance of that and how do we even address that?"

In addition to expanding their own knowledge and understanding, participants were able to take what they were learning back to their own agencies which expanded the reach of the council into the community. Participants shared ICIH generated projects and information about other organizations.

"So, we've been able to provide the other people that work with us information that we find out at ICIH and how it can benefit any of their populations. We were able to share the "how to access healthcare" videos. Yeah, we're part of the school system, so the text messaging and that kind of thing that they've been working on, ultimately, will benefit our families. So, yeah, we've been able to share."

"We got to take some of the concepts and the connections we learned at ICIH and bring them back to our fellow residents here. So, we've actually organized some didactic sessions, so like lecture series for our fellow residents as well. And so, I feel like that kind of helped to educate us, and then educate others from what we had learned."

Making Connections and Collaborating

Making connections and collaborating emerged as a theme as participants discussed what they thought was working well, benefits to participating and areas they thought could be improved. Participants mentioned that these connections helped them to be more informed about refugee issues, feel more compassion, expand awareness of their services, and even generated additional work for one organization. Participants specifically mentioned one of the physician leaders as helping to build a strong collaborative culture by valuing individual suggestions and feedback.

"I usually see it from the health care perspective, and then it branches out into the other things that always affect health care. But then when you hear about it from the educational perspective and from some of the other perspectives, it just I think really helps just to have a better understanding, to be able to provide better care."

"I think getting everyone in the same room has been wonderful, just to get people in a space where they can bounce ideas off of each other and understand more thoroughly what areas around town are doing. It's just been a great resource connector, I think. I think ICIH gives the opportunity for a lot of people to work together."

"A lot of the agencies that are involved we commonly make referrals to, and we get referrals from. So that's, all of these networking groups I think that's kind of a benefit of keeping all those agencies on the radar. "

"(The) culture of leadership was just incredible. And I think it went throughout the group. Her enthusiasm and passion were admired by a lot of folks at the table. I think that was a vital, key part."

Making connections and having the opportunity to collaborate were often mentioned as benefits to attending council meetings. Participants appreciated that one of the groups' strengths was bringing in many different services and perspectives.

"I feel like school, medical, those are two things that people recognize. But I've also appreciated the fact that the public library is involved. It's so powerful. Just to have all of those people around the table hearing the same conversation, I feel is very valuable."

"I think that that's how things become sustainable is from having all the different facets of the organizations that are there."

"(We have) a good group of people that worked with the population directly, so those who had the ability to help influence, or talk about and think about some of their needs, so I think that went really well."

Although the many different perspectives included in ICIH was considered a strength, many still saw room to expand even further. The most frequent suggestion for improvement was to include more people with ICIH. This included involving people around issues, like helping to write grants or inviting participation around specific issues. Another suggestion was to draw in more community partners around resources for parents such as language services and driving. A couple of people spoke of reaching out again to people/organizations in the community that do a lot of work with immigrants and refugees and perhaps an immigration attorney. Another idea was to spread the word of ICIH by sending ICIH reps to other organization/networking meetings. Importantly, all focus groups mentioned involving refugees themselves not only to learn about their needs but to potentially serve as a resource for those newly arriving.

"I feel like a voice we've kind of lost is the refugees/immigrant voice itself. I think that was there a little bit more when we first started... Yes, there are all these barriers that we have talked about before that make it hard and the timing is not always easy if it's in the middle of the day. There are random days – maybe we can make a consistent time to really ring a campaign around it. I feel like (we have) a lot of great organizations who do a lot of work with (refugees) and so they will have a lot of input from what they're observing. But it is not the same as being the people who are actually impacted by it."

"A lot of us are coming from a perspective of the children but talking about the parents and seeing other resources they really need. Maybe drawing in some community partners that would help with, like, language services for parents, or drivers ed courses for parents... There is a lot of things kids get through school, resources or activities. There is another barrier that the parents never overcome. They are not learning things in English. They are not learning English as easily as their children. They are not able to get a driver's license, so they are feeling isolated. Or, they're having difficulty getting jobs."

Improvement of Care

Most participants felt they were able to improve the services they provide to refugee and immigrant children and their families by utilizing the knowledge gained through attending council meetings. Another more direct improvement was the benefit families received through council projects such as developmental toy bags and informational videos.

"We've benefited from being able to have the toy bags and go and use them to help teach about development and to help teach about play. Our agencies benefited a lot from the ICIH group on so many levels, on a feeling of... On the platform of families feeling welcome, by being able to tell them, 'A group of doctors has worked really hard to try to make the healthcare system for you easier to access, and this bag of toys is a gift to you so that you can learn all of the different ways that your child is growing and developing, and how you help with that.' I think that it helps people to feel welcome, but it also ... I mean, it's just such a teaching tool. It's a hands-on teaching tool that they, then, can have, and you can do the lessons with that so that when you leave, they can continue those lessons."

Participants were more likely to make referrals to other agencies, refer interpreters to go to doctor's appointments, and to be more flexible with services because they better understood the struggles faced by refugee families. ICIH members felt better able to guide families due to increased knowledge about medical issues and were able to improve services by connecting families to experts that they learned about through attendance. Through better understanding of how things are interconnected, participants discussed taking the child and family's full situation into consideration more than they would have before becoming a council member. For example, also thinking about health issues in an educational context.

“It’s helped me feel more comfortable referring patients to the agencies that are at the table. Knowing that they’re refugee-friendly and have some skill or training or just even familiarity with treating and serving refugees.”

“I think that it has just made me more knowledgeable about when I’m guiding them (families) and when I’m teaching them certain aspects of the medical community and what things that we assume people know and how it’s just so very different from the population that I serve. So, trying to figure out how to be this middle voice between these two worlds that are really different, you know?”

“I think it maybe just opened my eyes to be a little bit more considerate that, you know, I could be a part of that. It may be small, but still, any time that I see somebody struggling... Even as people of different cultures come in, just taking the time, because of the language barriers, just taking a little bit extra time, with a smile on my face so that they feel comfortable, they feel welcomed, I think does a lot for just helping them to think, okay, I can survive here.”

“How can we pinpoint those needy areas and set up our summer feeding program so that we’re not making it a hardship that they have to get on the buses necessarily, but we’re going into those areas where there is a good-sized population of refugees or people that are in need of food?”

“I feel, or at least hope, that it’s helped me to kind of anticipate some of the needs of the family a little bit more from things that I wasn’t even aware would be issues or barriers. Now when I see families in clinic, like if they are 20 minutes late, maybe it’s because they didn’t have a ride, not intentionally, or just didn’t know where to go, or now I try to be a little more cognizant of definitely always using a translator, but still trying to anticipate (needs).”

ICIH participants were also able to improve care by working through problems during meetings.

“I had a family that was struggling with a health insurance issue, and someone present at one of the meetings had insight about navigating that. We followed up with someone from his office, and the family received the help they needed to get that coverage.”

“It’s also helped to track those trends that we’re seeing when the group meets regularly. Because for a while, somebody at the state was entering in all refugee Medicaid information wrong or in the wrong system, so we saw 60 plus patients affected by that. It was just, I thought I had done something wrong, and then at the group, we realized that everybody was being affected by it. Then we were able to target the right people to rectify the situation.”

Expanding Perspectives

Through sharing information about their own services and their experience with refugee communities, council members expanded their perspectives. They learned information about other organizations including processes, responsibilities, populations served, limitations of others’ roles, challenges faced, and that there was a larger (community) push to address refugee needs.

“Just learning about what families face when I refer them to a place. What is the process? It’s helpful to me, because I have a relationship with families, and sometimes that can be our home visit. That we’re going to... We went to a dentist appointment, a family fairly recently, and an interpreter met us there. I just didn’t know what I didn’t know. It’s been very helpful.”

“I think that the top thing that I have learned has... This might sound a little bit backwards but was how uninformed we all were of what each other did. That was the initial thing, was how many of us are trying to reinvent the wheel, or how many of us just don’t fully understand the limitations of each other’s roles.”

“I’m glad to know that there are medical communities that are willing to identify these needs and figure out how we, as a community, are going to pick up some of these services.”

“I also learned a lot about who’s providing services and which services. But the challenges that those folks face, and trying... Whether those are outreach issues, education issues, awareness issues, resource issues, and some of those. So that was useful.”

“Something I learned (was) the specific agencies in our community that work with immigrant and refugee populations... making sure that if we have families that (they) are...hooked up and referred.”

Importance of Education

Through participation in council meetings, several came to recognize that regardless of the service they are providing, education about culture and social norms is an important component in working with refugees.

“What I’ve learned the most is that we’re all in the business of educating them on culture and their new world... I’ve been talking with the teachers to get to enlighten them on (issues outside of school). Because it’s all about education no matter where we are... When they’re on a home visit to say, “Hey, have you been to the doctor? Have you been to the dentist?” Which is not something that we normally think of just as being a teacher... But bringing the whole family into that picture, I think is important.”

“I think it’s very hard for us to understand that things as basic as knowing why your skin gets hot when you’re sick and that that’s a fever and that this is how you ... This is what you should do with that. Those are the types of things that we’re teaching, so it’s not just teaching how to navigate a medical system, it’s teaching how to understand medicine.”

“We talk a lot about safe sleep. In other countries parents have always slept with (their children) ...it wasn’t everybody got their own mat. So, when they come here, if you are wanting them to trust you... you can’t tell them all of the things they are doing wrong. Because that was that way in their country. Realizing that there is a fine line of, you have to do your job and educate on things, but also you want them to trust you.”

Emotional/Relational Support

Several participants noted the relational benefits of attending meetings. They were able to make friends and connect with others who were like-minded and with whom they shared common goals. They received support that helped them to feel empowered and less isolated in their work.

“It’s wonderful to not feel like you’re the only one working on a problem... not only is it more effective, but it also just invigorates the process... On a personal level, it’s really gratifying to know that there’s a whole lot of other people working on it too.”

“It is rewarding, but it’s also daunting...When you feel like you’re the only person, the only group trying to help, and the obstacles are mountains - they’re just huge. But when you realize that other people are also trying to get over the same obstacle, over the same mountain... it’s liberating really. It gives you hope.”

“We talked a lot... about the fatigue that you feel as a support person. It’s a real thing. Just knowing that other people are experiencing the same things is... It’s empowering, because then you know that you’re not the only person, and everybody’s going through the same struggle... Plus I make friends, and I appreciate that.”

“It’s been very nice to not feel like I was isolated in how to solve some of these problems, and so it’s given me a nice pool of people that I could reach out to and network with.”

Discussion

Although the ICIH is a young organization, it has been able to accomplish several meaningful projects that required a high degree of collaboration. Our research provides insight into the success of the group. Meyer et al. identified four principles of creating a productive community academic partnership. [1] We saw these four principles at work in the ICIH (**Table 3**):

1. Respectful, trusting, and genuine relationships are important to creating strong partnerships. We saw this when participants discussed emotional support gained through interaction with others struggling to overcome similar obstacles. This demonstrates the value of the relationships fostered by the partnership as they appear to empower partners to continue serving their population;
2. Agreement on mission, values and goals for the partnership was seen as participants discussed expanding perspectives through the sharing of information between agencies, the improvement of care using knowledge learned through ICIH, and the importance of education in properly serving refugee population. The first two themes represent the embracing of partners’ perspectives and the ability to identify and respond to community-identified needs, both of which have been defined as ‘Critical Concepts’ to achieve this principle. The lack of education on population needs has been identified as a priority to help reach the shared goal of effectively serving the refugee population;
3. Balanced power and resource sharing are seen in the discussion of making connections and collaborating with diverse group of agencies and increased awareness of challenges faced by refugees. The latter represents the ex-

- change of knowledge as a resource among partners—through the sharing of experiences and observations made while serving refugees, partners have broadened their awareness of the obstacle’s refugees must overcome;
- Open-accessible communication between partners is seen in discussion of the creation of well-informed group-generated products through collaboration of diverse backgrounds. The communication between partners of the ICIH has allowed for the development of tangible products—developmentally-appropriate toy bags, educational text messaging for parents, and a multi-lingual video series to learn about accessing healthcare—that target identified needs of the community served.

Table 3. Comparison of study themes to Meyer et al. principles of creating productive community/academic partnerships.[1]

Principles of creating a productive community/academic partnership	Study Themes
Build a relationship between partners characterized by mutual trust, respect, genuineness, and commitment	<ul style="list-style-type: none"> • Emotional support gained through interaction with others struggling to overcome similar obstacles • Making connections and collaborating with a diverse group of agencies
Build agreement on mission, values, and goals for the partnership	<ul style="list-style-type: none"> • Improvement of care using knowledge learned through ICIH • Importance of education of providers and community members in properly serving population
Balance power and share resources among partners	<ul style="list-style-type: none"> • Making connections and collaborating with a diverse group of agencies • Increased awareness of challenges faced by refugees (by sharing beyond the group)
Create an open, accessible communication between partners and develop a common language	<ul style="list-style-type: none"> • Creation of well-informed group-generated products through collaboration of diverse backgrounds • Making connections and collaborating with a diverse group of agencies

Furthermore, the partnership has demonstrated many facilitating factors for a strong Community-Academic Partnership (CAP) as defined by Drahota et al. [3] Some of these factors include respect among partners, shared vision, goals, and/or mission, good relationship between partners, effective and/or frequent communication, positive community impact, and mutual benefit for all partners. Presence of open dialogue has been a prerequisite for the development of successful and sustainable interventions and programs in existing CAPs. [14] Additionally, the diversity of organizations in the ICIH helps to maintain long-term partnerships and ensure their sustainability. [15] In contrast, inconsistent partner participation or membership can be a hindering factor. This hindering factor was addressed by some participants who indicated a desire to involve more people, including ‘core’ organizations, that were initially very involved including resettlement agencies. The identification of this necessity for improvement demonstrates the presence of specific aims to achieve a common goal among partners, a defining quality of CAPs. [3]

Based on the results of this study, the group plans to conduct a detailed needs assessment of the local refugee and immigrant population; continue reaching out to additional community partners; and continue coordinating resources to provide education to service providers, community members, and the refugee and immigrant population. They will also be pursuing ways to stay in-touch between meetings and investigating ways to support more individualized attention to refugee and immigrant children and their families. One limitation of this study is that most of our participants represented regular attendees of ICIH meetings. It would be helpful to gain the perspectives of those who are less frequent attendees.

Based on the results of this study, the following are recommendations for starting and sustaining a community partnership:

- Do not limit your visions for membership to obvious services. You get great benefit when you have a diversity of perspectives – do not forget your public library, food bank, transportation providers and city officials. Also realize that you can have core members and invite others to participate around specific projects.
- Think about assessment from the very beginning. How will you measure your impact? This can be a challenge, but there are multiple good resources available.

3. Consider spreading the influence of your group by having members attend other community meetings as representatives.
4. Create a means of connecting between meetings – a list serv or closed social media group are a couple of ideas.
5. Involve refugees in group planning as much as possible. This may be too overwhelming for someone new to the country but consider those who are settled and can provide important insight.
6. Implement a consistent meeting schedule and place so that members can drop in and out as their time permits.

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