Experiences with Refugees: New Land, New Realities

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Executive Summary

Student nurses enrolled in a lab course on community and population health nursing at Boise State University partnered with the Agency for New Americans (ANA) to supplement their community health worker program and work with refugees in the Boise, Idaho, area. Students used the Anderson and McFarlane Community Assessment model to evaluate the health of Boise and develop interventions targeting specific healthcare-related problem areas for the refugee population in Boise (Anderson, 2000). Students developed a health promotion education project (HPEP) brochure entitled "Your Guide to Health Care" which they delivered to ANA in an electronically editable format. This allowed ANA to translate the brochure into different languages and print multiple copies in order to meet the needs of the refugee population they serve. Students also participated in home visits with refugee families, with a goal of supplementing ANA's community health worker program. Significant limitations included language and communication barriers, misunderstanding of expectations, limited time frame, and lack of buy-in. Despite these limitations, students improved their understanding of community health nursing, improved their communication and cultural awareness skills, and provided useful information to ANA. Students made recommendations for future student/agency projects, including having clearer expectations, coinciding student visits to refugee families with community health worker visits, offering student-run mobile health clinics, and using student input in project selection and placement.

Keywords: refugees, community health worker program, student nurses, community and population health nursing, Boise State University, Boise State School of Nursing, Agency for New Americans

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Experiences with Refugees: New Land, New Realities

Nurses interact with a variety of patients from many different cultures and backgrounds. This requires them to be knowledgeable about cultural differences as well as common concerns faced by different populations. While bedside nurses focus on individuals, community and population health nurses look at groups in aggregate and plan interventions appropriate for the needs of the group. As student nurses enrolled in a lab course on community and population health nursing at Boise State University, we spent a semester learning about the refugee population in Boise, Idaho. We partnered with a community agency working with refugees, sought out experiences to help us understand what life in the United States is like for refugees, and personally interacted with refugee families in the area to better understand their experiences and needs. In accordance with the nursing process, we assessed the population and situation, diagnosed the needs of the population, planned interventions to meet those needs, implemented our planned interventions, and evaluated the process and outcomes. This paper represents a summary of the group's process and activities as we practiced community and population health nursing.

Background

During times of war and devastation, the ability for a country to accept people who are fleeing from their homes is essential. Among these countries, the United States has a long-standing history of welcoming newcomers into its borders. In fact, since 1975 the U.S. has provided a new home to over 3 million refugees from all over the world (Bureau of Population, Refugees, and Migration, 2017b)! However, refugees are not the only people entering the United States. According to the Department of Homeland Security (2017), during the fiscal year 2015 over a million people were granted lawful permanent residence in the United States. These

statistics include individuals who were admitted as temporary nonimmigrants, granted asylum or refugee status, or naturalized (Department of Homeland Security, 2017). Of those one million people, 70,000 were refugees (Bureau of Population, Refugees, and Migration, 2015).

The following is a description of how individuals enter the U.S., specific issues that face refugees as they begin life in the U.S., and an introduction to the Agency for New Americans and the role they play for refugees in the Boise, Idaho, and surrounding Treasure Valley areas.

Entering the United States

People travel from other countries into the United States for many different reasons. Some travel for business and employment, others come as exchange students to study, many people come as tourists for vacations, and still others migrate to the U.S. for a new life. There are many terms used to describe these groups of people who come to the United States. While the terms refer to distinct groups of individuals, they are often confused or used interchangeably. Because this paper deals specifically with the refugee population, it is important to understand the difference between refugees and other groups of people who enter the United States. Therefore, the following is a brief explanation of immigrants, visas, refugees, asylees, and the DACA program.

Immigrants. While the term "immigrant" has been used for many years, it can often be confusing when describing the status of people moving to United States. In general use, the term immigrant refers to a person who had no U.S. citizenship at the time of their birth (Nguyen & Kebede, 2017). Segal and Mayadas (2005) further explain that an immigrant is someone who has moved to the United States of their own volition because life appeared more preferable and the attractiveness pulled them to the United States. However, there was careful planning involved in this move which enabled them to bring some assets with them. Despite the tendency to group

immigrants and refugees together, there is a huge difference in their psychosocial profile and it is therefore important to distinguish between them (Segal & Mayadas, 2005).

Visas. Before individuals can legally enter the United States they must first apply for and obtain a visa. (However, it is important to note that applying for refugee status is a different process and does not involve visa requirements. Refugees are discussed in more detail below.) There are two major categories of visas: immigrant and nonimmigrant.

Nonimmigrant visas are for people coming to the United States temporarily for business, pleasure, or some combination of the two. To apply for a nonimmigrant visa, individuals must first submit forms either online or to the U.S. Embassy and schedule an interview with a consular officer (Travel.state.gov, n.d.). Before the interview, interviewees must have a valid passport with photo identification and pay the visa application fee. Additional documents may be required to prove the purpose of travel, intent to depart after the visit, and ability to pay all travel expenses (Office of Refugee Resettlement, 2015b).

There are several types of immigration visas a person can apply for depending on the circumstance of immigration: employment-based, adoption, diversity, or family-based (Travel.state.gov, n.d.). The requirements to obtain visas differ depending on the type of immigration visa being sought. For instance, applicants for family-based visas must have a relative in the U.S. that will sponsor them and who can prove they have the financial assets to support the immigrant (U.S. Department of State, n.d.). In general, immigration visas can only be obtained if the potential immigrant is sponsored by a U.S. citizen or lawful permanent resident (either a relative or prospective employer). Immigrants granted visas are required to abide by the laws of the United States and may only come if they have work or relatives to live with (Travel.state.gov, n.d.).

Refugees. According to United States law, a refugee is defined as someone located outside of the United States who is forced to leave their country of origin due to persecution (or fear of such) based on race, religious beliefs, nationality, social group, or political beliefs (Bruno, 2012). The Bureau of Population, Refugees, and Migration (PRM) estimates that over 22 million people have sought refugee status in another country to flee from conflict and persecution (PRM, 2017a). Individuals who request protection before entering the United States are termed refugees, while those requesting protection after entering the U.S. are termed asylum seekers. Less than one percent of refugees worldwide are resettled annually. The United States has historically led the world in terms of refugee resettlement and today remains the top resettlement country (Zong & Batalova, 2017). "In fiscal year 2016, the United States resettled 84,994 refugees" (Zong & Batalova, 2017, p.1).

Because conflicts are not merely located in one region, refugees accepted into the United States represent diverse backgrounds of origin. The majority of refugees admitted to the U.S. during fiscal year 2015 came from the following countries: Burma (18,386 people), Iraq (12,676 people), Somalia (8,858 people), the Democratic Republic of Congo (7,876 people), and Bhutan (5,775 people) (Bureau of Population, Refugees, and Migration, 2015). Despite the current political landscape, refugees are still being accepted into the United States.

Through partnerships with international humanitarian organizations like the office of the United Nations High Commissioner for Refugees (UNHCR) and many non-governmental organizations (NGOs), the PRM works to provide relocation assistance to one of the world's most vulnerable populations: individuals and families seeking refugee status (PRM, 2017a). To apply for a refugee program individuals must contact an international non-profit volunteer agency, UNHCR, or a United States Embassy or Consulate (Office of Refugee Resettlement,

2015b). The organization must then refer the individual for a refugee program. Individuals with immediate relatives of United States citizens are ineligible for refugee status and must instead follow the steps to apply for an immigration visa (Travel.state.gov, n.d.).

Once eligibility has been determined, applicants receive a packet of various forms to complete and must provide proof of persecution in their home country (U.S. Department of State, n.d.). There are no fees for the application process. If the individual is approved, their immediate family members (spouse, children, etc.) will also be granted refugee status provided they are with the applicant at the time of the interview process. If not, those family members are required to apply for refugee status separately (Office of Refugee Resettlement, 2015b).

Asylees. The difference between asylees and refugees is subtle. "Asylees are people who meet the same criteria as refugees but are already in the U.S. or at a port of entry when they apply for asylum" (Cassidy, n.d.). Essentially, the location of the individual when they make the request (whether or not they are already in the U.S.) distinguishes between asylee status and refugee status. Although asylees and refugees are similar, their paths to citizenship are not the same. While both refugees and asylees can apply for naturalization (to become a citizen) four years after getting their green cards, the green card application process is slightly different; a refugee can apply for a green card twelve months after being relocated in the U.S., but an asylee must apply for a green card one year after getting their asylum status (Wernick, 2015), which is another process that takes a minimum of 180 days after one applies for it (U.S. Citizenship and Immigration Services, 2015a).

Individuals granted asylee status can live and work in the United States for the rest of their lives and can apply for their spouse and unmarried children younger than twenty-one years to join them (Brown & Wheeler, 2017). With citizenship status, asylees enjoy the rights and

responsibilities that all U.S. citizens should respect and exercise, which helps them feel at home. If an individual's application for asylum is denied, the U.S. Citizenship and Immigration Services forwards the case to the immigration court where a judge evaluates the application independently and decides whether to grant or deny the asylum status (U.S. Citizenship and Immigration Services, 2015b). In the case of denial, the applicant has the option to restart the application process if they have a stronger argument or documents that make their application more likely to be eligible for approval (U.S. Citizenship and Immigration Services, 2015b). This can prevent them from being deported back to their home country.

DACA. The previously discussed methods of entry into the United States are completed through proper legal channels before individuals are allowed to enter the U.S. In contrast, Deferred Action for Childhood Arrivals (DACA) is a program created in 2012 to offer unauthorized immigrants (those who immigrated illegally), who were under the age of 16 upon arrival, the opportunity to remain in the United States if they pay a $495 fee and meet certain criteria (U.S. Citizenship and Immigration Services, 2017a). Participants in DACA are sometimes referred to as *Dreamers* or *DACAmented* individuals. According to the U.S. Citizenship and Immigration Services (2017a), DACA does not give these individuals legal status; rather, it allows them to request deferred action - the "use of prosecutorial discretion to defer removal action" - to temporarily avoid deportation (What is DACA section, para. 1). If granted, the individual receives permission to remain in the United States for a period of two years during which time they can be eligible for work authorization. At the end of the two year period, the individual must apply for renewal of their status (and again pay the $495 fee) if they wish to stay in the U.S. (U.S. Citizenship and Immigration Services, 2017a). On September 5, 2017, DACA was rescinded and began a six month phase-out period (U.S. Citizenship and

Immigration Services, 2017b). This means individuals who have been allowed to remain in the United States due to DACA will no longer be eligible for this option.

Refugees: Issues Coming to the United States

While all individuals immigrating to the United States face hardship, refugees coming to the U.S. face many unique challenges. Some of these challenges include making the transition from their home or host country to the U.S., issues related to assimilating into a new community and culture, and physical and mental health concerns.

Transition. Transitioning from their home or host country to the United States can be a complicated and difficult undertaking for refugees. To assist with this transition, provisions and programs have been developed. Legal provisions that protect refugees are enacted and enforced by the United Nations High Commissioner for refugees (Lepore, 2015). Dr. Mark Lepore (2015) discusses the challenges in adapting to a new life, the Refugee Resettlement program, services provided by this program, and ways to ease the transition experience for refugees. The Refugee Resettlement program provides cash and medical assistance for up to eight months from the date refugees arrive in the United States. Through multi-agency collaboration, "Project Liberty" was established to promote casework services that lessen culture shock and assist refugee families and students with needs (Lepore, 2015). These casework services include obtaining a translator and providing advocates for the family to assist with goals in the school or job setting. Additionally, Lepore (2015) explains that effective orientation has been shown to reduce problems through the transition phase. Interventions that enhance cultural understanding include community involvement and support through translation and transportation (Lepore, 2015).

Assimilation. Assimilating to life in the United States can be a real challenge for those new to this country, especially if the U.S. was not their ideal resettlement destination. In order to

study the effectiveness of assimilation by refugees, the Center for American Progress performed a study using data from the U.S. Census Bureau between 1990 and 2008 (Myers & Pitkin, 2010). Six different benchmark areas were assessed to determine how well refugees assimilate to U.S. culture and way of life: homeownership, citizenship, English language proficiency, educational attainment, occupation, and income (Myers & Pitkin, 2010). This study compared nine states where most refugees are relocated to determine if certain areas were more conducive to refugee resettlement (Myers & Pitkin, 2010). The study found that refugees who were resettled in New Jersey, Florida, or Georgia had the best chance at success after an 18-27 year timespan. Success was measured by evaluating the percentage of refugees that owned their home, obtained a higher paying job, and learned English (Myers & Pitkin, 2010). This information gives placement agencies an idea about where to place refugees in order to give them the best chance of successful relocation. It also allows assessment of what makes those areas so successful, enabling those processes or programs to be implemented in other resettlement destinations.

Myers and Pitkin (2010) explain that "assimilation is a process that takes place over time" (pg. 11). Life changes necessitate time for adjustment, and the changes refugees experience while trying to integrate into a new culture and community certainly fall into this category. One important factor that influences a refugee's ability to assimilate is the age at which they arrive in the United States. According to Myers and Pitkin (2010), some aspects of assimilation such as English language proficiency and educational attainments are achieved quicker for younger refugees. This makes sense as refugees that are younger trend toward education, while those that are older often decide instead to pursue a career.

Physical and mental health issues. Refugees come to the United States from diverse regions of the world. They bring with them health risks and diseases common to all refugee

populations as well as some that may be unique to specific populations. Because of this, a medical examination is mandatory for all refugees coming to the U.S. (Centers for Disease Control and Prevention, 2014). Additionally, outside the U.S., medical examinations are performed as part of the screening process before transition. "All … refugees must have a medical examination to check for inadmissible health-related conditions before they can enter the United States" (Office of Refugee Resettlement, 2015a, p.2). If a refugee is found to have an inadmissible health-related condition, he or she must be treated prior to arrival in the United States.

The initial history and physical examination is a critically important first step in the assessment of newly arrived refugees. As stated by the Centers for Disease Control and Prevention (2014), "the first step in the examination of a newly arrived refugee is to obtain a detailed history, including any current symptoms, past medical problems, medications, allergies, social/family history, and a mental health assessment" (p. 1). Refugees often suffer from chronic conditions such as type 2 diabetes, heart disease, hypertension, overweight/obesity, and cancer as well as infectious diseases such as HIV, hepatitis B, and hepatitis C (Pace, Al-Obaydi, Nourian, & Kamimura., 2015). Because standards of care, access to health care and treatment, and exposure to infectious diseases vary by country, newly arriving refugees may experience different health problems than U.S.-born individuals (Centers for Disease Control and Prevention, 2014). Some of these diseases include tuberculosis, mumps, measles, rubella, and viral hepatitis. According to the domestic medical examination for newly arrived refugees checklist, during the medical examination for newly arrived refugees a thorough screening should be performed for things such as hepatitis, HIV, intestinal parasites, lead, STDs,

tuberculosis, nutrition and growth concerns, malaria, mental health concerns, and immunizations (Centers for Disease Control and Prevention, 2014).

Even after refugees receive pre- and post-arrival medical screenings, they may suffer from unrecognized and/or untreated physical and mental health conditions. Therefore, continuing medical care after arrival is vital for refugees. The Refugee Medical Assistance (RMA) is available for up to eight months starting when a refugee enters the U.S. (Office of Refugee Resettlement, 2015a). In addition, Medicaid or the Children's Health Insurance Program (CHIP) is available for refugees who meet the eligibility requirements of the programs. After refugees are on RMA for eight months, they are eligible to apply for health insurance through the Marketplace of the Affordable Care Act. Barriers to access of care experienced by refugees are complex and include not only language barriers and the lack of health insurance but also unemployment, lack of transportation, and distrust of physicians (Pace et al., 2015).

Researching mental health conditions in the refugee population is challenging because populations are dispersed and each culture of origin is unique unto itself. Nonetheless, mental health disorders including depression and post-traumatic stress disorder (PTSD) are prevalent in nearly all refugee populations worldwide. Because PTSD is a common finding in people fleeing persecution, its influence on refugees is discussed in more detail here.

Post-traumatic stress disorder. Research compiled by the Refugee Health Technical Assistance Center (2015) estimates the prevalence of PTSD among refugees to range from 10-40% and lists the primary risk factors to be trauma, delayed asylum application process, detention, and loss of culture and support systems. According to studies reported by the U.S. Department of Veteran Affairs, the most commonly reported traumatic events experienced by displaced people include forced isolation (imprisonment and separation), torture, continuous

trauma, starvation and depravation, being placed in a combat situation, and being close to death (Bolton, 2016).

Although PTSD is recognized as a concern for refugees, there are challenges related to its research. These include bias, qualifying the events that induce PTSD on a given population, translation of diagnostic measures into language of origin, cultural variation, and standardizing evaluation measures. Other issues affecting research include varying traumatic experiences related to the impacts of war, living in displacement camps, pre-existing health conditions, and a suite of new stresses brought on once arriving and assimilating in the new host country.

Given the challenges of researching PTSD in refugee populations, assessment and treatment can be complicated. Most often, refugees seek treatment prompted by legal advocates during the process of attaining citizenship, and are referred to seek help (Chu, Keller, & Rasmussen, 2012). The most commonly reported stressor predictive of PTSD symptomatology was immigration status and legal instability, followed by physical and emotional assault, religion, education, and socioeconomic status (Chu et al., 2012).

The Agency for New Americans

Within the Treasure Valley, the Agency for New Americans (ANA) has worked tirelessly to achieve their mission of "guiding and advocating for individuals forced from home and country to integrate into the community and achieve self-sufficiency during their resettlement period" (Bayard, 2017). They welcome hundreds of refugees every year from all over the world, the majority of which come from the Democratic Republic of Congo (35%), Syria (34%), Afghanistan (13%), Bhutan (6%), and Somalia (6%) (Bayard, 2017). Although the amount of refugees entering Boise has slowed, ANA has remained one of the largest integration organizations in Boise. In the fiscal year 2016, ANA resettled 223 refugees (Bayard, 2017).

When a refugee family arrives in Boise, they typically require extensive cultural, housing, and transportation orientation. The family may also need English and employment classes in order to begin working. English classes are mandatory (five days/week) to receive financial aid from the U.S. government (Bayard, 2017). ANA assists many refugees as they transition to a new life in Boise by connecting them with interdisciplinary teams that coordinate care and allocate resources for the family's needs.

From the point of arrival, a caseworker from ANA is at the airport to greet the new family and get them settled into housing. If housing is not yet established, ANA has a contract in place with some housing companies to get the family off to a good start. This contract allows the family to stay in a furnished apartment for $30 a night and provides a hot meal (Bayard, 2017). After arrival, the caseworker meets with the refugee family throughout the first week to assess the family's needs. The family may need basic orientation to things like household appliances or finding a grocery store. After the first week, the family will take English classes until they are fluent enough to seek employment. At that point, ANA provides them with community resources to help them write a resume and get a job interview (Bayard, 2017).

Newly arrived refugee families have continuous health and education-related appointments until their 30-day check-in with the caseworker from ANA. At this point, the caseworker determines if the refugees understand how to get a job, how to pay rent and utilities, where to get groceries, how to cash a check, how to use the public transportation system, if they can differentiate between emergent and non-emergent health conditions, and other important resettlement topics (N. Ball, personal communication, October 20, 2017). After 90 days, the caseworker does an in-depth examination of the family's understanding of their new resettlement area (N. Ball, personal communication, October 20, 2017). Throughout this entire process, the

caseworker checks in with other interdisciplinary groups who helped to resettle the family to assess for extra or specific needs.

Community health worker program. In order to facilitate their mission of self-sufficiency, the ANA created a program aimed at assisting new refugees in navigating the U.S. healthcare system. ANA's community health worker program employs successfully resettled refugees to assist new refugees with their healthcare needs. Health workers speak the language of the refugee family and provide solutions to better manage health and illnesses through allocating tools and resources and encouraging self-confidence (Bayard, 2017).

Boise State students supporting community health workers. As service-learning participants from Boise State University and seniors in Boise State's School of Nursing, we were expected to work in conjunction with the community health workers and their assigned refugee families to further identify the family's health and environmental concerns. Our role was to build a relationship with our assigned refugee families through weekly home visits, taking the time to get to know them and their needs. To enhance our understanding of the community health worker program and what role we would fill, a literature review was conducted.

Literature Review

Using Academic Search Premier through the Albertsons Library website, we searched for articles referencing both "community health workers" and "refugees". Our search resulted in 30 articles. After narrowing down the publication date range to 2010-2017, there were 20 articles to be reviewed. Of these, 4 articles were applicable for the purpose of our research. Beyond Academic Search Premier, a thorough search using Google Scholar revealed 11 other pertinent, peer-reviewed articles related to refugee community health worker programs throughout the world and the United States.

Research indicates that refugee health workers serve two very important purposes. First, many refugees were previously trained medical professionals within their home countries. Upon arriving to their host country, they are able to fill the gaps and shortages that exist within that country's healthcare system (Garber, 2017). Secondly, refugees trained to be health workers within their new community can relate to the experiences of fellow refugees as well as speak their language and understand their cultural background more readily than a medical professional within the host country (Garber, 2017). The research is overwhelmingly supportive of the implementation of community health worker refugee programs.

When examining the role that refugees play in filling medical professional shortages within their host country, the benefits become clear. Garber (2017) explains:

> [B]y resuming their education, training, and livelihoods, refugee health workers are able to maintain their skills, restore their dignity, and serve the community. Many have gone through the same traumas as fellow refugees, speak the same language, and are uniquely positioned to care for them. (para. 11)

Beyond this, they are able to "provide highly trained health workers [...] to fill gaps and meet the increased health demands caused by conflict" (Garber, 2017, para. 11). Furthermore, according to Kerry (2017), the World Health Organization reports a global healthcare shortage of 7.2 million doctors, nurses, and midwives. This number is expected to increase to 18 million by 2030! However, there are 3,000 immigrant and refugee doctors in Massachusetts alone who, if they are not unemployed entirely, are being forced to work low-paying, low-skill jobs (Kerry, 2017). The common sense solution is to utilize these medical professionals to fill the gaps within their new country of residence.

Community health worker programs have been created not only in the United States and Canada but also in other countries within Europe, Asia, and Africa. The implementation of community health worker programs and how those health workers' roles manifest differ from program to program. For example, a community health worker program in Nairobi, Kenya, conducts home visits to their Somali refugee families:

> [T]hey talk to refugee families about nutrition, sanitation, maternal health care, and other related topics. They refer families to clinics where they can receive affordable medical care. If a particular health issue seems to be a common concern for many families, [they] will organize community education forums for larger groups. (Hamilton, 2014, para. 5)

Within the United States, Rhode Island performed a pilot study of a community health worker program and found that following implementation of this program, refugees had an increased knowledge of health-based issues as measured through a knowledge assessment questionnaire completed prior to and following implementation of the program (Saya, Aung, Gast, & Lewis, 2016). Community health workers within this program assisted refugees with public transportation, medication adherence, making calls to doctors, etc. (Saya et al., 2016). This project illustrated that the program provided employment for these refugees in the form of community health worker positions, allowed physicians to focus on acute medical concerns while health workers provided general health information in a culturally competent way, and improved health outcomes in a cost-effective way for the entire health system (Saya et al., 2016).

Understanding and describing the benefits of community health worker programs is essential in illustrating the necessity for adoption of these programs throughout the United States and other countries around the world that host refugees. According to Torres, Labonte, Spitzer, Andrew, and Amaratunga (2014), benefits found within a community health worker program in

Alberta, Canada, included fostering collaboration between refugee communities and primary care institutions in order to "potentially reduce cost by improving health outcomes" (para. 40). Moreover, they found that healthcare professionals were extremely satisfied with the role that community health workers played in helping refugees navigate the healthcare system (Torres et al., 2014). Incorporating a community health worker program into a refugee-served community can increase refugee health outcomes, increase healthcare professional satisfaction, reduce costs through better collaboration of care, and make the overall transition into a new healthcare system more navigable for refugees.

Methods

With an understanding of the role of community health workers, students developed a plan for assessing the refugee community in Boise and developing strategies to support ANA and the community health workers. First, students performed a community assessment of Boise to determine what issues might exist for refugees. Next, students developed an educational pamphlet to address specific needs identified through the community assessment. Finally, students visited refugee families in their homes to further assess refugee needs and support the community health workers.

Community Assessment: Boise and Refugees

The model utilized for this project was the Anderson and McFarlane Community Assessment. This model employs a community-as-partner philosophy to assess the health of the community (Anderson, 2000). We chose to use this model to systematically focus on the health of the community in the aggregate and allow us, as student nurses, to develop interventions that target specific problem areas for the refugee population in Boise, Idaho. The assessment model is represented by a wheel with the people in the community at the center, surrounded by areas that

influence them. These areas include the physical environment, education, safety and transportation, politics and government, health and social services, communication, economics, and recreation. Each of these areas are discussed below.

Physical environment. Boise is the capital city of Idaho with a population of 223,154 people. It is nestled in the foothills of the Rocky Mountains, surrounded by mountains, rivers, lakes and vast expanses of open desert. It is classified as high desert with four distinct seasons and an elevation of 2,730 feet (City-Data, 2017). The Boise population enjoys outdoor opportunities including wilderness adventures, skiing, hiking, cycling, camping and visiting hot springs. Growing urban developments such as living spaces, a remodeled history museum, and new libraries are also enjoyed by this population. Although Boise visitors and residents celebrate the surrounding beauty and discuss numerous ways to enjoy a healthy lifestyle, the area also has its challenges related to physical environment. Air quality, water quality, and high desert temperatures pose potential health complications.

Boise's air quality is compromised by the physical geography of the Snake River Basin. Air pollutants can hover over the basin, creating an inversion of unhealthy air lasting for days or weeks, posing a threat to healthy lungs. Wildfires from the local and regional forests can also cause an excess of smoke to build up and linger over the Boise area. While the smoke and pollutants eventually clear, special precautions must be taken by residents during these times. The Idaho Department of Environmental Quality (DEQ) states that children, elderly, people suffering from lung and/or heart disease, and others with sensitivities or pre-existing conditions such as asthma, can be adversely affected by breathing in air pollutants (Idaho Department of Environmental Quality, 2016). The Idaho DEQ is diligent about alerting the public during these times and offers suggestions for ways to minimize exposure when air quality is subpar.

Overall Idaho is known for its abundant, free-flowing water, boasting over 8,900 rivers and streams throughout the state (Idaho Department of Water Resources, 2010). While much of the water is high quality, the very same industries that have helped Idaho to prosper - mining, logging, and agriculture - have also created water pollution issues that endanger Boise's drinking water. Drinking water in Boise and surrounding areas is frequently monitored for safety and quality standard assurance. Newcomers to the area will often hear discussion and debate over this most precious resource.

Temperatures in Boise range from below zero during winter months to over one hundred degrees in summer months. The combination of high elevations and extreme temperatures can create a harsh climate for new residents, especially if pre-existing health challenges such as respiratory or kidney disease exist. Keeping hydrated and protected from the sun are important during the summer months. Winter months can be severe and require extra layers of clothing, boots, hats, and coats to maintain comfort and warmth.

Education. In Boise there are 33 elementary schools, 8 junior high schools, and 5 senior high schools. Parents enrolling their students for the first time in the Boise School District must provide proof of age, identity, district of residency and proof of immunizations (Boise School District, 2017). As a state, Idaho does not rank very high in education. However, the city of Boise does well compared to the rest of the state. The high schools in Boise are ranked among the top 11% in the nation (Boise School District, 2017).

Boise offers many opportunities for higher education with multiple universities, colleges and technical programs. Boise State University, in the heart of downtown Boise, has 23,886 students, offers approximately 170 accredited programs, and boasts an 82% acceptance rate (U.S. News and World Report, 2017). Other universities located in Boise and the surrounding area via

satellite campuses include Idaho State University, the University of Idaho, and Concordia School of Law. There are a few colleges that surround Boise as well, the most popular being the College of Western Idaho, which also has a few buildings located in Boise. Brown Mackie, Carrington, Stevens-Henager, and the Milan Institute are all technical programs located in the Boise area.

Safety and transportation. In recent years, increased numbers of people from all over the United States have been moving to Idaho in hopes of a better quality of life. Boise, Idaho, is consistently rated as one of the top places to live in the United States because of the employment opportunities, outdoor activities, and family-centered style of living. According to a Reddit thread, Boiseans said that they feel safe living in Boise (Saunders, 2013). The FBI crime reports for the year 2016 rank crime rates in Boise as 8% lower than the national average and violent crimes in Boise as 23% lower than the national average (Areavibes, 2017). However, when analyzing all cities in the United States as a whole, Boise was only rated as safer than 38% of all other cities. Boise was ranked as the 37th best city to live in the United States and received a B- in crime and safety based on violent and property crimes (Niche, 2017).

Public Transportation in the Treasure Valley is provided primarily by Valley Regional Transit (VRT), the Regional Public Transportation Authority for Ada and Canyon counties. VRT offers fixed route bus service, the companion paratransit ACCESS service which is available to those who are unable to access the fixed route service due to disability, and the GoRide volunteer driver rides (VRT, 2017).

Fixed route bus service on ValleyRide is available on weekdays from 5:15 AM to 6:45 PM. Eight routes offer service on Saturdays between 7:45 AM and 6:45 PM, but there is no bus service on Sundays. Fares are $1 per ride or $2 for a one day pass. Riders can purchase stored value cards in $10 and $20 increments or long term passes can be purchased in 31 day, 3 month,

6 month, or 1 year time periods (VRT, 2017). Passes can be purchased at City Hall in Boise, through VRT, or at WinCo and Albertsons locations throughout the valley. Rider training and trip planning assistance is available through VRT for those new to using the bus in the Treasure Valley (VRT, 2017).

In addition to the fixed route bus service, VRT also coordinates a volunteer driver ride program, GoRide. These rides are available to anyone in the service area but are by reservation only. Passengers must be independently mobile, accompanied by a caregiver, or require minimal assistance from the driver. Since drivers use their own vehicles, passenger access is limited to what the driver is able to accommodate. Rates for this service are $3 per eight-mile segment. Reservations must be made at least 2 days in advance (VRT, 2017).

Transportation for non-emergent medical needs is available in the Boise area for Idaho Medicaid eligible appointments and is currently provided through a contract with Veyo Medical Transport (Idaho Department of Health and Welfare, 2017a). These trips must be scheduled in advance and are available based on driver schedule and availability. There are also several taxi companies and Uber rides available for transportation in the Boise area. Fares for these services vary by provider and require reservations.

Politics and government. Idaho has been welcoming refugees for more than forty years (Barnhill, 2015). There are two resettlement programs in Idaho: one in Boise and the other in Twin Falls. However, the future of Idaho's refugee resettlement programs is uncertain. Idaho has always been a Red state, and currently the Governor of Idaho, the two federal representatives and senators, and the majority of the state legislative branch are Republican (Ballotpedia, n.d.). Due to their political leaning, the vast majority of elected public officials at both the state and federal level support the immigration travel ban, which "restricts entry into the United States by nations

from six pre-dominantly muslim countries ….[and] decreases the number of refugees to be admitted to the United States each year to 50,000 from about 110,000" (Congressional Digest, 2017, para. 2-4; Dentzer, 2017). The mayors of Boise and Twin Falls are among the few public officials who support the refugee resettlement program (Shane, 2017; Berg, 2017).

Health and social services. Within the Treasure Valley, there are an abundance of health services. From major hospitals like St. Luke's Regional Medical Center and Saint Alphonsus Regional Medical Center to various clinics like Primary Health Medical Group, Saint Alphonsus Urgent Care, and St. Luke's Urgent Care, the residents of Boise and the Treasure Valley have plenty of access to healthcare. Beyond major health systems, there are clinics within the valley that offer sliding scale payments as well as free access for individuals without insurance. These include Family Medicine Residency of Idaho, Terry Reilly, Genesis Community Health, Vineyard Free Medical Clinic, and Saint Alphonsus Friendship Medical Clinic. Overall, Boise and the surrounding Treasure Valley area are well-equipped to provide quality care for residents.

In addition to the available medical services, the Idaho Department of Health and Welfare offers a multitude of health and social services including food/cash assistance, food stamps, child care assistance, WIC (Women, Infant, and Children program), CHIP (Children's Health Insurance Program), Medicaid, etc. (Idaho Department of Health and Welfare, 2017b). There are two locations for the Department of Health and Welfare: one is in downtown Boise on State Street and the other is in west Boise on Fairview.

Specifically for refugees, there are resources available that include the Idaho Office for Refugees, the Internal Refugee Committee, Global Gardens, the Refugee Health Information Network, and the U.S. Committee for Refugees and Immigrants. Tidwell Social Work is a non-profit organization located in Boise that provides various services to the refugee population;

these include “therapy/counseling, play therapy, community based rehabilitation services, case management, peer support, training/consultation services, and community building/healing” (Tidwell Social Work, 2017, para. 2). In the event that a refugee requires emergency assistance, they may call the 2-1-1 Idaho Care Line and speak with someone that knows their language (For Idaho Refugees, 2017). Other social resources available include taxi companies like Pamir Taxi, Mountain Taxi, and ABC Taxi that have drivers who speak various refugee-spoken languages (For Idaho Refugees, 2017). There also various food banks, shelters, and housing assistance programs within the Treasure Valley that refugees may qualify for. Overall, there are a multitude of health and social services available to refugees within our community.

Communication. Boise has many methods for communication, including newspapers, TV news stations, radio stations, community boards, telephone hotlines, automated text messaging, and online communities such as Facebook and Nextdoor. Unfortunately for refugees, the majority of these resources are only available in English. This can make communication especially difficult for refugees who do not speak fluent English. The situation becomes even more complicated when the topic of discussion turns to health. For non-English speakers and even fluent English speakers, understanding health information and health teaching can be extremely challenging. To address this issue, the major hospitals in the Boise area offer interpretation and translation services for patients and the language line is available by telephone for real-time interpretation (Language Line Solutions, 2017; Saint Alphonsus, 2017; St. Luke’s, 2017). While hospital services are useful for interpreting health care information during inpatient settings, outpatient or home settings can be of concern for refugees. Although the language line may seem like the obvious solution because it is available by telephone any time, it can quickly become prohibitive as it costs $3.95 per minute (Language Line Solutions, 2017).

Economics. Boise, Idaho, has a unique economy. There are a variety of jobs available, low rates of unemployment, and a low cost of living when compared to the greater United States. The cost of living in Boise is 1.8% below the national average (Forbes, 2016), and the current minimum wage is $7.25. Unemployment is at 2.3% (Hyer, 2017), and the annual job growth is 2.6% (Forbes, 2016). Boise is fairly spread out over a large land area, and median home prices are $201,200 (Forbes, 2016).

The average annual income in Ada County was $46,053 in 2015 with 12.3% of individuals falling below the federal poverty level (Hyer, 2017). Trade, utilities, and transportation jobs predominated the workforce by the quantity of employed persons. The average wage was $43,291. The highest earners in Ada county include those in manufacturing, mining, and finance. The lowest wage earners include those in hospitality ($16,904), service-based other ($28,071), and agriculture ($34,818) (Hyer, 2017).

Recreation. For those that enjoy spending time outdoors, Boise has a long list of recreational activities. The Boise River passes right through the middle of town, providing convenient access for floating and paddling. Boise also has a large number of parks with ponds for swimming, large grassy areas for sports-related activities, and plenty of trees for shade. There are many spaces for hiking and biking, including parks and recreation trails. The Boise greenbelt runs for 33 miles and is a popular path for both recreational activities and commuting by walking, jogging, biking and other recreational modes of transportation (City of Boise, 2017). The Idaho Botanical Gardens boasts 50 exclusive acres of serene specialty gardens and is a perfect place to immerse yourself in nature within city limits (Idaho Botanical Garden, 2017). Boise Parks and Recreation offers numerous intramural sports activities and tournaments throughout the season (City of Boise, 2017).

There are a few refugee-specific activities currently in place. The Boise Bicycle Project, a local nonprofit organization, has implemented projects to fund and give away bikes to many refugees in the community (Boise Bicycle Project, n.d.). They also offer free classes to help people learn how to troubleshoot and fix their bikes. The University of Idaho has a grant funding a mobile recreation van in the summer months that picks up refugee youth at the Boise Bench apartments and takes them to parks for recreational activities (Fritz, 2009). There are also recreation-specific classes incorporated within the school systems such as soccer camps with the Boise Community Schools, ski lessons with Bogus Basin Nordic Team, and an array of intramural sports and camps through Boise State University and other surrounding colleges.

Assisting ANA

The partnership between ANA and Boise State University allowed nursing students to assist ANA while simultaneously accomplishing course objectives. One specific course requirement was to develop a project that would assist with health promotion in the community. To accomplish this, students sought input from ANA about possibilities for educational material that would be beneficial to refugee families. To assist ANA with their community health worker program, students participated in weekly home visits with refugee families.

Health promotion education project: "Your Guide to Health Care" pamphlet.

Assessment of the Boise community revealed that Boise is overall well-suited for refugees from all over the world. It has a moderate climate, many employment opportunities, several education options, and excellent healthcare. However, we discovered two specific areas that make life difficult for refugees in Boise: transportation and navigating health care needs. As nursing students, we developed a health promotion education project (HPEP) focused on assisting refugees to meet their basic healthcare needs in this new environment. This HPEP took the form

of an educational brochure, titled "Your Guide to Health Care" (see Appendix). The details of the pamphlet are discussed below in the Results section.

Home visits. Supplementing ANA's Community Health Worker program included student groups of two or three being assigned to a refugee family and then performing weekly and as-needed home visits. Groups were assigned families from varying ethnic backgrounds and who have been in the United States for varying periods of time. Initially, students met with their assigned families for the first time accompanied by the community health worker and the ANA program head. During this initial visit, students were introduced to their refugee families and expectations of the students' involvement in the program were explained. Each subsequent week, student groups met with the refugee families at pre-established times. Students assisted families with concerns when practical and directed families to the proper resources if their requests fell outside students' knowledge or scope of practice.

Results

The results of our interactions with the refugee community allowed us as nursing students to grow in knowledge and cultural awareness. Additionally, we were able to assist ANA through the completion of our HPEP and the home visits. These activities enabled us to meet course objectives.

Student Growth

Challenges always offer the opportunity to learn and grow. Although individual student growth is difficult to measure and is most accurately assessed through self-reporting, challenges have been abundant throughout the semester and therefore general statements can be made regarding student growth. Student growth was most apparent in the areas of communication and cultural awareness.

Communication. While everyday life presents communication challenges, those experienced by students while partnering with ANA were unique and included language barriers and cultural differences. Many people first experience language barriers when traveling outside of their homeland. However, this semester students experienced the discomfort of language barriers firsthand during weekly visits with refugee families. Although students asserted their best efforts, language barriers posed an enormous hurdle as many of the families had no experienced English speakers. Efforts to overcome this resulted in both personal and professional student growth. Ultimately, nurses must learn how to overcome uncomfortable situations with patients, striving to establish trust and ease. This only develops through practice, and communicating with refugee families provided an excellent opportunity for students to practice this important skill.

Students also improved communication skills as a result of the group experience. Adhering to group norms, establishing and maintaining roles, and open communication were all found to be challenges. Each student was invited to assess group function, verbalize areas for improvement, and offer to perform group responsibilities. While this was an uncomfortable process at times, it provided important opportunities for students to practice successful team communication strategies.

Cultural awareness. Students were able to expand their cultural awareness through communication with refugee families as well as contrived experiences such as bus excursions, viewing educational videos about different cultures, doing research about specific cultures, and attendance at community events highlighting refugee experiences. Issues such as timing, privacy, and spatial norms were all vetted during contrived experiences and weekly refugee family visits. Most refugee families were from Asia, Southeast Asia and the Middle East. Although students

addressed a myriad of cultural differences with such a wide variety of cultures, many groups reported similar challenges.

ANA Partnership

Partnering with ANA allowed students to be involved with refugees in Boise indirectly by creating the HPEP and directly through home visits.

HPEP. The "Your Guide to Health Care" brochure (see Appendix) was developed in English and delivered to ANA electronically in an editable format. This will allow ANA to translate the brochure into different languages, print copies as needed, and distribute the brochure to refugee families when they arrive in the U.S. The brochure contains three main sections. The first section offers guidelines for when to call 911, when to seek help at a hospital emergency department, and when to make an appointment at a clinic. The second section lists addresses, phone numbers, and hours of health clinics in the Boise area. These clinics are divided into two groups: free clinics and fee for service clinics. The third and final section of the brochure contains a list of basic patient rights and responsibilities in the U.S. healthcare system.

Although ANA never gave feedback regarding the HPEP, students shared the brochure with their refugee families. Families received it well and expressed specific appreciation for the list of clinics provided.

Home visits. Throughout the semester, students worked in groups of two or three with refugee families assigned by ANA. Some of the assigned refugee families have been in Boise for only a few months while others have been here for multiple years. One of the student pairs had the privilege of meeting their refugee family at the airport upon arrival to Boise, but most student groups were assigned to families who were already at least partially established in Boise. There appeared to be some correlation between time spent in the U.S. and the involvement/interest of

the refugee family with nursing students; refugee families more established seemed less interested in student involvement while newer families expressed more interest.

Students attempted to meet with their assigned refugee families in their homes weekly for an hour or more. During this time, students assessed the living environment and other aspects of daily life with which refugee families needed assistance. Some families asked for help with English, housing, and transportation, while other families were looking strictly for companionship. Although students were not permitted to drive the refugee families (due to organizational agreements between ANA and Boise State University), we were able to educate families on how to use the bus system and other modes of transportation available to them. Basic English was taught via the use of flashcards which families were able to keep after the visit. Housing was addressed by contacting ANA regarding families' concerns so that ANA could further assist with this need. Students visited with families seeking companionship and attempted to find common interests to pursue. Following weekly home visits, students communicated with ANA via email regarding activities performed during the visit.

Evaluation: Meeting Course Objectives

Students completed course objectives by collaborating with ANA's CHW project. Students learned about the refugee culture and practiced communication and other interpersonal skills that community health nurses need. Our framework included the Anderson and McFarlane Community Assessment model (Anderson, 2000). Students provided recommendations for short- and long-term goals for ANA and refugee populations in Boise. Students set boundaries and followed student-created guidelines, advocating for the needs of Boise's refugee population. Students participated in a wide variety of community activities while providing privacy and

building rapport with diverse groups of people. Students collaborated inside and outside of the classroom, communicating with one another to support ANA.

Limitations

Our project experienced some significant limitations. These included language and communication issues between students and refugees; a misunderstanding between ANA, students, and the professor of the course regarding expectations of the project; a finite time period due to semester constraints; and lack of buy-in on the part of students, refugees, and ANA. Each of these limitations is discussed in detail below.

Language and Communication

Idaho has become home to refugees from a wide variety of nations and cultures. In fact, refugees who have been resettled in Idaho come from more than 45 countries and speak more than 73 languages (Richert, 2016). Along with this rich diversity come the problems of language barriers and cultural differences. These issues negatively affect the communication between refugees and English language speakers. This was a significant limitation of weekly home visits because most refugee families were not fluent in English, and students did not possess adequate language skills for effective translation. Therefore, many refugee families had to rely on relatives for translation and interpretation. This negatively affected home visits because English-speaking relatives were not always present to translate and interpret for students. This led to ineffective communication during visits, which in turn led to frustration on the part of students and refugee families.

Misunderstanding of Expectations

With any large group of people working together, there are bound to be occasional miscommunications and misunderstandings. When language differences, time constraints, and

various other barriers are added to such a situation, the chance of miscommunications and misunderstandings occurring increases dramatically. In this project, students, faculty, and refugee families misunderstood the students' roles within the Community Health Worker (CHW) program.

Our work with ANA's CHW program began with an introductory presentation from ANA's program coordinator. She explained to the students and faculty that our role would include "support[ing] the CHW's plan of action, weekly home visits, build[ing] a relationship with the family, and regular communication with CHW and CHW coordinator about progress" (Bayard, 2017). The program coordinator made it clear that students were not allowed to drive the refugees anywhere. However, what was not clear was exactly how students would be assisting the community health worker. Students and faculty expected that students would perform health assessments and interventions during weekly home visits. However, during the initial home visit students were introduced by the program head to refugee families as "friends" who were there to "spend time" with refugee families.

After the first introduction with refugee families, it became apparent that many of them did not understand why the students were visiting them. Many of the refugee families we were assigned to had been in the United States for a number of years and were firmly settled. They did not desire "relationships" with the students. Instead, they expressed a desire for help with transportation in the form of personal rides from the students and help with obtaining citizenship - two things with which students were unable to assist.

Beyond this issue, students found it difficult to "support the community health worker's plan of action" as CHWs were often unavailable to us. We were continuously unsuccessful in contacting CHWs as they rarely answered calls, texts, or emails. Student visits to refugee

families almost never coincided with CHW visits. Furthermore, it became clear as time went on that many students would not be assisting refugee families with anything health-related because they were either too private, had no health concerns, or were being managed completely by the CHW.

Lastly, when misunderstandings and miscommunication did arise, students attempted to contact both the ANA program head as well as the community health workers to no avail. When students communicated their concerns to the faculty, it was further confirmed that we would not have answers to our questions from ANA as the program head also did not respond to the instructor. It proved difficult to successfully perform our responsibilities without understanding those responsibilities or receiving timely feedback regarding concerns. Students did their very best to build relationships with refugee families and help them with anything we could. However, our support of the CHW program could have been more effective if these barriers were adequately addressed.

Limited Time Frame

Another limitation this group experienced was the short time students were able to engage with refugee families. Students were unable to meet their assigned refugee families until roughly the middle of the semester, leaving just over a month for home visits. This meant the time necessary to build a strong relationship and trust was not available. Trust is the foundation to every good relationship, forming powerful bonds to help communicate openly (Frost, 2017). It was very difficult to work with families who have been through traumatic experiences without having adequate time to build trust, learn to communicate with each other, or provide support for chronic health issues.

Lack of Buy-in

The concept of buy-in relates to the support or investment an individual or group attaches to a project or idea (The Free Dictionary, 2015). For this project to meet with success, buy-in regarding home visits and the HPEP was necessary on the part of students, ANA, and refugee families. Unfortunately, not all parties were sufficiently invested in all aspects of the project.

The lack of buy-in regarding home visits on the part of students and refugee families affected the success of the visits. While some student groups felt very involved and even connected with their refugee families, other student groups felt refugee families were simply tolerating the home visits rather than benefitting from them. Some refugee families did not interact with students during home visits, and others rarely (if ever) responded to student requests for visits or were not at home for scheduled visits. Students who felt refugee families did not want them in their homes quickly became less invested in repeating home visits. Similarly, when refugee families received clarification regarding what students were actually able to do, they became less invested in having students in their homes. ANA requested students submit weekly reports on home visits via email. Students rarely received responses from ANA regarding these reports. This increased students' impression that ANA was not interested in the content of home visits.

ANA expressed little interest or involvement in the HPEP portion of the project beyond giving the initial suggestion for the pamphlet. Although feedback on the pamphlet was specifically requested via email, students received no response from ANA. This lack of buy-in on the part of ANA caused students to question the value of the HPEP and its usefulness to the agency and refugee families.

Recommendations

After completion of this project, we have some recommendations regarding future student projects involving refugees and/or ANA. These include having clearer expectations of the role of students, coinciding student visits to refugee families with community health worker visits, offering mobile health clinics to refugee populations, and allowing more student input into project selection and placement to improve student buy-in.

Clearer Expectations

We feel that this project would be greatly improved with clearer expectations and ground rules for both the families and students involved. Some refugee families had the impression students would be able to assist them in areas that were specifically forbidden (such as students providing transportation). Students were told that refugee families knew the ground rules. However, a few of the families were disappointed when they realized that students were not allowed to drive them anywhere or did not have the knowledge to assist them in areas such as obtaining a green card, explaining the process of sponsoring someone from another country, or helping them with the process of moving from one apartment to another. Once it became clear that students were unable to assist them in the ways they had hoped, a few of the families became distant and disinterested. Many refugee families that were already established in the area seemed uninterested in the simple things students could provide and in taking time out of their busy schedules to spend time with students. Students and faculty require a more defined set of expectations, while refugee families require a more concrete understanding of activities students are able to perform.

Student Visits to Coincide with Community Health Worker Visits

Communication was a huge barrier for students working with refugee families. Many refugee families did not speak English, making it very difficult to build a trusting relationship. For future projects to be more successful, we suggest that students visits coincide with the CHW visits. This would allow CHWs (who speak both English and the language of the refugee family) to translate for students and refugee families, making home visits more productive. Students often felt the refugee families did not understand why we were visiting them. Asking and answering questions could have allowed students to possibly address some health needs that refugee families had and clear up misunderstandings. If the CHW was present, refugee families could have had a clearer understanding of what the students' objectives were. Home visits would have been smoother and more comfortable for everyone involved.

Mobile Health Clinics

One of the ways that future student cohorts could provide nursing services to the refugee community of Boise is by setting up mobile health screening clinics. These clinics would drive to and park in neighborhoods that are densely populated with refugee families. Student-run mobile health clinics would arrive on scheduled days for specific hours, in known locations.

The advantages to such clinics are numerous. First, services provided would be basic but would allow for nursing students to practice clinical skills such as patient assessments, blood glucose monitoring, blood pressure checks, and patient education and outreach. Students would also have the opportunity to develop deeper patient interactions and communication skills. Having patients with limited English-speaking skills would help student nurses learn how to ask simple questions and practice patience with their patients. Second, mobile health clinics would allow for nursing students in community health classes to participate with the refugee population

in an actual health-related manner. The current format of student home visits through ANA offers very few opportunities for health related activities to occur between students and refugees. Third, having a mobile health clinic would allow refugees to interact in a casual way with healthcare workers. This would open the door for developing trusting relationships and could provide positive social interactions between healthcare workers and the refugee community. Finally, these clinics would be an excellent way for new nurses to gather disease prevalence and incidence data on the refugee population in Boise.

Because few resources are available to the students in the community health class, it would be advantageous to reach out to other resources in our community who have a vested interest in population health and working with Boise's refugee community. Possible partner organizations for mobile health clinics could include The Red Cross, The Boise Center for Disease Control, Saint Alphonsus, and St. Luke's.

Student Input in Project Selection and Placement

While buy-in on the part of ANA and refugee families is outside the control of students and the Boise State University School of Nursing, student buy-in could be improved through a change in the registration process for the course. It is recommended that students have the opportunity to be involved in selecting community health projects and placement in those projects. Offering students choices regarding projects and placement increases the likelihood that students will self-select into a project that matches their interests. Had students selected (rather than received an assignment) to participate in the community project working with ANA and refugee families, their buy-in would have been increased from the beginning.

Conclusion

Participation in any project comes with inevitable barriers and limitations; however, if participants are determined to accomplish the goals set before them, success, growth, and learning may occur as well. Throughout this semester, students actively worked to assess their community's overall health, to learn about the refugees coming to and living in the United States (and specifically those living in Boise, Idaho), and to contribute helpful information/resources to their assigned families and ANA using their health expertise and experience. Students provided ANA with an informational brochure aimed at increasing health awareness for refugees; they aided the community health workers through weekly home visits to refugees; and in the process, students gained an increased awareness of what it means to be a refugee in the United States.

All of these experiences contributed to the students' understanding of community and public health nursing and increased their global worldview. In the future, ANA may benefit from the recommendations presented in this paper. Through implementation of even a few of the proposed changes, they may find that refugee families, community health workers, and Boise State students all work together more effectively to accomplish the goals of the Community Health Worker program.

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Patient Rights

You have the right to…

- ❑ Privacy
- ❑ A language interpreter
- ❑ Designate someone that will be your personal representative or support person
- ❑ Have your provider or family notified of hospitalization or injury
- ❑ Informed consent
- ❑ Make decisions about treatment and medication
- ❑ Make appointments convenient for you
- ❑ Request a different provider or interpreter
- ❑ A copy of your medical records
- ❑ Help with billing claims
- ❑ Have your cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected as long as they don't harm others

Patient Responsibilities

It's your responsibility to…

- ❑ Arrive on time for appointments
- ❑ Bring list of current medications
- ❑ Tell provider about current symptoms, past illnesses, and hospitalizations
- ❑ Report changes in your symptoms
- ❑ Participate in and ask questions about your plan of care and treatment
- ❑ Communicate with provider about your pain
- ❑ Follow the rules of hospitals or clinics
- ❑ Be prepared to pay your bill

Your Guide To Health Care

BOISE STATE UNIVERSITY
COLLEGE OF HEALTH SCIENCES
School of Nursing

Produced by
Nursing 417 Community & Public Health
Fall 2017 Students
For the Agency for New Americans

Call 911 if someone has:

- ❑ Stopped breathing
- ❑ Severe chest pain
- ❑ Severe burns
- ❑ Lost consciousness
- ❑ Head, neck, or spine injury
- ❑ Heavy bleeding
- ❑ Weakness/inability to move one side or both sides of body
- ❑ Seizures (no prior history of seizures)

Go to Emergency Room for:

- ❑ Possible broken bones
- ❑ Suicidal thoughts
- ❑ Severe allergic reactions
- ❑ Possible poisoning/overdose

Go to a clinic/doctor's office for:

- ❑ Earaches, Headaches
- ❑ Fever
- ❑ Rash
- ❑ Nausea, vomiting, diarrhea
- ❑ Sore throat, coughing, runny nose
- ❑ Pain and minor injuries

Free Clinics:

Genesis Community Health
Call for hours and appointments
215 W. 35th St
Garden City, Idaho
208-384-5200

Vineyard Medical Clinic Barnabas Center
Wednesday and Saturday
9:00am - 11:00am
4950 N. Bradley St
Boise, ID 83714
208-954-2059

Friendship Medical Clinic
Monday & Tuesday evenings by appointment
704 S. Latah
Boise, ID 83705
208-429-6678

Fee Based / Insurance:

Family Medicine Residency Clinic
Call for hours and appointments

777 N. Raymond
Boise, ID 83704
208-514-2500

6565 W. Emerald St.
Boise, ID 83704
208-514-2510

Terry Reilly
Monday - Friday 8:00am - 6:00pm

300 S. 23rd St
Boise, ID 83702
208-344-3512

848 La Cassia St.
Boise, ID 83705
208-344-0086

St. Luke's Clinic - Capital City Family Medicine Urgent Care
Sunday - Saturday 8:00am - 8:00pm
1520 W. State St. Suite 100
Boise, ID 83702
208-947-7700

Saint Alphonsus Federal Way & Saint Alphonsus CARE Clinic (Maternal/Child healthcare)
Call for hours and appointments
1880 W. Judith Lane
Boise, ID 83705
208-367-6910