University of Wisconsin-Milwaukee
Institute for Urban Health Partnerships
Teaching Today's Students for Tomorrow's America (TTSTA) Project
Bev Zabler, PhD, RN, Project Director

Community Health Assessment: City of Milwaukee Refugee Community

Developed by
Kris Peterka, BSN, RN, UWM DNP Student and
Winter Turner, BA, UWM MSW Student
in collaboration with the TTSTA Project Team
December, 2017

This HRSA-funded project (2015-2018) implemented and evaluated an interprofessional collaborative practice (IPCP) model through an across-system partnership, including a nurse-managed health center, a major local health system, and a community-based resettlement organization. Aims of the project were to improve access to and quality of primary care for local refugees while preparing healthcare providers and students to care for this population.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Nurse Education, Practice, Quality and Retention (NEPQR) Interprofessional Collaborative Practice (IPCP) and Interprofessional Education (IPE) Cooperative Agreement under grant number, UD7HP28542, for $1,337,115. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Project Background

Refugees in the United States, as in many other countries, are a vulnerable, isolated, and underserved population. The barriers they face while acclimating to a new country create additional layers of complexity in the already overwhelming experience of resettlement. Current primary health services are often not seen as welcoming by refugees, who then do not return for further care. The three-year, federally funded partnership project, *Teaching Today's Students for Tomorrow's America* (TTSTA), implemented new solutions to the problems of access to and quality of primary health care for a local refugee population while educating health providers for future practice environments. Our across-system, across-site partnership included a local healthcare system (HCS); an academic nurse-managed health center (NMHC); and a community-based organization (CBO) focused on refugee resettlement. To improve the quality of health care, the project partners implemented a model of interprofessional collaborative practice (IPCP) that is community-based, patient-centered, and culturally responsive: a refugee Community-Centered Health Home (CCHH). This model expands the concept of primary care medical homes beyond the walls of a traditional primary care clinic and endorses that a person is only as healthy as the community in which they live (Cantor et al, 2011). Table 1 on the next page holds a side-by-side Primary Care model comparison.

The two aims of our project were to improve access to and quality of primary care for local refugees and to develop the IPCP competencies of their providers. One strategy to achieve the first aim was to perform a Community Health Assessment (CHA). This report shares our findings through the second year of the project.

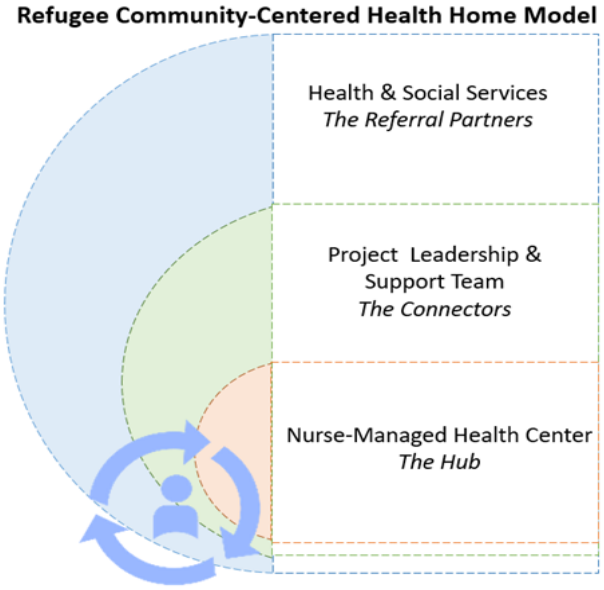


Figure 1: The *Teaching Today's Students for Tomorrow's America* Project Community-Centered Health Home Model, © Bev Zabler, 2018

Table 1. Comparison of Primary Care Delivery Models

Feature	Traditional Model (Lundeen, 1995)	Collaborative NMHC Model (Lundeen, 1995)	CCHH Model (Cantor et al, 2011; Mikkelsen et al, 2014)
Location	Community-based	In existing CBO	Across institutions
Structure	Stand-alone primary care center	Interdependent partnership	Collaborative healthcare institution partnerships
Community of Service	Registered clinic clients	All members of an identified community	Patients, families and, indirectly, all members of an identified community
Determination of Services	Defines and develops services on staff mix, marketing data	Defines & continually modifies on a continual engaged assessment of community needs & strengths	Strategically engages partner efforts to improve community environments
Point of Entry	At clinic registration	Community residents determine	Clinic, community services or community health promotion
Service Unit	The individual (and sometimes the family)	Individual, family, population, and whole community	Participate to improve health & safety for whole community
Access	Restricted by criteria of insurance coverage or membership	Open and unrestricted by criteria of insurance or membership	Multiple partner institutions coordinated between providers
Setting	Clinic only	Inside and/or outside the clinic setting	All partners with active involvement in community advocacy & systems of change
Clients	Individuals and families who become registered	All community members (seen in the clinic or not)	All members of an identified community
Service Coordination	Competitive with other primary care providers	Complementary to other primary care providers	Complementary to existing community partners
Timing	Services are episodic	Services are continuous	Ongoing active involvement
Level of care	Mostly secondary or tertiary prevention focused on cure	Mostly primary prevention (even in the clinic setting)	Mostly primary prevention with focus on care management & coordination
Care Coordination	Within the primary care center/affiliated delivery system	Coordination of all health and health related services	Translates medical conditions to involvement in community advocacy and change
Other Provider Relationships	Largely referrals, information sharing, general planning activities	Largely collaborative	Requires the coordinated capacity & engagement of multiple partners

Community Health Assessment Framework: City of Milwaukee Refugee Community

The results of a Community Health Assessment (CHA) describe the health status and quality of life of a particular population. The CHA illuminates the community's strengths and assets, and identifies health improvement priorities. These health priorities can then drive an efficacious Community Health Improvement Plan (CHIP). The population's strengths and assets are resources harnessed to support the CHIP.

High quality CHAs are community driven and follow an assessment framework. The TTSTA grant team chose a commonly used framework (Figure 1) that has a strong component for assessing community strengths and assets: **M**obilizing **A**ction through **P**lanning and **P**artnerships (MAPP). MAPP was developed in 2000 by NACCHO in cooperation with the CDC and Public Health practice. The purpose of the MAPP framework is to guide a "community driven strategic planning process for improving community health" (NACCHO, 2017). In an ongoing process over two years, we gathered information through the CHA portion of the MAPP Framework. We developed the refugee CCHH services based on our growing understanding of the local refugees' needs.

Figure 2: MAPP Framework (NACCHO, 2017)

TTSTA MAPP Process

Six Phases of the MAPP Framework

1. Organize for Success/ Partnership Development
2. Visioning
3. Assessments
   - The Community Themes and Strengths Assessment
   - The Local Public Health System Assessment
   - The Community Health Status Assessment
   - The Forces of Change Assessment
4. Strategic Issues
5. Goals/Strategies
6. Action Cycle

Phase 1. Organize for Success/Partnership Development

The initial TTSTA partners came together after identifying a need to improve primary health care access and quality for the refugee population in the City of Milwaukee. The partners began discussions and teambuilding in 2013 and, in 2015, received three years of federal funding to develop, implement and evaluate a refugee CCHH model while training current and future providers to care for this population. Included in the project workplan was the objective to complete a formal CHA process to identify the health needs of the City of Milwaukee refugee population. Project leadership, clinical teams and an advisory board met regularly during the CHA process. The meeting proceedings were documented and later used as a data source for the CHA.

Phase 2. Visioning

The TTSTA project partnership is rooted in a common vision of:

> Health equity for Milwaukee Immigrants and Refugees that transcends social determinants of health.

This can be accomplished by expanding the TTSTA refugee Community-Centered Health Home network through interprofessional collaborative practice (IPCP) and interprofessional education (IPE) environments across sites and systems.

Phase 3-6. Summary

The next sections of this document will address three of four MAPP Phase 3 Assessments. Although we connected with the leadership of refugee-serving programs within the City of Milwaukee Public Health Department, our CHA did not include a formal local Public Health System Assessment. Finally, we identified Strategic Issues, MAPP Phase 4, which are shared at the end of this document.

We share our CHA findings to support the development of a Community Health Improvement Plan (CHIP). This can be accomplished by expanding the CHA and completing the final MAPP Phases: 5. Goals/Strategies and 6. Action Cycle.

Phase 3: Community Themes and Strengths Assessment

Community themes and strengths can be identified through community asset mapping. Asset maps can answer the questions, “what health concerns are important to the community?” and “what community assets could improve population health?” The map highlights aspects of the community that have the potential to contribute to the overall quality of life. Community assets are resources that could be leveraged for a community health improvement project. The asset map below, completed during the time of the TTSTA project for our local refugee population, identifies community individuals and organizations contributing to refugee health in Milwaukee.

Individuals

Community health workers and local Resettlement Agency (VOLAG) staff

Organizations

VOLAGs , Cermak, El Rey, SSNC, HOP, Sojourner, SEA Literacy, Neighborhood House, UMOS, Milwaukee Time Exchange

Institutions

Office of Refugee Resettlement

Department of Children and Families

Department of Health Services

Economic

Patrick Cudahy

Religious

Milwaukee Myanmar Christian Church

Chin Baptist Church

Archdiocese of Milwaukee

Web

Milwaukee Refugee Supporters
https://www.facebook.com/groups/196330597367630/about/

Phase 3. Community Health Status Assessment

Data and Definitions

A major challenge to the development of a comprehensive picture of health in the refugee population in the City of Milwaukee is a dearth of data. Another challenge is the lack of consistency in grouping this population. Some data sources group by foreign born status which includes refugees, asylees and immigrants. Other data sources group by refugee status. Incongruous population groupings compromise the validity of population health monitoring, the identification of health risk indicators and the prediction of healthcare utilization patterns. (Hatcher et al., 2015)

The Migration Policy Institute, the Wisconsin Department of Children and Families, and the Wisconsin Department of Human Services provided the majority of health statistics for this CHA. The Migration Policy Institute tabulates data from the U.S. Census Bureau's American Community Survey and Decennial Census.

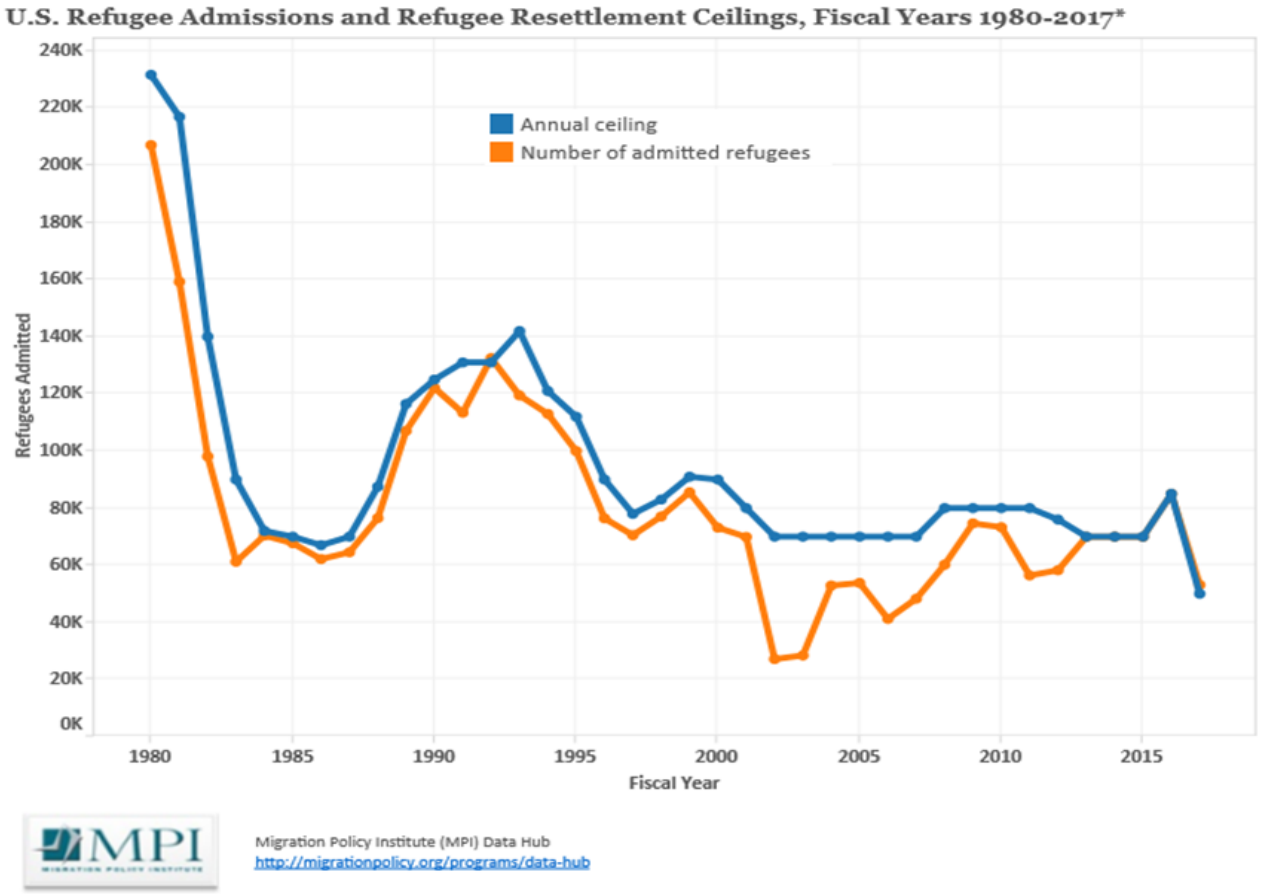
Definitions

Foreign born: Anyone who is not a U.S. citizen at birth. Includes those who have become U.S. citizens through naturalization, asylees, refugees, foreign students, immigrants and unauthorized immigrants. (US Census, 2016)

U.S. born: Anyone born in the United States, Puerto Rico or other U.S. territories, or born abroad of a U.S. citizen parent or parents. (US Census, 2016)

Refugee: Someone who has been forced to flee his or her country of nationality who is unable or unwilling to return to that country because of persecution, based on the person's race, religion, nationality, membership in a particular social group, or political opinion war, or violence. (US Immigration, 2018)

Refugee Resettlement Ceilings and Admissions to the United States



The Immigration and Nationality Act requires, before the start of the fiscal year, that the President of the United States presents the Proposed Refugee Admissions Report for the upcoming fiscal year to the members of the Committees on the Judiciary of the Senate and House of Representatives. This reports includes the ceiling and the allocation of refugees to be admitted to the United States.

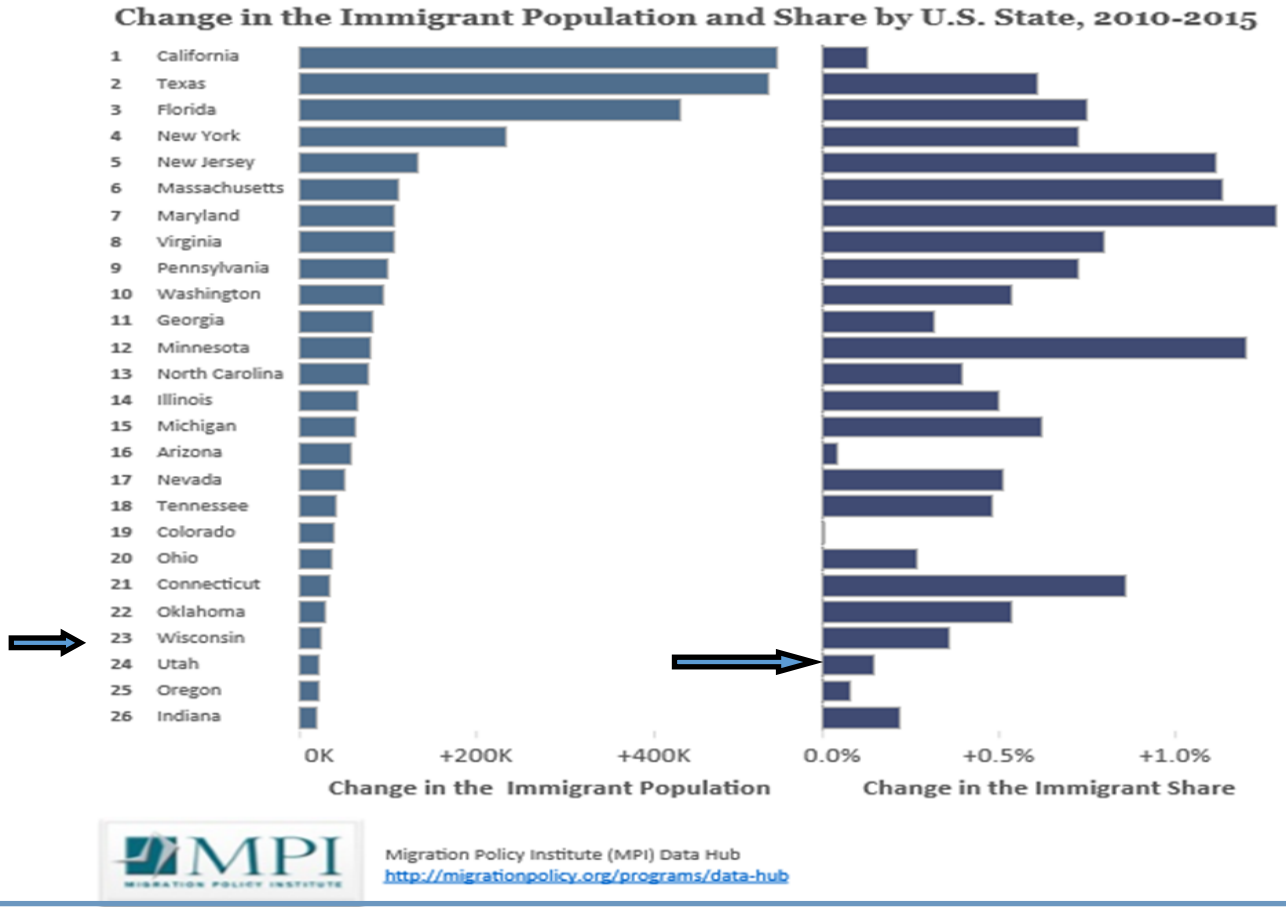
In 2016, President Obama proposed a ceiling of 110,000 refugee admissions.

In 2017, President Trump proposed a ceiling of 45,000. (41% reduction from prior year)

Source: Proposed Refugee Admissions Report 2017; Proposed Refugee Admissions Report 2018

December 4, 2017 the Supreme Court granted the federal government's request to enforce President Trump's "travel ban." This proclamation limits the entry of nationals from eight countries: Yemen, Somalia, Iran, Libya, Syria, North Korea, Venezuela, and Chad. As of the date of this report submission, the proclamation continues to be challenged in federal appeals courts.

Refugee Arrivals in the United States and Wisconsin 2001 to 2015



MPI MIGRATION POLICY INSTITUTE

Migration Policy Institute (MPI) Data Hub
http://migrationpolicy.org/programs/data-hub

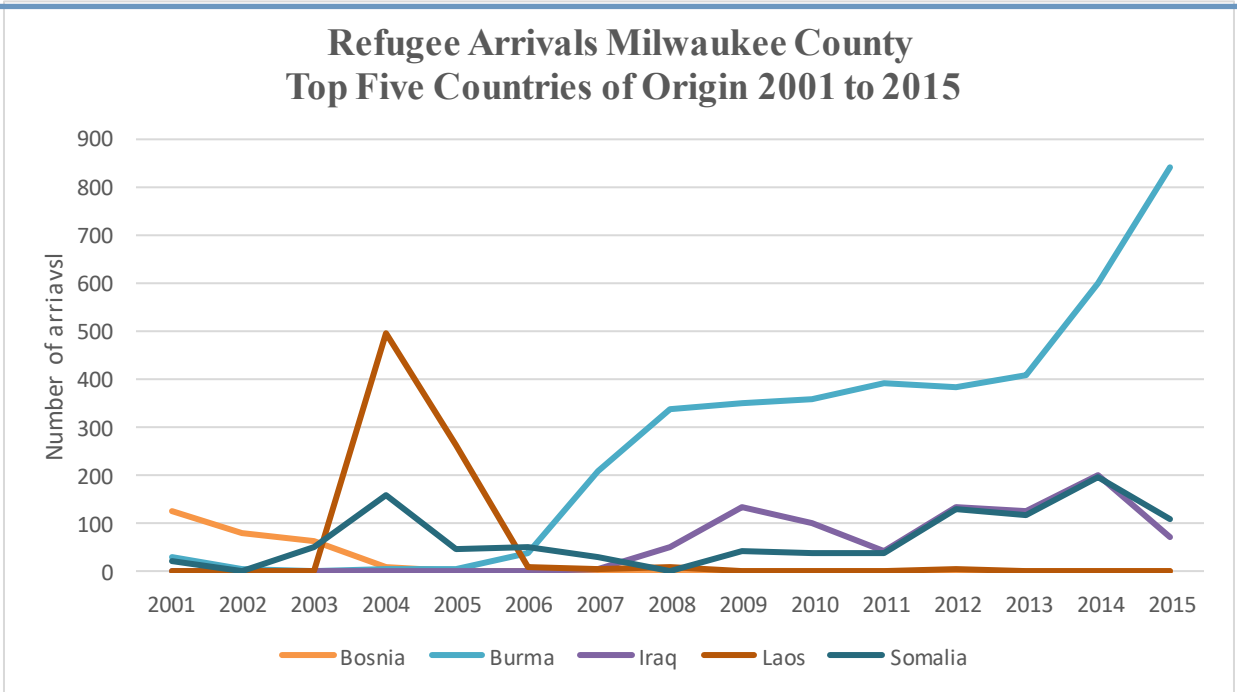
In 2015, the Wisconsin Office of Refugee Resettlement (ORR) served 1,415 refugees. Newly arrived refugees are provided case management services, limited cash assistance, temporary medical assistance, English as a second language education, and job readiness and employment services to help them transition to life in their new communities. (Office of Refugee Resettlement, 2017)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of Refugee Arrivals in WI	472	221	238	2421	1163	332	353	457	630	847	684	960	880	1382	1292
Percent of US Refugee Admis-sions	1%	1%	1%	5%	2%	1%	1%	1%	1%	1%	1%	2%	1%	2%	2%

Source: Migration Policy Institute State Data Profiles (n.d)

Refugee Arrivals in Milwaukee County by Country of Origin

To ensure their survival refugees leave their homes and seek protection in a foreign country. To obtain refugee status, an individual has to prove persecution based on race, religion, nationality, or membership in a social group.



Source: Wisconsin Department of Children and Families

Refugees Arrivals in Milwaukee Top Five Countries of Origin 2016	
Country of Origin	**# of Arrivals**
Burma	396
Somalia	108
Iraq	72
Congo	44
Syria	38

Source: Wisconsin Department of Children and Families

Wisconsin had an increase in refugees from The Democratic Republic of the Congo (DRC) and Syria in 2016.

The escalating violence of the Syrian Civil War that began in 2011 is increasing the number of Syrian refugees worldwide.

The Democratic Republic of Congo has seen nearly 18 years of war, violence, and human rights abuses.

Wisconsin may continue to absorb a significant number of Burmese refugees due to continued conflict in Myanmar.

Refugee Arrivals in Milwaukee and Wisconsin by Gender and Age 10/2/16—9/30/17

	Female			Male			Total Child	Total Adult	Grand Total
	Adult	Child	Total	Adult	Child	Total			
Milwaukee	168	190	358	187	160	347	350	355	705
Wisconsin	257	251	508	263	232	495	483	520	1003

Source: Wisconsin Department of Children and Families

Adolescent Adjustment

Acculturation, or the dynamic process of adapting to a new culture, involves learning a new language, norms, customs, and acclimating to mainstream culture (Berry, 2005; Lincoln et al., 2016). Struggles with language barriers, discrimination, and the inability to participate in the host culture can lead to acculturation stress (Lincoln et al., 2016) This process can be especially fraught for adolescent refugees who are already grappling with normal adolescent developmental changes. Acculturation issues have been correlated with PTSD and depressive symptoms in adolescent Somali refugees who resettled in the U.S. (Lincoln et al., 2016)

Women's and Maternal Health

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Female population (ages 15-50)	12,980,017 / 63,571,102	88,868 / 1,221,738
Gave birth in last 12 months	781,001 / 3,150.052	4,852 / 61,075
Married and gave birth	75.4% / 61.6%	82.0% / 64.2%
Unmarried and gave birth	24.6% / 38.4%	18.0% / 35.8%

Source: Migration Policy Institute State Data Profiles (n.d)

Refugee women's health considerations: (Gagnon & Robinson, 2002)

- **Pregnancy rates** vary among refugee women due to a number of factors: varying knowledge, belief and availability of contraception; desire for more children to repopulate or replace deceased children; uncertain future, marital separation and economic instability.
- **STDs and HIV** pose a threat to refugee women as they may be at an increased risk due to husbands having extramarital relationships when separated from their wives. Economic disruption may force women to trade sex for goods or food for themselves or their children. And there may be an increased risk of rape during their journey.
- **Sex and gender-based violence** is used as a weapon of war. Female genital mutilation (FGM) still occurs in Malaysia, some Middle Eastern and Eastern African Countries. In 2012, 513,000 girls in the U.S were at risk of FGM and its consequences (Goldberg et al., 2016).

Children

Household and Family Size

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Average house size*	3.35 / 2.35	3.14 / 2.39
Average family size	3.83 / 3.15	3.74 / 2.96

Source: Migration Policy Institute State Data Profiles (n.d)

Children Under Age 18

2015	United States	Wisconsin
Children under age 18	69,944,384	1,238,445
Only native born parents	52,078,695	1,099,616
One or more foreign born parent	17,865,689	138,829

Source: Migration Policy Institute State Data Profiles (n.d)

Food:
Major Source of Stress

TTSTA case managers report new refugees, in particular mothers, worry about how to feed their children once settled in their new community. Confusion about nutrition labels, fear of food ingredients, ubiquitous fast food, and lack of access to native foods contributes to this concern.

Resettlement in the United States forces a change in the dietary habits of refugees. This is a common source of stress for individuals and families. In addition, the American diet may negatively impact the health of refugees since it is higher in fat, sugar and salt. Refugee perception of the American diet is that it is unhealthy. Many refugees increase their energy consumption after resettlement as a result of increased intake of sweets, sweetened beverages, fruit juices and fast food (Wang et al., 2016).

Refugees have difficulty finding native foods and worry about timely use of food stamps. Stress is compounded by a lack knowledge of ingredients in American foods, locations of food outlets, and how to cook American foods (Wang et al., 2016).

Language

2017 Top Ten Refugee Native Languages in the United States

Rank	Native Language	Arrivals
1	Arabic	12,175
2	Nepali	3,580
3	Somali	5,454
4	Sgaw Karen	5,454
5	Spanish	1,675
6	Kishwahili	3,516
7	Chaldean	369
8	Burmese	457
9	Armenian	457
10	Other major languages	699
Total		30,022

Source: US Department of State. Bureau of Population, Refugees, and Migrants

In comparison to Arab immigrants, Arab refugees resettled in a large midwestern city had higher rates of health insurance coverage but significantly more medical problems, lower education levels, fewer skills for coping with stress, more problems with transportation, and more language difficulties (Elsouhag, et al., 2015).

English Proficiency Age 5 and older

2015	United States	Wisconsin
English proficiency (age 5 and older)	43,014,670 / 258,610,344	277,200 / 5,157,294
Speaks only English	15.8% / 89.0%	21.1% / 95.1%
Speaks English "very well"	35.0% / 9.2%	36.2% / 3.9%
Speaks English less than "very well" (LEP)	49.3% / 1.8%	42.7% / 1.0%

Source: Migration Policy Institute State Data Profiles (n.d)

Education

Educational Attainment Age 25 and Older

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Population age 25 and older	37,721,311 / 178,725,852	229,967 / 3,689,030
Less Than HS Diploma	29.3% / 9.4%	28.7% / 7.3%
HS Diploma or GED	22.5% / 28.6%	22.9% / 31.7%
Some College/Associate's	18.7% / 31.1%	19.0% / 32.6%
Bachelor's	17.0% / 19.4%	14.9% / 19.2%
Graduate/Professional	12.4% / 11.4%	14.4% / 9.1%

Source: Migration Policy Institute State Data Profiles (n.d)

Employment

Civilian Labor Force

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Population age 16 and older	41,366,218 / 214,801,540	259,641 / 4,368,149
% in civilian labor force	65.8% / 62.1%	69.1% / 66.7%
% unemployed	5.5% / 6.5%	4.9% / 4.2%
% of recent arrivals (arrived within last 10 years) who are employed	24.1%	26.9%

Source: Migration Policy Institute State Data Profiles (n.d)

Occupational hazards such as movement injuries and skin, eye, and lung exposure to toxic chemicals are health risks seen in the refugee population (Gagnon & Robinson, 2002).

Employment

Percentage of Foreign Born by Industry

2015	United States	Wisconsin
All civilian workers	17.1%	5.8%
Agriculture, forestry, fishing and hunting, and mining	23.6%	11.6%
Construction	24.8%	4.5%
Manufacturing	18.9%	7.9%
Wholesale trade	17.6%	3.1%
Retail trade	14%	4.2%
Transportation and warehousing, and utilities	17.1%	3%
Information	13%	3.3%
Finance and insurance, and real estate and rental and leasing	13.6%	4.1%
Professional, scientific, management, administrative, and waste-management services	19.9%	7.9%
Educational services, and health care and social assistance	14.1%	5.1%
Arts, entertainment, recreation, accommodation, and food services	20.7%	7%
Other services (except public administration)	21.7%	6.4%
Public administration	8.7%	2.9%

Source: Migration Policy Institute State Data Profiles (n.d)

Brain Waste

Brain waste is skill underutilization among college educated workers age 25 and older. These workers are either unemployed or underemployed

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Total civilian, college-educated labor force, age 25+	7,861,900 /40,124,400	50,300 / 797,500
Number underutilized (i.e., unemployed or employed in low-skilled jobs	1,779,800 / 7,082,200	9,100 / 146,500
% of civilian, college-educated labor force, age 25+	22.6% / 17.7%	18.1%/ 18.4%

Source: Migration Policy Institute State Data Profiles (n.d)

Often refugees are employed in industries in which they are overqualified . This can signify a drop in social status when they are not employed at their level of skill and expertise (Gagnon & Robinson, 2002). Further, it represents a brain drain or loss of human skills and resources from the county or origin and a brain gain for the resettled country (International Organization for Migration, 2017).

Income

Poverty

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Population for whom poverty is determined	42,709,800 / 270,766,600	274,283 / 5,345,940
Below 100% of the poverty level	17.3% / 14.3%	17.0% / 11.8%
100-199% of the poverty level	23.2% / 17.5%	23.6% / 16.5%
At or above 200% of the poverty level	59.5% / 68.2%	59.4% / 71.7%

Source: Migration Policy Institute State Data Profiles (n.d)

2015	United States Foreign born / US born	Wisconsin Foreign born / US born
Median household income	$51,482 / $56,458	$47,575 / $56,025

Source: Migration Policy Institute State Data Profiles (n.d)

Health Insurance

2015	US Naturalized citizens	US Noncitizens	Wisconsin Naturalized citizens	Wisconsin Noncitizens
With health insurance	91.6%	65.1%	93%	65.2%
With private health Insurance	66.6%	45.1%	93%	52.3%
With public coverage	35.9%	22.5%	35%	16.2%
No health insurance coverage	8.4%	34.9%	7%	34.8%

Source: Migration Policy Institute State Data Profiles (n.d)

Lack of formal interpretation services, language barriers, lack of providers sensitive to traditional medicine, depression and unfamiliarity of the US health system lead to health issues within the refugee population (Gagnon et al., 2002).

Newly resettled Burmese Karen refugees report wanting physicians to understand their health in the context of their traumatic experiences, validate their experiences, educate on the impact of trauma on health and on treatment options. Refugees may not initiate the conversation out of shame (Cook et al., 2015).

Priority Health Conditions of Resettled Refugees

Burmese Refugees	
Physical Health Condition	**Behavioral Health Condition**
Hepatitis B	PTSD (most common etiology is torture, war)
Intestinal parasites	Alcohol abuse (more common in men)

Source: US Department of Health and Suman Services (2016). Burmese Refugee Health Profile. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/pdf/burmese-refugee-health-profile.pdf

Iraqi Refugees	
Physical Health Condition	**Behavioral Health Condition**
Diabetes	PTSD (most common etiology is war; torture)
Hypertension	Depression
Malnutrition	Anxiety

Source: US Department of Health and Suman Services (2014). Iraqi Refugee Health Profile. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/pdf/iraqi-refugee-health-profile.pdf

Congolese Refugees	
Physical Health Condition	**Behavioral Health Condition**
Parasitic infections	PTSD (most common etiology is personal violence, sexual and gender based violence)
Malaria	

Source: US Department of Health and Suman Services (2016). Congolese Refugee Health Profile. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/pdf/congolese-health-profile.pdf

Syrian Refugees	
Physical Health Condition	**Behavioral Health Condition**
Anemia	PTSD (high incidence in children d/t war)
Diabetes	
Hypertension	

Source: US Department of Health and Suman Services (2016). Syrian Refugee Health Profile. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/pdf/syrian-health-profile.pdf

Phase 3. Forces of Change Assessment

Click on icon to open assessment in Word

Microsoft Word
Document

Phase 4: Strategic Issues

Following are some of the major strategic issues identified by the TTSTA Project CHA. This final list of major concerns can be used as a springboard for a community health improvement project through the MAPP Framework Phases 5. Goals/Strategies and 6. Action Cycle.

- Current U.S. policy is anti-refugee and nationalistic. It is instilling fear and confusion within the refugee community and fueling anti-refugee sentiment within the larger community. On the other hand, this extreme stance has created a backlash heightening awareness of refugee concerns and generating momentum at a grassroots level and local policy level for refugee support.
- Need for more translations and interpreter services
- Need for more ESL services so refugees do not have to rely on interpretation/ translation services for lengthy periods of time. Refugees expressed wanting to be independent in their interactions with others.
- Brain waste. The skills, education levels, and talents of the refugee population are not maximized. Many refugees are underemployed. This represents a drain of skills and resources from the country of origin and a missed opportunity for the U.S.
- CHWs from and living within the community are invaluable to helping refugees assimilate. Challenges are 1) not enough qualified individuals to become CHWs and 2) no available formalized, quality CHW training that is tailored to the specific needs of the refugee population.
- Health system design and navigation: The U.S. health system is often vastly different than the health system of a refugee's country of origin. Acclimating to the US system is a challenge for refugees.
- Diet concerns. The literature and focus group participants identified one major stress for new arrivals is food security, distrust of American food because it is perceived as unhealthy, and difficulty with understanding American food ingredients and labels.
- Mental health services. Many refugees come to this country after experiencing traumatic events either in their country of origin or the camps where they resided prior to arrival.
- More robust data collection. New arrival screening data is no longer collected at a state or national level. There is a dearth of data on health behaviors, health needs and mortality specific to refugees.

References

Berry, J. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations., 29*(6), 697-712.

Cook TL, Shannon PJ, Vinson GA, Letts JP, Dwee E. War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study. *BMC International Health and Human Rights*. 2015;15:8. doi:10.1186/s12914-015-0046-y.

Elsouhag, D., Arnetz, B., Jamil, H., Broadbridge, C.L. & Arnetz, J. (2016). Factors associated with healthcare utilization among Arab immigrants and refugees. Journal of Immigrant and Minority Health, 17(5), 1305-1312.

Gagnon, A.J., Mary, L. & Robinson, K (2002). A systematic review of refugee women's reproductive health. *Refugee, 21*(1), 6-17.

Goldberg, H, Stupp, P., Okoroh, E., Besera, G., Goodman, D.& Daniel, I. (2016). Female genital mutilation / cutting in the United States. Updated estimates of women and girls at risk, 2012. *Public Health Reports*, 131, 1-8.

Hatcher, J., Richards, H., Homan, C. & Zhu, V. (2015). Building a population grouping methodology and cost weights, Canadian Institute for Health Information, Canada. Retrieved from https://www.cihi.ca/sites/default/files/document/building_a_population_grouping_methodology_and_cost_weights.pdf

International Organization for Migration (2017). Key migration terms. Retrieved from https://www.iom.int/key-migration-terms

Lincoln AK, Lazarevic V, White MT, Ellis BH. The Impact of Acculturation Style and Acculturative Hassles on the Mental Health of Somali Adolescent Refugees. *Journal of immigrant and minority health / Center for Minority Public Health*. 2016;18(4):771-778. doi:10.1007/s10903-015-0232-y.

Lundeen, S.P. (1995), ©Comparison of Primary Care Delivery Model Elements: Lundeen Collaborative CNC Model and Traditional Primary Care Model of Delivery. Handout. UW-Milwaukee College of Nursing

Migration Policy Institute (n.d). State Immigration Data Profiles. Retrieved December 2017 from https://www.migrationpolicy.org/data/state-profiles/state/income/WI/US

Mikkelsen, L., Cohen, L., & Frankowski, S. (2014). Community-centered health homes. Engaging health care in building healthy communities. National Civic Review, 57-59.

Office of Refugee Resettlement (2015). Refugee arrival data. Retrieved from https://www.acf.hhs.gov/orr/resource/refugee-arrival-data

US Census Bureau. (2016). *Foreign Born.* Retrieved from https://www.census.gov/topics/population/foreign-born/about.html#par_textimage

US Immigration. (2018). *Glossary: Refugee.* Retrieved from https://www.usimmigration.org/glossary/refugee

Wang, F., Min., J., Khuri. J. & Amdersen, L.M. (2016). A systematic review of food intake and adaptation to the food environment by refugees settled un the United States. *American Society for Nutrition, 7,* 1066-1079 doi:10.3945/an.115.011452

Wisconsin Department Children and Families (n.d). Refugee statistics, population & census data. Retrieved December 2017 from https://dcf.wisconsin.gov/refugee/statistics-population

Cantor, J., Cohen, L., Mikkelsen, L., Panares, R., Srikantharajah, J., & Valdovinos, E. (2011). Community-centered health homes. Bridging the gap between health services and community prevention. Prevention Institute, i-19.