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Q & A with Carol T. Lewis, MD
Creating a Medical Home for Refugee Kids at Hasbro

MARY KORR
RIMJ MANAGING EDITOR

Whether her patients speak English or not, Dr. Carol T. Lewis’ passion for her work is not lost in translation. As the director of the Pediatric Refugee Health Program (PRHP) at Hasbro Children’s Hospital, she greets new patients with a smile, a hug, or a kiss on the forehead.

Within 30 days of their arrival, these newcomers, who are mostly from the Middle East and Africa, are seen in the monthly refugee clinic. They are referred by Dorcas International Institute of R.I., the state’s primary refugee resettlement agency, or by the Diocese of Rhode Island.

On this particular week, Dr. Lewis has been told to expect five children from Burundi in the next clinic. They are pre-screened on a Friday, so that by Monday morning at the clinic, designed as a patient-centered medical home (PCMH), Dr. Lewis and her team have all the lab results at hand, and an interpreter if necessary.

Partially because of the success of the PCMH model at the clinic, Hasbro has applied to PCMH-Kids, an initiative developed by the state, RI Medicaid and health insurers. Ten pilot programs will be selected this winter.

“Toward that end, it’s an opportunity to provide for all of the kids that we see here the type of PCMH we are offering for refugees,” Dr. Lewis said, during an interview with RIMJ when she spoke about her professional journey and the refugee program.

Q. How did you personally get interested in pediatrics and then caring for refugees?
A. Many years ago I realized I liked the little ones. You are not dealing with an isolated patient; you are always dealing with the family. But also it’s so incredibly dynamic – from taking care of a 6-month-old infant to a 16-year-old adolescent. You get to watch all those different stages of development.

The fact that I’m here and not in private practice is because I love working with this population in general. When you are working with kids and families with limited resources, their access to healthcare is much more difficult. Here in the refugee clinic, we see the tip of the iceberg. Over time, you are allowed more into their story. I am very humbled by them and their incredible resilience.

Q. The pediatric refugee clinic opened in 2007. How did it start?
A. It had its roots following Liberian civil wars [1989–2003] when the influx of children to Rhode Island, between 2003–2006, was great and the slots available for them to be seen by hospital pediatricians was limited.

In 2006, we held a Saturday screening session at the International Institute; 30 kids came in and were seen by volunteer doctors and nurses. When we finished, we agreed it was so much better than trying to piecemeal it together. We then asked ourselves, ‘How can we do this better and create a patient-centered medical home (PCMP) for the refugee kids?’
Q. Are there many pediatric refugee clinics nationwide?
A. It is unusual to have a pediatric refugee clinic. In most states, the initial intake exams go through the Department of Health, which contracts out to providers.

Once they come here for the first visit, we don’t refer them out. The physician who sees them on their first visit becomes the primary care provider. Trust is huge with refugee populations. Healthcare is so different here. The concepts of prevention, the whole concept of primary care, is new to them.

Q. After a family is referred to the clinic, what happens?
A. The CDC guidelines are to see refugees within 30 days. Doreen Pelland is our refugee health nurse; she does a lot of the care coordination at the initial Friday pre-screening. I pop in for a visit, and then see these families the following Monday morning.

Comprehensive and culturally-sensitive care is part of the concept of the PCMH. We have Dr. Nicole Nugent available. She specializes in mental health care in diverse groups; she has time and funding set aside and can see a child within a week or two down here. In addition, St Joseph’s Hospital has a pediatric dental residency program. They send a dentist over on the very first intake day – oral health is a real problem with this population. And the interpreters – many are former refugees – and the community health workers, they are the real heroes.

Q. What advice do you give medical students and residents you work with?
A. Many students I come into contact with have some global health experiences and are interested in cultural differences. Probably the advice I give them is it’s the relationship piece that’s huge – not the one-time visit. If you are a medical student or resident and want to join me on that first visit, you’re going to commit to seeing these patients in that first year, and deal with their chronic issues and the preventive issues to keep them well – you are going to be the first line.

I tell them it’s the listening, making sure they use their resources, that they are knowledgeable about what’s culturally appropriate and what’s not – hugging may be okay for Burundians but not for Nepali families. As long as you are always respectful and always listening and learning how to interact with people, you will be fine.