



the foundation | BlueCross and
BlueShield of Minnesota

*Critical Links:
Study Findings and Forum Highlights
on the Use of Community Health Workers
and Interpreters in Minnesota*

May 2003



About the Blue Cross and Blue Shield of Minnesota Foundation

The Blue Cross Foundation looks beyond health care today for ideas that create healthier communities tomorrow. We are the state's largest grantmaking foundation with assets exclusively dedicated to health. Since 1987, the Blue Cross Foundation has provided grants totaling \$13.8 million to fund programs that build healthier communities, foster healthy lifestyles, improve access to care, and find solutions to health care problems. The Blue Cross Foundation is a member of the Minnesota Council on Foundations and subscribes to its principles and practices.

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We hope this report is helpful to you. For more information about this project or to receive an executive summary of this report, call the Blue Cross Foundation community line at 1-866-812-1593 or e-mail us at foundation@bluecrossmn.com.

This report is dedicated to Minnesota's community health workers and foreign-language interpreters, their employers, and those they serve.

A message from Daniel Johnson, executive director



Every one of us is the product of our circumstances and our culture — factors that shape our experiences, our behaviors and our values. Just as our particular culture may define our relationship to family or our understanding of education, our culture defines how we perceive health and illness and, consequently, how we view treatment and prevention. Cultural beliefs and practices play a significant role in the health of individuals and communities.

In 2001, the Blue Cross and Blue Shield of Minnesota Foundation launched Growing Up Healthy in Minnesota, a \$1.4 million multiyear initiative, to address challenges and barriers faced by Minnesotans from a variety of cultures (American Indians, communities of color and foreign-born populations) when interacting with the health care system. Our initiative strives to increase access to and use of preventive services among children and adolescents from these diverse cultures. A related objective is to improve the cultural competence of the health care providers who serve them.

Though we endeavor to improve the level of cultural competence in the health care system, it is unreasonable to expect providers to know everything about every culture. It's important to have front-line staff — community health workers and foreign-language interpreters — who can serve as a bridge between patients' cultures and languages and health care providers. As a result, Growing Up Healthy includes a project focused on community health workers and interpreters.

At the Blue Cross Foundation, our interest in community health workers is not new. Several years ago, we recognized that community health workers play a key role in helping people with unique cultural needs navigate our complex health care system. Since then, we've funded a variety of projects involving community health workers. In spring 2002, we conducted a statewide survey of health and human service agencies to learn about the use, training and employment prospects of community health workers and medical interpreters. Our work represents the first-ever look at community health workers in Minnesota and builds on existing research about medical interpreting in our state. In November 2002, we hosted a forum for policymakers, educators and health care representatives to share our survey results, invite comments by experts, and foster discussion among attendees.

We are pleased to share the results of our survey and forum. Our goal is to direct greater attention to the contributions of community health workers and the challenges faced by employers who hire them. We hope the report may lead to improvements in training to foster health care cultural competence and increased use of community health workers. We look forward to working with you to increase access to and use of health services by all Minnesotans.

A handwritten signature in black ink that reads "Daniel Johnson". The signature is fluid and cursive, with a long horizontal stroke at the end.

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Minnesota's growing diversity

Minnesota is one of 12 states in the United States with a greater than 144 percent increase in the Latino population between 1990 and 2000.

Immigration accounts for much of the increase in the state's overall population. In 2000, one in 19 Minnesotans, 5.3 percent of the total population, was born outside the United States. The majority of immigrants and refugees have settled in urban areas (for example, one in ten Hennepin County residents is foreign-born); however, many rural communities have experienced recent increases of immigrants from around the world.¹

I. Background

Minnesota's population is changing dramatically. Though the state remains less diverse than the United States as a whole, 11.8 percent of Minnesotans identified themselves as nonwhite or Hispanic in the 2000 Census.¹ While this figure cannot be compared directly to previous census data, demographers estimate a minority growth rate of 113 percent between 1990 and 2000.² Foreign-born people — refugees and immigrants — account for much of the increase.

These striking demographic changes are reflected in hospital emergency departments, rural health clinics and other health-related organizations throughout Minnesota, which are working to understand the needs of their new patients and respond with culturally and linguistically appropriate health services.

In urban areas that have been home to immigrant and minority communities for nearly a generation or more, health-related organizations are better positioned to meet the cultural and linguistic needs of their patients. They have more years of experience and a larger and more diverse workforce from which to recruit ethnically and culturally diverse providers, interpreters and community health workers (CHWs). As a result, many urban hospitals such as the Hennepin County Medical Center offer multi-lingual interpreting to help patients navigate the health care system. Health organizations in rural areas face greater challenges in meeting the cultural and linguistic needs of their patients due to less experience serving different cultures, health care worker shortages, and smaller populations of ethnically and culturally diverse residents from which to draw health care workers.

Strategies for increasing health care cultural competence

Through a variety of approaches — including the use of CHWs and interpreters — health care organizations are striving to become more culturally competent. While CHWs and foreign-language interpreters are not new to health care, they are receiving greater attention as strategies for meeting the cultural and linguistic needs of Minnesota's growing populations of color, American Indians and foreign-born populations.

The importance of CHWs and interpreters as a bridge between cultural and language differences is underscored by varying degrees of health status in Minnesota. It has been well documented that Minnesota's populations of color, American Indians and foreign-born populations experience

Culturally competent health care

Culturally competent health care means health care services that are respectful of and responsive to the health beliefs and practices and cultural and linguistic needs of diverse patient populations.

The Center for Linguistic and Cultural Competence in Health Care. Federal Office of Minority Health, U.S. Department of Health & Human Services

poorer health than the white population.³ The causes of these disparities are numerous, complex and intertwined. Research clearly implicates poverty as one contributing factor but income alone does not explain the difference in health status between populations.⁴ Even when access-related factors such as insurance status and income are controlled, racial and ethnic minorities tend to receive a lower quality of care than non-minorities.⁵ Health care providers and the systems in which they practice are often unaware of or insensitive to the cultural attitudes, beliefs and health practices of their patients. For example, in certain cultures, illness is viewed as punishment for past actions. With this belief, people can feel hopeless about their condition and may disregard treatment recommendations. In other cultures, people do not seek medical care unless their illness prevents them from fulfilling their daily responsibilities. People with this belief may not understand or recognize the importance of preventive health care. The abilities of immigrant and minority populations to access and benefit from the health care system are also affected by their individual and collective historical experience with the health care system, fear and distrust of mainstream medical services and limited English proficiency.

About community health workers

The use of CHWs is one strategy for bridging the cultural gap between a health care delivery system and those it seeks to serve. Throughout the developing world and increasingly in the United States, CHWs are used to deliver culturally appropriate health education, health promotion, and supportive health services. In the United States, they are typically used to reach people who are in some way inaccessible to those providing mainstream health care services. Although health care services may be readily available, foreign-born populations, American Indians, and other ethnic and racial groups may not access them because they are unaware of them, unaware that they need them, unaware of options for paying for them, or are distrustful and afraid of them. Community health workers build trust with these populations and help them overcome barriers that prevent them from accessing and benefiting from health care. In addition to helping patients access health care services, CHWs can enhance a health care system's ability to address the socioeconomic determinants of health. Traditional medical services offered in clinic and hospital settings do not typically address factors such as substandard housing or access to health insurance that directly or indirectly impact patients' health. In their outreach and referral capacities, CHWs can help patients with these needs, thereby broadening the health care system's ability to improve health beyond the prevention, detection, treatment and management of illness, injury and disease.⁶

The term community health worker refers to a paraprofessional who fulfills certain roles (for example, providing street outreach and education to homeless people about HIV prevention) for a health-related organization. Outreach workers, lay health advisors and health advocates are other terms used to describe similar positions. Typically, people employed as CHWs are selected because they are members of the community they are intended to serve. They are also hired for qualities such as leadership and caring rather than specific education or training. Most CHWs receive training for their specific job responsibilities after they are hired.⁷

Community health workers are employed in a wide variety of settings — from urban housing projects to migrant labor camps, from street corners to senior high-rise buildings. In Minneapolis, African American cancer survivors perform a variety of community outreach functions to encourage other African American women to seek mammography screening. In Rochester, Minnesota, Somali and Cambodian immigrants teach newer members of their respective communities how to schedule clinic appointments, request interpreters, and better communicate with their health care providers. Although CHWs often work in health care settings, they typically do not provide clinical or hands-on patient care.

Multiple studies have demonstrated preliminary support for the effectiveness of CHWs in increasing access to health care, promoting knowledge gain and behavior change and improving health outcomes in target populations.^{8,9} Their effectiveness stems in part from their knowledge of target populations' customs and beliefs, their ability to build trust among alienated or hard-to-reach individuals and groups, and their bilingual capabilities.¹⁰

About foreign-language interpreters*

The ability to communicate effectively is essential to a successful medical encounter. Interpreters increase the likelihood of a successful encounter by acting as a communications conduit between patients and health care providers. Many anecdotal stories and multiple research studies reveal the impact that language barriers have on providers' ability to deliver and on patients' ability to receive quality care. Speaking a primary language other than English nearly doubles a patient's likelihood of having a communication problem when receiving health care.¹¹ Patients who do not receive needed interpreter services are less likely to access preventive care, seek cancer screening, keep appointments, or comply with treatment and

* Often, the terms interpreter and translator are interchanged mistakenly. Interpreters assist with oral communication; translators assist with written communication. This report discusses interpreters only.

Minnesota's many languages

As Minnesota's immigrant and refugee populations grow, interpreters will be in greater demand. According to the 2000 Census, 8.5 percent of the state's population reported that a language other than English was spoken at home and 167,511 people reported that they speak English "less than very well."

Table DP1, Profile of General Demographic Characteristics, Minnesota, U.S. Census, 2000.

medication. In addition, they are more likely to strain the health care system by inappropriately using health care facilities (for example, visiting emergency departments rather than clinics for nonurgent care) and by requiring longer office visits and more tests. Conversely, patients who work with an interpreter report increased satisfaction with clinical encounters, increased understanding of medical instructions, and better understanding of how to pay for their care and for prescription drugs.¹²

Although the ability to speak and understand another language enables someone to interpret for others, bilingualism alone does not qualify an individual to serve as an interpreter. In addition to translating one language to another, interpreters must understand nuances in language and culture, know specialized vocabulary and concepts, find equivalent means of expression in each language, demonstrate effective communication skills, and operate under a specific set of ethics.¹³

Title VI of the 1964 Civil Rights Act and Minnesota statutes (144.651, 148B71, 256.01) entitle non-English speaking people to an interpreter upon request when accessing health care that is funded by government programs such as Medicare and Medicaid.¹⁴⁻¹⁵ With variations and exceptions, this means that public and private clinics and hospitals must provide interpreters to patients with insurance funded through federal dollars. Beyond compliance with federal and state mandates, health-related organizations are incorporating interpreters into their services to reduce liability and improve the quality of patient care.

II. Employer survey on community health workers and interpreters in Minnesota

To better understand the role and use of CHWs and interpreters in the delivery of health care in Minnesota, the Blue Cross Foundation commissioned a statewide employer survey of CHWs and foreign-language interpreters in health and human service organizations.

Specifically, the study examined:

- Characteristics of organizations that employ CHWs and interpreters
- Job functions performed by CHWs
- Sources of funding for CHWs and interpreters
- Employers' perceptions of the training needs of CHWs and interpreters
- Employers' projections of their future need for CHWs and interpreters

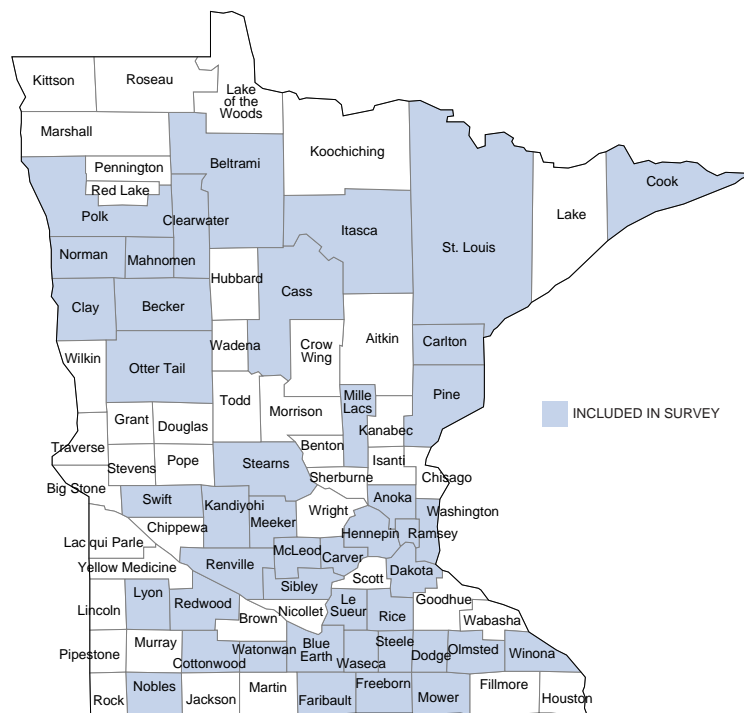
A. Methods

Study design and sample

Because the goal of the survey was to learn about the roles of CHWs and interpreters in health-related organizations rather than to measure the prevalence of these types of workers, the research team determined that a key informant approach would yield the most useful information.*

Figure 1

Counties included in employer survey



The sampling frame included health and human service organizations in 44 Minnesota counties with a minority population of 5 percent or greater, an American Indian reservation, or a health-related organization that was identified by one or more key informants as serving bicultural and bilingual individuals. The organizations in the sample included county public health agencies, county human service agencies, hospitals and clinics, community-based organizations, mutual assistance associations, and American Indian tribal organizations. For the purposes of this survey, community-based organizations were defined as nongovernmental, not-for-profit organizations. Mutual assistance associations were defined as community-based organizations primarily managed by and for a specific ethnic group.

* A limitation of the key informant design is that respondents are not chosen randomly; therefore, the findings should not be generalized to organizations outside the sampling frame.

Survey instrument

The survey instrument (Appendix 1) was modeled after a similar tool developed and administered by the Community Health Training and Development Center in San Francisco.¹⁶ The survey included questions related to the employment, training, functions, effectiveness and future needs of CHWs and interpreters. Questions included multiple choice and open-ended response options. Because this study is the first in Minnesota to research CHWs, it was intentionally designed with a greater focus on community health worker employment than on interpreter employment.

Survey implementation and data analysis

A telephone survey was selected as the most appropriate data collection method for this study. Qualified respondents were the employer representatives identified as the most knowledgeable about employees who work with bicultural or bilingual patients or clients.

The interviews were completed between April 29, 2002, and June 4, 2002, by SNG Research Corporation's staff of trained, monitored and supervised interviewers. Interviews varied in length from 15 to 90 minutes, with an average of 30 minutes. Ninety percent of the organizations contacted participated in the study, a high participation rate for survey research. SNG Research Corporation coded, tabulated and analyzed the data.

Figure 2

Type of organizations surveyed,
n=156

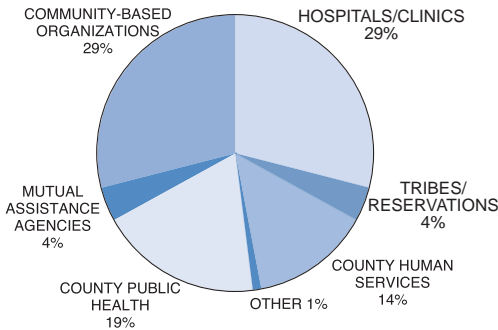
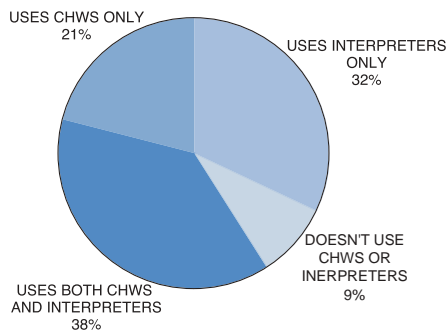


Figure 3

Organizations' use of community health workers and interpreters,
n=156



B. Findings

The study findings are based on data gathered from representatives of 156 organizations in Minnesota. The titles of the people interviewed included public health nursing director, clinical service director, and executive director. Responding organizations divided almost evenly between those in the Twin Cities seven-county metro area (51 percent) and those in Greater Minnesota (49 percent). Figure 2 indicates the proportion of the various organization types participating in the study.

The number of patients or clients served by responding organizations in a typical year ranged from 35 to 500,000 with a median of 5,000. One in five organizations reported that at least 75 percent of their patients or clients spoke a language other than English. The majority of respondents (74 percent) noted an increase in limited English proficiency (LEP) patients or clients over the past five years. The median percent increase was 50 percent. Spanish speakers accounted for the greatest portion of the increase, followed by speakers of East African, Eastern European and Asian languages.

Finding 1: Community health workers and foreign-language interpreters are widely used in Minnesota

As shown in Figure 3, the vast majority of respondents (91 percent) indicated they used CHWs or interpreters in their organization. County public health agencies and county human services were the types of organizations most likely to use both. The 40 percent of organizations that did not employ CHWs indicated that they served their bilingual and bicultural patients or clients through interpreters, bilingual staff or language lines.

Community health workers: After hearing the survey's definition of a community health worker, 59 percent of the respondents indicated that they employed staff performing community health worker functions, even if they do not refer to them by this title.* In fact, only 7 percent of organizations hiring CHWs referred to them this way. More common titles included outreach workers, health educators and case managers.

*Community health workers or CHWs provide a wide range of services. Generally CHWs are bicultural, bilingual individuals who provide a link between cultural or ethnic communities and health care organizations. By reducing cultural and access barriers, the goal of CHWs is to improve the cultural competence and effectiveness of the organizations that employ them. CHWs have many titles, including community health aides, client advocates, outreach workers, bilingual or bicultural workers, health educators, public health assistants and family resource workers. Some work in communities offering information, referrals, transportation or materials, while others work within agencies, providing counseling, advocacy or education. This survey includes both people based in clinics and outreach workers. Our definition of community health workers does not include physicians, nurses or others that provide clinical care nor those who primarily serve as spoken language interpreters.

Figure 4

Community health workers and interpreters by organization type, n=156

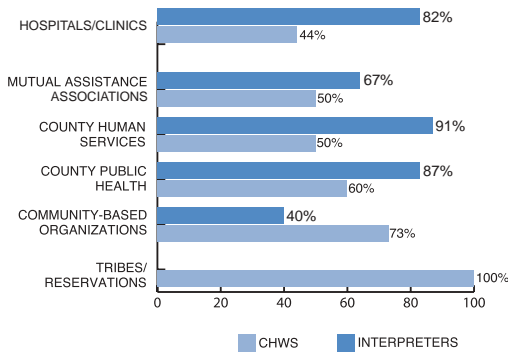
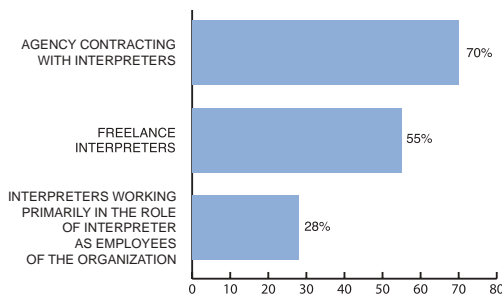


Figure 5

Types of interpreters used, n=122



Community health workers were most prevalent in tribal communities (Figure 4). In fact, all of the tribal organizations surveyed (n=6) employed CHWs. Community-based organizations were the second most likely to employ CHWs (73 percent), followed by county public health agencies (60 percent). Hospitals and clinics were the least likely to employ CHWs (44 percent). Geographically, a greater portion of metro organizations employed CHWs (63 percent) than organizations in Greater Minnesota (55 percent).

The number of CHWs per organization ranged from one to 86 with a median of four. Organizations in Greater Minnesota were twice as likely as metro organizations to have only one community health worker.

Respondents were asked to indicate approximately how many patients or clients they served each month with CHWs. Their responses ranged from six to 7,800. County human service agencies reported the highest median number of contacts (350) per month while mutual assistance associations reported the lowest median number of contacts (25). Per community health worker, the median case load ranged from 13 to 67 patients or clients per month. In general, CHWs in tribal organizations had the largest caseloads.

Most respondent organizations reported that their CHWs primarily served populations speaking a language other than English. Nearly three-quarters of organizations (72 percent) employed CHWs to work with Spanish-speaking populations, while 51 percent of organizations hired CHWs to serve patients or clients speaking African languages such as Somali, Oromo and Amharic.

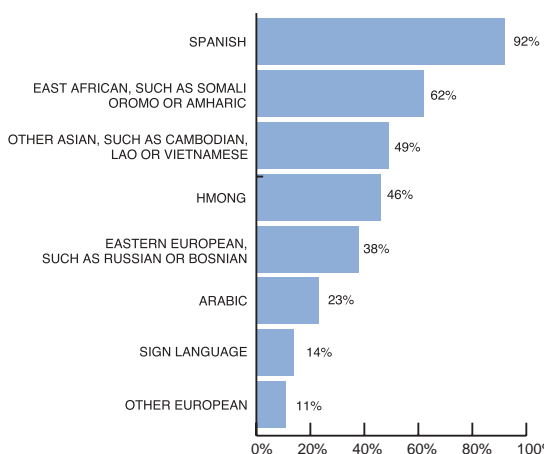
Interpreters: Overall, most respondent organizations (78 percent) used foreign-language interpreters. Tribal organizations were an exception, with none indicating they used interpreters.

While most respondent organizations use interpreters, the majority do not employ them in their organization. In fact, most organizations (70 percent) used agencies contracting with interpreters and more than half used freelance interpreters. Only 28 percent of organizations reported having interpreters on staff — employees working primarily in that role (Figure 5). Hospitals and clinics were more likely than other types of organizations to have interpreters on staff.

Among the 34 organizations directly employing staff in the role of interpreter, the number of interpreters ranged from one to 300 with a median of four. In general, hospitals and clinics reported the highest numbers of interpreters on staff, whereas county human services and mutual assistance associations had the fewest.

Figure 6

Language interpreting offered by respondents, n=109



The number of patient or client contacts, per organization, requiring an interpreter ranged from less than one to 10,000 per month. Hospitals and clinics and reported the highest median number of contacts per month, while county human service agencies reported the lowest median number of contacts. Organizations in the metro area had more interpreter contacts per month (median = 50) than organizations in Greater Minnesota (median = 20).

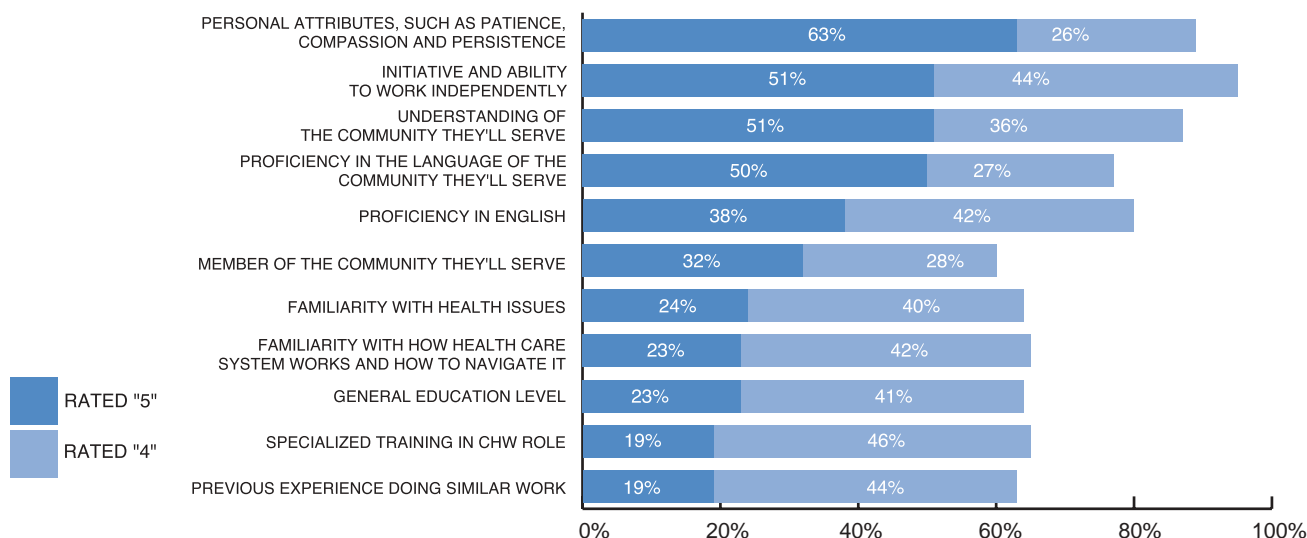
Most organizations (75 percent) offered interpreting for more than one language. The vast majority of organizations (92 percent) using interpreters (staff, agency or freelance) used someone speaking Spanish (Figure 6). In addition to Spanish-speaking interpreters, 62 percent of organizations used interpreters speaking East African languages, and nearly half used interpreters who speak Hmong (49 percent) or other Asian languages (49 percent).

Finding 2: Employers hire community health workers based on personal traits and then train them for their position

Hiring: As shown in Figure 7, in hiring CHWs, most organizations rated personal attributes as an “extremely important” job qualification, followed closely by initiative, ability to work independently, and an understanding of the community they would serve. The value of these qualities was emphasized by one respondent who said, “The most essential ingredient for a good community health worker is within the self. The spark [to serve others] has to be there or all the training won’t help.”

Figure 7

Importance of hiring qualifications by organizations employing community health workers*



*Rated on a 5 point scale where 5 means “very important” and 1 means “not at all important”.

“Community health workers are a very important part of rural health care.”

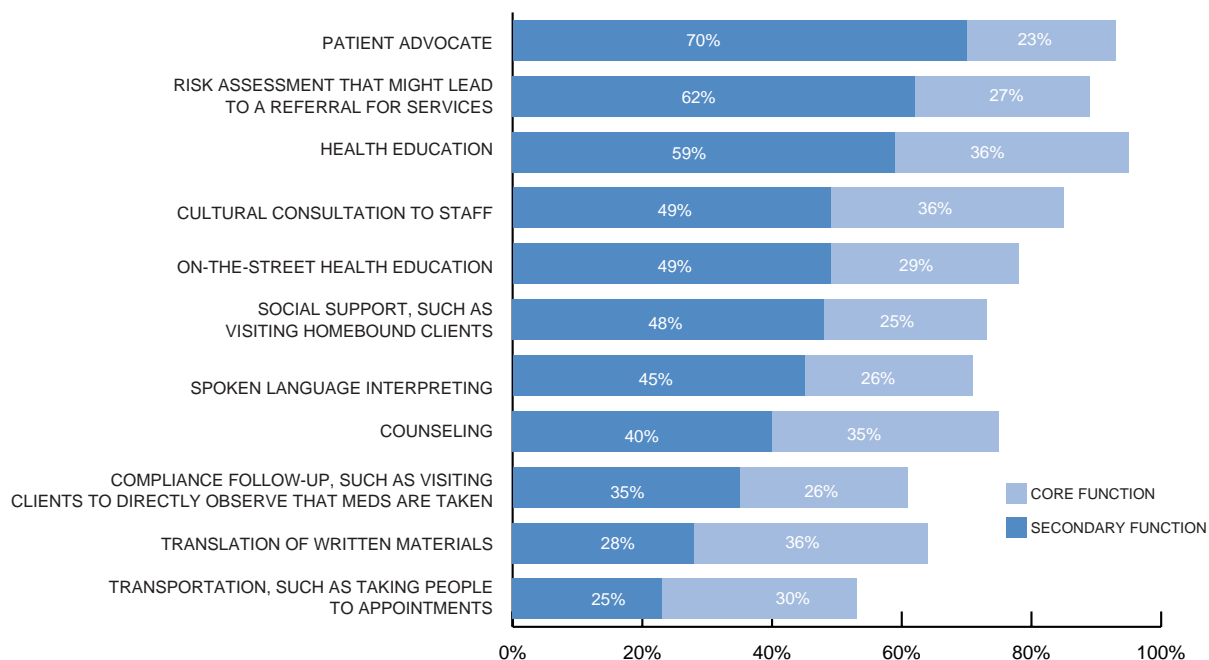
—Tribal organization, Greater Minnesota

On-the-job training: Ninety-five percent of respondent organizations employing CHWs devoted time to training new hires for their positions. Community health workers received a median of 40 hours of training before they could work independently. Nearly all CHWs received a “great deal” of training in confidentiality and data privacy as well as documenting and reporting client information. Most organizations offered at least “some” training in job responsibilities such as providing referrals and coordinating client care. Training is provided primarily on-the-job and through short-term, off-site opportunities.

Finding 3: Employers consider their community health workers and interpreters effective and valuable

Community health workers: Community health workers fulfilled a variety of functions for their employers (Figure 8). Respondents (70 percent) rated patient advocacy as the most common core function of CHWs. Compared to the other types of organizations surveyed, hospitals and clinics were more likely to consider patient advocacy as a core function of CHWs. Other functions categorized as core by multiple respondents included health education and risk assessment that might lead to referral for services.

Figure 8
Functions of community health workers



Most CHWs (95 percent) addressed multiple health topics with their clients. Health care access, well child care, substance abuse, chronic disease management, infectious disease, HIV prevention or case management, and environmental safety were the topics most likely addressed by CHWs.

Community health workers carry out their jobs in a variety of settings. As would be expected, almost all CHWs did at least some of their work in homes and in the community. Far fewer respondents (one in 7) indicated that their CHWs did most of their work in hospitals and clinics.

When asked to rate the effectiveness of CHWs in helping organizations provide service to bicultural and bilingual community members, 82 percent of respondents rated them a 4 or 5 on a 5-point scale (where 1 means “not at all effective” and 5 means “extremely effective”). Comments related to their effectiveness included:

Having staff in our organization that fulfill these functions or link the cross cultural, language barrier is an absolute essential need. We couldn't function without it.

— *CHW employer, Greater Minnesota*

Our community health workers keep our people going for the medical care needed. . . I feel our workers are vital to the understanding of all cultures and the health care of our Indian population.

— *Tribal organization, Greater Minnesota*

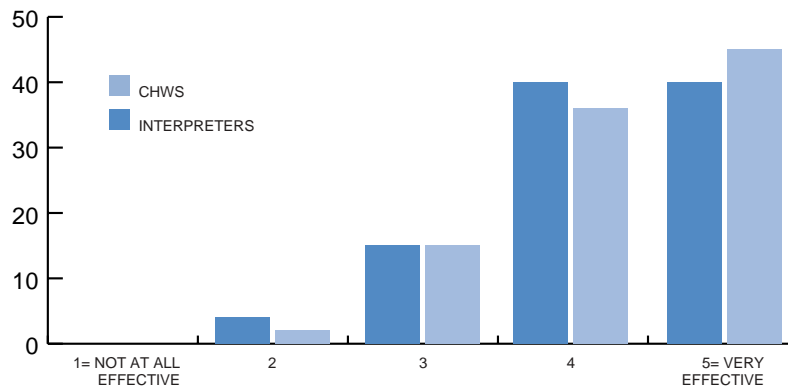
I think it is a very good opportunity to give services to the residents of a community in their own language by someone who knows the culture and the community. . . It shows the community that an agency has concerns about them.

— *County public health department, Greater Minnesota*

In addition to their value in helping organizations serve bicultural individuals, one respondent explained that CHWs are cost-effective because they assist their clients in seeking preventive care and early screening. Expensive medical treatments often can be avoided through preventive and early detection. One respondent said, “Every dollar spent on CHWs is money saved on. . . [treating] sickness.”

Figure 9

Perceived effectiveness of community health workers and interpreters



Interpreters: Over four-fifths (83 percent) of organizations employing interpreters said they are “very effective” in helping the organization provide service to bicultural or bilingual community members (Figure 9). One respondent offered, “Interpreters have a great effect on how we are able to do business for our clients.”

Finding 4: Employers face barriers in hiring and retaining community health workers and interpreters

Serving small populations of diversity

Community health workers: In many Greater Minnesota communities, there are small pockets of ethnic and non-English speaking populations whose health needs would be better served with the assistance of CHWs. Because these pockets are small, it is not financially feasible for most organizations to hire a CHW to serve them. As one respondent explained, “The needs in smaller communities are different than urban communities. In rural Minnesota, the population is becoming more and more diverse but the diversity is not large enough to have the luxury of having a community health worker for each different culture.” Another respondent said, “We have a small population of ethnic groups and could not justify hiring community health workers for a specific group. [We have] just enough population to need help but not enough to warrant hiring or funding a community health worker.”

Interpreters: Health and human service organizations face a similar dilemma related to interpreters. It is particularly problematic for organizations trying to serve patients or clients whose primary language is less common in their community. For example, Spanish and Somali-speaking populations are growing rapidly in many rural communities, whereas others (for example, Oromo) are present but in limited numbers.

In rural Minnesota, because we have a small group of individuals in each culture, the interpreter would need to be multicultural and multilingual.

— *County public health department, Greater Minnesota*

For us to have a full time interpreter would be almost impossible. We would need someone who could speak Spanish and Russian to be able to keep one person busy. Plus our needs and their schedules would clash. . . [Our] need could be at 2 a.m. or for several days and then nothing for days, making it impossible to have someone here all of the time.

— *Hospital/clinic, metro area*

Organizations addressed their intermittent requests for interpreters in a variety of ways. Some relied on bilingual employees (for example, receptionist) to interpret and others called the AT&T Language Line. Some organizations also used “on call” or agency interpreters; this solution generated its own challenges related to cost and availability:

Our hospital works seven days, 24 hours and our need for interpreter service could be at odd hours. They are not always available when we need them.

— *Hospital/clinic, Greater Minnesota*

[We’ve] had a problem getting a timely response from agencies. We need someone now and the agencies don’t respond that quickly.

— *Hospital/clinic, metro area*

Lack of adequate and stable funding

Community health workers: More than 80 percent of organizations reported they use government grants for paying their CHWs (Figure 10). Less than half of organizations received funding from foundations or insurance programs. Organizations in the metro area were more likely to receive funding from government grant funds and from foundations than were those in Greater Minnesota. The latter were more likely to rely on internal funding. In their qualitative comments, many respondents spoke about their problems related to CHW funding:

They are an effective part of the clinic team and highly overlooked. [We] don’t get reimbursement for the services they give. . . For a normal visit, only one fee is paid and they are not included in that payment.

— *Hospital/clinic, metro area*

Grant funding needs to be sustained over a long period of time. The need to provide for the community. . . keeps growing.

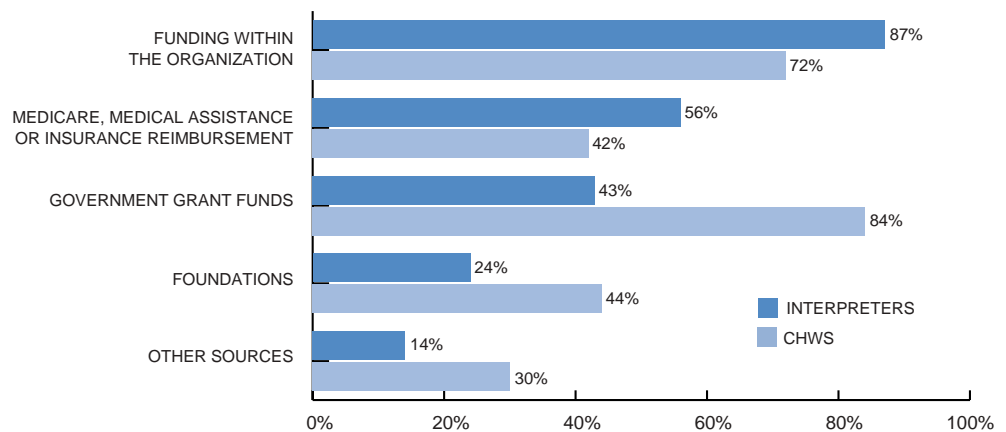
— *County public health department, Greater Minnesota*

Compensation for community health workers

According to the respondents, the median pay rate for CHWs was \$13.72 per hour, with a range of \$7 to \$24 per hour. The vast majority of organizations offered CHWs vacation, sick leave, pension plans and health, disability and life insurance.

Figure 10

Funding sources for community health workers and interpreters



Interpreters: In general, employers pay for interpreter services by combining funds from multiple sources. Internal funding and reimbursement — Medicare, Medical Assistance and insurance — were cited most frequently. Community-based organizations were the most likely to rely on government or foundation funding while more hospitals and clinics relied on support from within their organization. As with CHW funding, many respondents cited financial challenges related to the use of interpreters. Some respondents cited budget cuts, while others mentioned the cost of interpreter services: “We may need an interpreter only for a 15-minute encounter but must pay the service for a two-hour minimum.” Insufficient reimbursement was also mentioned as a major barrier: “Basic services are required by the law, but billing and reimbursement don’t happen. The insurance companies will not pay the amount billed, only a fraction of the cost for interpreter services. This means we eat the cost.”

Shortage of qualified workers

Community health workers: In their open-ended responses, many respondents mentioned a shortage of qualified workers as a major barrier to employing CHWs:

[It’s a] problem finding people in the community with sufficient education to perform the community health worker role.

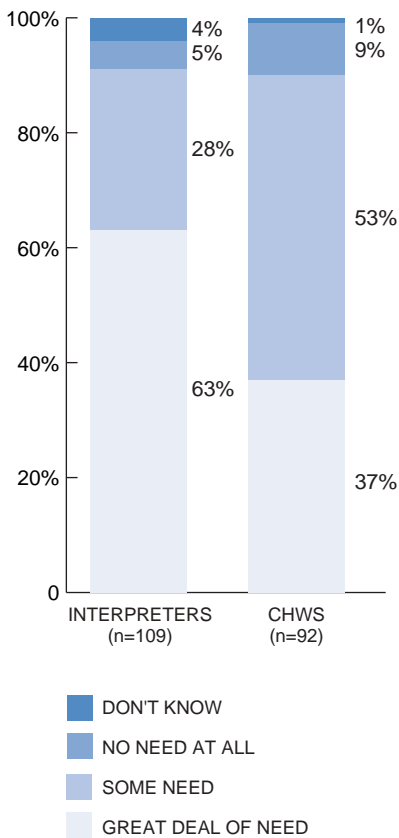
— *Community-based organization, metro area*

I have a real problem finding people with the necessary skills. The need for these skills is not understood by the formal education system.

— *Community-based organization, metro area*

Figure 11

Need for standardized training



Exacerbating the shortage of qualified CHWs was a high turnover rate. As one respondent explained, “We have a shortage of community health workers. . . Basically these workers are hired out from under you, going to the highest bidder.”

Interpreters: A shortage of trained interpreters was also mentioned as a barrier to employing interpreters by a number of respondents, especially in rural areas. One respondent stated, “It is a challenge getting an interpreter. . . if we had to hire only trained interpreters, it would be nearly impossible.” Finding interpreters for languages present but not widely spoken in communities was another challenge for employers. For example, Hmong interpreters were cited as particularly difficult to find in Greater Minnesota.

Finding 5: Employers support standardized training for community health workers and interpreters

Community health workers: During the survey, respondents were told that other states had developed formal CHW training programs focusing on core competencies of the role. When asked how much need they saw for standardized training of this sort in Minnesota, most respondents (53 percent) saw “some need” while more than one-third (37 percent) saw “a great deal” of need for training (Figure 11). Their open-ended responses suggest that standardized training could address the shortage of qualified CHWs and formalize the role:

We could employ more people but they need to have some skills other than just being bilingual or bicultural to be hired.

— County public health department, Greater Minnesota

CHWs are often trained and taught by people who are themselves poorly trained or educated in the field, leaving the workers to learn by the seat of their pants.

— Hospital/clinic, metro area

The largest barrier is the recognition of community health workers and what they bring to serving the community. . . There is a lack of consistent definition of what is being done, the skills needed and used. . . and what is expected of the services that are provided from place to place, county to county. They need to be uniform and consistent.

— County public health department, metro area

When asked about the likelihood of sending the CHWs they currently have on staff through formal training, 23 percent indicated “very likely.” Another 45 percent indicated “somewhat likely.” The types of organizations most likely to send employees were mutual assistance associations and hospitals and clinics. Some respondents cautioned that standardized training might be unaffordable for aspiring CHWs. One commented, “Scholarships need to be available so that . . .immigrants can get the education necessary to be in these fields.”

Nearly one-third (30 percent) of organizations indicated they were “not at all likely” to send CHWs through formal training because of financial constraints or because they provided their own training.

Interpreters: Fewer than half (45 percent) of the organizations using interpreters required formal interpreter training, yet nearly two-thirds (63 percent) saw a “great deal of need” for standardized interpreter training. An additional 28 percent indicated “some need” for such training. Metro respondents were more likely to express a “great deal of need” than respondents in Greater Minnesota.

In their open-ended comments, many respondents reiterated their support for standardized interpreter training. One respondent stated, “[There is a] need to standardize the industry. I would like to see some sort of certification process with ongoing recertification testing.” Specifically, respondents cited the need for training on medical terminology, professional communication, ethics, and the scope of their roles:

I find there are inconsistencies in the skill of interpreters. A number of interpreters lack familiarity with medical terms.

— *Hospital/clinic, Greater Minnesota*

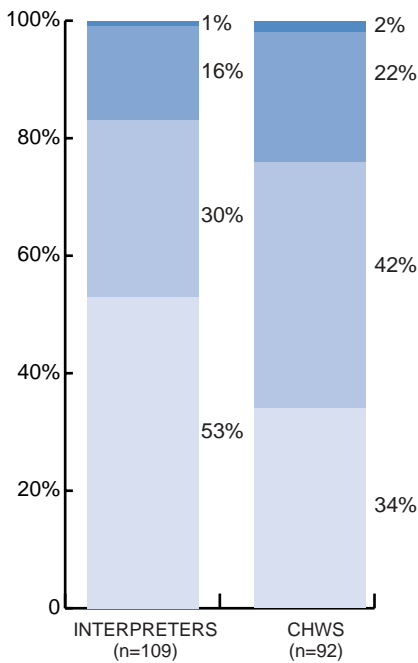
They [interpreters] do not always look at or talk directly to the client. They change the meaning of the information. . . giving the information the way they want, not the professional information, which can cause harm to our client.

— *County public health department, metro area*

In addition to improving patient care, standardized interpreter training could help employers better assess interpreters’ qualifications. As one respondent expressed, “I really have no way to figure out how proficient they are in interpreting. It’s a leap of faith.” Notably, a slim majority (51 percent) of the organizations using interpreters were “not all familiar” with any of the interpreter training programs currently available in Minnesota. Among the 48 percent of organizations that were “very” or “somewhat” familiar with existing programs, the University of Minnesota’s interpreting program was by far the most well known.

Figure 12

Likelihood of hiring more community health workers and interpreters



- DON'T KNOW
- SOMEWHAT LIKELY
- NOT AT ALL LIKELY
- VERY LIKELY

Although most respondents expressed the need for standardized training, some identified barriers to offering or requiring training. Some agencies reported they cannot afford to offer their own training or send employees to external training programs. Other organizations cited the lack of available training in their community as a problem. As one respondent explained, “Trained interpreters provide better service but the training is not offered often enough and close enough to be available to most interpreters in our region.” Even if training were available and affordable, some respondents expressed concern that its length and cost could be prohibitive for some people:

Two years for the U of M program is long for someone needing to work now.

— *Hospital/clinic, metro area*

A basic concern is the cost to become an interpreter. The cost of workshops, classes and materials are prohibitive.

— *Community-based organization, Greater Minnesota*

Finding 6: The need for community health workers and interpreters will grow

Community health workers: As indicated by Figure 12, more than one-third of respondent organizations were “very likely” to increase their number of CHWs in the future. An additional 42 percent thought it “somewhat likely” they would add CHWs. Metro respondents and community-based organizations were the most likely to report plans to add CHWs. When asked how soon the organizations were likely to add CHWs, approximately the same percentage said they plan to add them in the next year (43 percent) as said they plan additions in the next one to three years (46 percent). Most of these organizations (66 percent) indicated they would hire one to two CHWs. Approximately one-fifth of respondents did not plan to increase the number of CHWs on staff, primarily due to lack of funding.

Interpreters: More than half of the organizations using interpreters were “very likely” to increase their number of interpreters in the next one to three years. Another 30 percent were “somewhat likely” to use more. Mutual assistance associations were the most likely to say they would “very likely” increase the number of interpreters used.

Keynote speaker:
Linda Okahara, BA

Community services director of
the Asian Health Services in
Oakland, California

Panelists:
Estelle Brouwer, MPP

Director of the Office of Rural
Health and Primary Care at the
Minnesota Department of
Health, St. Paul

Bruce Downing, PhD

Associate professor of linguistics
and director of the Program in
Translation and Interpreting in
the College of Continuing
Education at the University of
Minnesota, Minneapolis

Jack Geller, PhD

President of the Center for Rural
Policy and Development at
Minnesota State University –
Mankato

Jeanne Nelson, MSN, RN

Coordinator of the Multicultural
Healthcare Alliance in Rochester,
Minnesota

Miguel Valdez

Minority Heritage Health
Disparities Program, Olmsted
County Health Department,
Rochester, Minnesota

III. Highlights from the bicultural and bilingual health workers forum

In November 2002, the Blue Cross Foundation convened an
invitational forum at the Lao Assistance Center of Minnesota, Inc. to
share the findings of the employer survey and to generate action
promoting the use of community health workers and interpreters in
Minnesota's health care system. Before the forum, the keynote speaker
and panelists reviewed the results of the employer survey and
responded to its key findings based on their expertise and experience.
Specifically, they were asked:

- How do CHWs and interpreters help rural communities respond to
the health care workforce shortage?
- How do CHWs and interpreters contribute to the creation of a more
culturally competent workforce?
- What are some of the opportunities and challenges associated with
recruiting, hiring and retaining CHWs and interpreters?
- What can be done to address the training needs and the shortage of
CHWs and interpreters identified by the survey?
- What are some of the issues and trends related to the training of
CHWs and interpreters?

Discussion highlights

Increasing health care cultural competence through community health workers and interpreters

Changing demographics call for cultural competence.

The need for a culturally competent health care system is particularly apparent in rural Minnesota, where demographics have changed rapidly. Statewide, Minnesota experienced a 113 percent growth rate in populations of color between 1990 and 2000. In 26 counties, the rate exceeded 200 percent for the same time period. This demographic change and its consequences were more significant in Greater Minnesota, where some towns went from a completely homogeneous population to a diverse one. The majority of growth in populations of color has occurred in southern Minnesota, but all regions of the state have experienced it to some degree. For example, Pelican Rapids in northwestern Minnesota experienced a 630 percent increase in its population of color; Worthington in the western part of the state has seen a 375 percent increase in its population of color.

Rural organizations are adapting to their increasingly diverse communities.

Many rural communities are struggling to provide services for their increasingly diverse populations. Unlike the metro area, most rural communities don't have mutual assistance associations (for example, Confederation of Somali in Minnesota) to help immigrants connect with services and help providers to understand and meet the needs of clients. Panelists indicated that health and human service organizations are beginning to realize that in the absence of these agencies, they need to adapt their services to better meet the needs of new community members. One panelist noted, "These communities are transitioning from an old mindset of 'the new people need to learn how we do things around here' to 'maybe we should be doing things differently to meet the needs of the new people.'" Community health workers and interpreters could serve as a bridge between clients who need to know "how things are done" and organizations that need to adapt their services to better meet the needs of their new clients.

Community health workers can help address the effects of rural health care worker shortages.

The changing demographics pose a challenge to rural health care systems that are already struggling to meet the basic medical needs of people in their community. The average statewide distribution of full-time physicians is 22.5/10,000 people; 11 Minnesota counties however, have fewer than 5 full-time physicians per 10,000 people. Because the health care systems in these counties are already stretched beyond their capacity, they are less able to adjust to new languages, new health care needs and new health beliefs that accompany the changing demographics. Community health workers have the potential to reduce the demand on providers by promoting healthy behaviors, teaching clients how to seek and use the health care system appropriately and providing information and referral to community services. Community health workers and interpreters also contribute to a more culturally competent workforce. In the short term, they help people from different cultures access and appropriately use Minnesota's health care systems. In the long term, some may become health care providers themselves, thereby increasing the cultural diversity of Minnesota's clinical care workforce. Panelists provided examples of CHWs who sought further training to enter medicine, nursing and other allied health fields.

Work readiness: employing community health workers and interpreters

Employers often struggle to assess applicants' skills.

Assessing the skills and work readiness of potential CHWs and interpreters can be challenging, especially when the interview skills of applicants can vary widely. Many people from other cultures have never had a job interview in the Western sense, leading some organizations to reexamine and modify their interviewing and hiring processes. Employers have reported that it can be difficult to screen interpreters, particularly those who speak foreign languages that are not as prevalent in the United States (for example, Bosnian). It can be even harder to assess interpreter skills such as accuracy regarding what's being said during the patient-provider encounter, dealing with cross cultural misunderstandings and knowledge of relevant subject matter.

Level of training and education varies widely among CHWs.

There is general consensus that language skills and the ability to navigate the community and the health care system are more important hiring criteria for CHWs than technical skills or job experience. As a result, the work experience of CHWs varies widely, creating challenges for employers. As one panelist said, “Some staff are highly educated, and others cannot read and write in their own language. For others, it is a struggle to tell time and keep a calendar.” Employers who are open to hiring people with fewer job skills invest time and resources in training and must accommodate varying education and experience levels on their staffs. The length of time CHWs and interpreters have been in the United States can also pose a challenge for employers. Some CHWs and interpreters are themselves new arrivals to the United States and are trying to learn the things they are teaching others.

Cultural values can differ between employers, CHWs and interpreters.

Supervisor-employee dynamics can be challenging because of differences in cultural values and employees’ work experiences. For example, employers of CHWs and interpreters confronted different culturally based perspectives related to work ethics. As one panelist explained, “We share our expectations for the job when we hire them, but people come with their own values about what the expectations mean.” For example, employees and their supervisors may differ on what it means to “do a good job.” The value that Western culture places on excelling in one’s profession is compatible with some cultures but contrary to those in which “rising above the crowd” is considered unacceptable. In addition, it can be challenging for supervisors when their employees do not value — and therefore do not perform — job responsibilities such as documentation or maintaining confidentiality. Furthermore, employees may be afraid to admit they need help because they fear repercussions, despite assurances to the contrary. Similarly, women may find supervising older men who come from patriarchal cultures difficult.

Shortage of community health workers and interpreters

Solutions are needed to address CHW and interpreter shortages.

Employers already face shortages of qualified CHWs and interpreters, especially in Greater Minnesota, yet, as indicated by the survey, many plan to expand their CHW and interpreter staffs. Without measures to increase training opportunities and the number of people who go through them, the shortage of CHWs and interpreters is likely to worsen. The lack of interpreters in Greater Minnesota also presents a challenge for organizations trying to provide culturally and linguistically appropriate services to patients and trying to meet federal mandates requiring interpreter services for patients with federally funded health care coverage. Patient care may be compromised when interpreters are not available or lack adequate skills and training. Any new and innovative approaches will resolve the current shortage of and future need for qualified CHWs. Existing efforts to address Minnesota's health care workforce shortage focus on medical, nursing and dental providers. There is no specific workforce strategy to recruit and train CHWs in this state. In addition to the shortage, health-related organizations struggle to retain their CHWs and interpreters who consider their jobs to be entry-level. Organizations are discovering that they must offer more competitive salaries to avoid spending valuable time and resources in training workers who subsequently move to higher-paying positions within the same organization or elsewhere.

Minnesota has a growing pool of potential CHWs and interpreters.

Most panelists agreed that Minnesota has a large untapped labor force of potential interpreters and CHWs within its growing population of immigrants. Among the newcomers are highly trained health care professionals who are unable to practice in the United States due to licensing requirements.

Standardized training of community health workers and interpreters

Standardized training takes various forms.

Panelists described the distinction between a certificate program and certification. A certificate in interpreting, such as the one offered by the University of Minnesota, signifies the successful completion of a training program, whereas certification signifies a passing score on a certification exam, administered by the state or a private certification agency. In Minnesota, there is no certification for interpreters or CHWs. One panelist described some controversy and concern about interpreter certification. On one hand, certification might ensure that potential interpreters possess at least a minimum level of knowledge and skills. On the other, certification could worsen the interpreter shortage if the steps necessary to achieve certification discourage people from entering the field.

Many employers are unaware of Minnesota's interpreter training programs.

While interpreter training programs exist in Minnesota, more than half of the survey respondents were unfamiliar with them, suggesting that employers may be overlooking a potential pool of trained interpreters. Tapping into Minnesota's existing programs may be one option for meeting organizations' need for trained interpreters.

Expanding interpreter training programs throughout Minnesota has been difficult.

The shortage of trained interpreters in Minnesota is exacerbated by the shortage of instructors qualified and trained to teach interpreting, especially in Greater Minnesota. Initial efforts to expand the University of Minnesota's interpreting certificate program outside of the Twin Cities and Rochester were unsuccessful, in part, because these communities had no qualified instructors and because Twin Cities' trainers have been unwilling to travel throughout Minnesota. Rural communities need additional efforts to increase their capacity for developing and administering interpreter training programs.

CHW training could be standardized.

While there are some similarities in the training of CHWs and interpreters, there are also many differences. Because the interpreter role is more uniform and narrowly focused, the emphases of training curricula are well-defined. It is more challenging to define the core competencies of CHWs because their functions tend to be broad and varied. At the same time, the survey results indicate some consensus about the job qualifications that are most important for community health worker positions. Perhaps in response to the lack of standardized training programs for CHWs, many employers in Minnesota have developed their own on-the-job training programs. In terms of time and resources, training may be costly for organizations, especially when there is high turnover of CHWs. Much of the content covered in training sessions is general and applicable to most CHW jobs and could be taught to students via community-based training programs such as community colleges. Currently, there are no standardized CHW training or certificate programs in Minnesota, but curricula from other states are available for replication. One panelist suggested that CHW training could be stratified to allow students with more skills to test out of core competencies such as basic computer use.

Developing career paths for CHWs could attract more people to the role.

Employers of CHWs feel fortunate when employees view their work as careers even when there is little opportunity for advancement. To attract more people to the field, employers must create opportunities for advancement within the CHW role or to other related roles. The coordinated design of health sciences curricula could support the development of career ladders for practicing CHWs. For example, educators might design CHW training programs so that credit for some core courses could be transferable to the required training for other health-related positions.

Funding for community health workers

Grant funding is considered unstable and inadequate.

Panelists discussed the problems associated with the categorical funding that pays for most organizations' CHW programs. In general, both foundation and government grants have funded CHW programs to target specific health conditions (for example, HIV/AIDS or diabetes). Organizations often have struggled to maintain their CHW programs after grants end and funding priorities shift. Panelists called for funding models that allow organizations to institutionalize their CHW programs and meet the comprehensive health needs of their clients.

Third-party reimbursement is not available for most CHW services.

Panelists noted a gap in third-party payment for CHW services and offered arguments to build a case for CHW coverage by government payors, health plans, and employers with culturally and linguistically diverse workforces. From a financial standpoint, employing CHWs has been a cost-effective strategy for helping clients learn how to find and use primary care, thereby reducing unnecessary use of more expensive hospital emergency departments. From a quality-of-care standpoint, patients who face cultural barriers are more likely to have better health outcomes when CHWs are part of the health care teams treating them.

IV. Community health worker profiles

Betty Sanders

**Woman to Woman Program, Women’s Cancer Resource Center,
Minneapolis**

Betty Sanders knows what it’s like to experience cancer. Looking back on her breast cancer, diagnosed in 1993, Betty remembers, “I was so scared and uneducated. I didn’t know anything about cancer and I made some quick decisions that weren’t good for me.” Her reaction is not unique. For many, cancer is perceived as a death sentence. After her experience with cancer, Betty became an outreach coordinator with Woman to Woman, a cancer support program providing outreach to Laotian, African American and Latina women. In this role, she works with local social service agencies to help make the health care delivery system more sensitive to the cultural needs of African American women. She also provides one-on-one assistance to women with breast cancer. Betty is particularly helpful in reducing the barriers that prevent women from completing treatment. She schedules appointments for clients who don’t have phones and provides transportation for those living in shelters for the homeless. Most important to Betty, she provides emotional support to women who are scared: “Many women are not confident in the medical system. They don’t know how to advocate for themselves, and they don’t know what questions to ask.” Betty attributes her effectiveness to her experience, faith and her passion for her work, “I go out and I try to reach women and touch their hearts like my heart has been touched by the Women’s Cancer Resource Center.”

Miguel Valdez

Formerly with the PathFinder Program, Multicultural Healthcare Alliance, Rochester

Miguel's desire to help other immigrants navigate the health care system grew out of his own experiences with it. On his third day in the United States, as an exchange student from Mexico, he sought medical care for injuries he sustained in a car crash. It took the hospital three hours to find someone — the janitor — who could interpret for him. Years later, Miguel's medical bills topped \$19,000 after he broke his leg. Fortunately, a community organization enrolled Miguel in Medical Assistance: "I was so thankful to them because they helped me — not only with the paperwork but they listened." Years later as a community health worker with the PathFinder Program, Miguel helped clients learn how to make clinic appointments, request an interpreter, and better communicate with health care providers. In one case, Miguel convinced a pregnant woman who was new to the United States to deliver her baby in the hospital, marking the first time she had ever been in one: "She was from a small village in Mexico and Spanish was her second language. It was challenging to communicate with her, even in Spanish, but I helped her obtain medical and economic assistance." To be a successful PathFinder, Miguel called upon his experience and training, yet his ethnic roots probably helped the most: "My background and understanding of Mexican culture helped me develop closer relations with my clients."

Patricia Tellez and Karina Sanchez

Comadres Program, Neighborhood House, St. Paul

Patricia Tellez and Karina Sanchez are community health workers who serve in the heart of St. Paul's Latino community. They reach out to Latinas at community gatherings and organize small-group discussions focusing on the prevention of HIV and other sexually transmitted infections. As a teenager in Mexico, Patricia wanted to be a doctor, but her family couldn't afford the schooling required. Today, she promotes Latinas' health by providing health education and guidance in accessing services. For example, Patricia helped a pregnant woman who had just moved from Texas: "She didn't know where to go or what to do to get care." Patricia helped her to find affordable care at a neighborhood clinic and to enroll in prenatal classes.

Karina also moved here from Mexico. With her extensive training in the prevention of teenage pregnancy and sexually transmitted infections, Karina counsels Latina adolescents and parents: "Sometimes it's the parents who can benefit the most from information and support." Karina recently received a call from the mother of a preteen girl who was nervous and afraid to talk to her daughter about sex. Karina said, "I gave her facts and helped her think of things to say. And, I told her that any time she needs to talk to her daughter, she can call me first to prepare."

V. What's Next: The Blue Cross Foundation's commitment to training

The goal of Growing Up Healthy in Minnesota is to increase access to and use of preventive medical and dental services by children and teens from populations of color, American Indian tribes and recent immigrant communities. Barriers associated with language, culture, geography, and socioeconomic status can affect a person's ability to access and benefit from preventive care and other health services. From our survey and forum, it is clear that CHWs and interpreters are valued and necessary to addressing these barriers. It is also clear that the potential contributions of CHWs and interpreters in the health care system may be stymied by challenges that organizations face in their efforts to recruit, hire, train and retain them. Overcoming these challenges will require multiple approaches and the involvement of agencies both public and private. In some cases, the work has already begun. On a national level, there are efforts to define standards for interpreters and CHWs. The Centers for Disease Control and Prevention has established a clearinghouse of information related to CHWs. San Francisco State University has developed, tested and implemented a CHW curriculum. Locally, the University of Minnesota is partnering with other educational institutions throughout the state to expand its interpreter training program.

The Blue Cross Foundation believes that increasing the diversity of our health care workforce can improve care for populations of color, American Indians and foreign-born populations. To this end, we will explore the feasibility of developing and piloting a CHW training program in partnership with practicing CHWs and representatives from health care and higher education. Such a program would fill the void in formal, standardized training for CHWs and ensure consistency in core training and competencies of CHWs. Most importantly, a training program would produce a cadre of graduates with the skills necessary to be effective CHWs who can help to meet the health care needs of Minnesota's diverse populations. In addition, the Blue Cross Foundation will explore ways to articulate a CHW curriculum with other health care training programs that will create a career ladder into other health-related positions. This development will contribute to a more culturally and ethnically diverse workforce and help address the overall health care professional shortage in Minnesota.

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Appendices

Appendix 1: Survey Instrument

B-135

BLUE CROSS FOUNDATION/HEALTH ADVOCATES

ID _____

CHW SURVEY

Spring '02

INITIALS _____

ASK TO SPEAK TO PERSON LISTED OR THE PERSON WHO KNOWS THE MOST ABOUT PEOPLE IN THE ORGANIZATION THAT WORK WITH BICULTURAL OR BILINGUAL PATIENTS OR CLIENTS.

Hello, this is (FULL NAME) and I'm a researcher calling on behalf of the Blue Cross and Blue Shield of Minnesota Foundation, which is the philanthropic arm of Blue Cross and Blue Shield of Minnesota. This is not a sales call. I'm with SNG Research Corporation and we're working with the Blue Cross Foundation on a study to assess the current use of bicultural and bilingual health workers in health care settings and health related agencies throughout Minnesota.

(IF NECESSARY: Just to check, are you the person within your organization that would be most familiar with the needs of bicultural or bilingual health workers and how those needs are met?)

All answers to the survey are confidential and will be reported in aggregate form only. By participating in the study, you will help to improve the quality of health care across the state of Minnesota. In appreciation of your time, we will be happy to provide you with an executive summary of the findings of the study.

The interview takes 10 to 20 minutes, depending upon your responses. Is this a good time for you? (IF YES, CONTINUE. IF NO, SCHEDULE A CALLBACK.)

There could be many different ways in which organizations refer to the type of worker we're interested in. The term we'll use will be Community Health Worker. I'll give you a definition of what we mean by this term:

Community Health Workers or CHWs provide a wide range of services. Generally CHWs are bicultural, bilingual individuals who provide a link between cultural or ethnic communities and health care organizations. By reducing cultural and access barriers, the goal of CHWs is to improve the cultural competence and effectiveness of the organizations that employ them. CHWs have many titles, including Community Health Aides, Client Advocates, Outreach Workers, Bilingual or Bicultural Workers, Health Educators, Public Health Assistants and Family Resource Workers. Some work in communities offering information, referrals, transportation or materials, while others work within agencies, providing counseling, advocacy or education. This survey includes both people based in clinics and outreach workers.

Please note that our definition of Community Health Workers does not include physicians, nurses or others that provide clinical care nor those who primarily serve as spoken language interpreters.

1. (ASK ONLY IF RESPONDENT SEEMS HESITANT)

Do you feel you understand what type of workers we'll be discussing for the survey?

- 1. YES > CONTINUE.
- 2. NO > RE-READ THE DEFINITION ABOVE OR ASK IF THERE'S SOMEONE ELSE IN THE ORGANIZATION THAT WE SHOULD BE TALKING TO.

2. My first series of questions is going to be about Community Health Workers as we just defined them. Does your organization currently have any employees that perform the Community Health Worker function, even if you do not refer to them as Community Health Workers?

- 1. YES > CONTINUE _____
- 2. NO
- 9. DON'T KNOW/REFUSED > GO TO Q30

3. What job titles does your organization use for employees that perform the Community Health Worker function?

(DO NOT READ LIST. CIRCLE ALL THAT APPLY.)

- *a. Interpreter (IF MAJORITY OF TIME IS SPENT AS INTERPRETER, DO NOT INCLUDE AS CHW.)
- b. Community Health Workers
- c. Community Health Aides
- d. Client Advocates
- e. Outreach Workers
- f. Bilingual or Bicultural Workers
- g. Health Educators
- h. Public Health Assistants
- i. Family Resource Workers
- o. Other (SPECIFY) _____

4. For consistency, we'll continue to use the term Community Health Workers or CHWs for these employees throughout the survey. How many Community Health Workers are currently employed at your organization . . . ?

- a. Full-time, meaning 32 or more hours per week _____
- b. Part-time, meaning less than 32 hours week _____
- TOTAL _____

*6. Overall, how effective have CHWs been in helping your organization provide service to bicultural or bilingual community members? Please use a 5-point scale where 1 means not at all effective and 5 means extremely effective.

NOT AT ALL			EXTREMELY		DK
1	2	3	4	5	9

7. How likely is your organization to increase the number of CHWs in the future?

Would you say very likely, somewhat likely or not at all likely?

- 1. VERY LIKELY > GO TO Q8
- 2. SOMEWHAT LIKELY
- 3. NOT AT ALL LIKELY > CONTINUE
- 9. DON'T KNOW/REFUSED > GO TO Q10

7a. For what reasons are you unlikely to increase the number of CHWs? (PROBE & CLARIFY)

GO TO Q10.

8. When would you be likely to hire additional CHWs? Would you say . . .

- 1. Within the next year
- 2. 1 – 3 years from now
- 3. More than 3 years from now
- 9. DON'T KNOW

9. How many additional CHWs are you likely to hire within that timeframe? _____

10. Please tell me whether each of the following is a funding source for hiring and retaining CHWs.

- a. Funding from within your organization 1. YES 2. NO 9. DK
- b. Government grant funds 1. YES 2. NO 9. DK
- c. Foundations 1. YES 2. NO 9. DK
- d. Medicare, Medical Assistance,
or insurance reimbursement 1. YES 2. NO 9. DK
- o. Any other funding sources? 1. YES 2. NO 9. DK
(SPECIFY) _____

11. What is the average hourly wage for CHWs within your organization? _____ per hour
998. DON'T KNOW 999. REFUSED

* In the final version of the questionnaire, question 5 was inadvertently omitted from the numbering sequence.

12. Do your CHWs receive any of the following benefits. (READ LIST)
- a. Health care insurance 1. YES 2. NO 9. DK
 - b. Other insurance, such as disability or life insurance 1. YES 2. NO 9. DK
 - c. Paid vacation 1. YES 2. NO 9. DK
 - d. Paid sick leave 1. YES 2. NO 9. DK
 - e. Pension or 401k 1. YES 2. NO 9. DK
 - f. Preferential hiring within your organization 1. YES 2. NO 9. DK
 - o. Any other benefits? 1. YES 2. NO 9. DK
(SPECIFY)_____

13. Which of the following do you use to recruit CHWs? Do you use ...
- a. Word of mouth 1. YES 2. NO 9. DK
 - b. Community advertising, such as posters or fliers in the community 1. YES 2. NO 9. DK
 - c. Want ads in the newspaper 1. YES 2. NO 9. DK
 - d. Hire from within your organization 1. YES 2. NO 9. DK
 - e. Any other methods? 1. YES 2. NO 9. DK
(SPECIFY)_____

14. Please rate how important each of the following criteria are when hiring CHWs. We'll use a 5-point scale where 1 means not at all important and 5 means extremely important. How important is...

	NOT AT ALL			EXTREMELY		DK
() a. General education level	1	2	3	4	5	9
() b. Specialized training they've had in the CHW role	1	2	3	4	5	9
() c. Understanding of the community which they'll serve	1	2	3	4	5	9
() d. Proficiency in the language of the community they'll serve	1	2	3	4	5	9
() e. Familiarity with health issues	1	2	3	4	5	9
() f. Familiarity with how the health care system works and how to navigate it	1	2	3	4	5	9
() g. Personal attributes, such as patience, compassion & persistence	1	2	3	4	5	9
() h. Previous experience doing similar work	1	2	3	4	5	9
() i. They are a member of the community they'll serve	1	2	3	4	5	9
() j. Initiative and the ability to work independently	1	2	3	4	5	9
() k. Proficiency in English	1	2	3	4	5	9

14a. What are other important criteria when hiring CHWs? (PROBE & CLARIFY)

99. NONE

15. My next few questions have to do with training. Do CHWs receive any training specific to the CHW role after starting employment with your organization?

1. YES > CONTINUE 2. NO > GO TO Q19

16. Thinking about training specifically on the CHW job duties, would you say your CHWs receive a great deal of training, some training or no training at all in each of the following areas...

	GREAT DEAL	SOME	NONE	DK
()a. Appropriate client contact during intake and interviewing	3	2	1	9
()b. Client orientation	3	2	1	9
()c. Confidentiality and data privacy	3	2	1	9
()d. Coordinating client care	3	2	1	9
()e. Documenting and reporting client information	3	2	1	9
()f. Providing referrals to appropriate health-related services	3	2	1	9
()g. Providing health education	3	2	1	9
()h. Client and community advocacy	3	2	1	9
()i. How the health care system works and how to navigate it	3	2	1	9

16a. What other areas specific to the CHW role do your CHWs receive training on?

99. NONE

17. And which of the following methods are used for training your CHWs on their specific job duties? (READ LIST, CIRCLE ALL THAT APPLY.)

- a. On the job training, such as orientation, learning by doing or mentorships 1. YES 2. NO 9. DK
- b. Other formal in-house training programs 1. YES 2. NO 9. DK
- c. Short-term external or off-site training 1. YES 2. NO 9. DK
- d. Longer-term school-based training, such as programs offered through community colleges or other schools 1. YES 2. NO 9. DK
- e. Other training methods 1. YES 2. NO 9. DK
- (SPECIFY) _____

17a. IF Q17C IS YES, ASK: What types of short-term external or off-site training do you use?

18. How many hours of training about their specific job duties does a CHW typically receive before they are able to work independently? _____ hours

19. In some states, formal CHW training programs have been developed that focus on the core competencies CHWs need to demonstrate. These classes are often available at a community college level with the option to obtain a four-year health-related degree. How much need, if any, do you see for standardized training of this sort for CHWs in Minnesota? Would you say you see a great deal of need for standardized training, some need or non need at all?

1. GREAT DEAL 2. SOME 3. NO NEED 9. DK

20. How likely would your organization be to send CHWs who are currently on staff through this type of formal training, if it were available? Would you say very likely, somewhat likely or not at all likely?

1. VERY LIKELY > GO TO Q22
 2. SOMEWHAT LIKELY > GO TO Q22
 3. NOT AT ALL LIKELY > CONTINUE
 9. DK > CONTINUE

21. Why would you be unlikely to send your CHWs to this type of training? (PROBE & CLARIFY)

22. I'm going to read you a list of activities and I'd like you to tell me if each is a core function of your Community Health Workers, a secondary function or is not a function at this time. The first one is ...

	CORE	SECONDARY	NOT	DK/REF
()a. Outreach, such as on-the-street health education	1	2	3	9
()b. Patient advocate	1	2	3	9
()c. Social support, such as visitinghomebound clients	1	2	3	9
()d. Counseling	1	2	3	9
()e. Transportation, such as taking people to appointments	1	2	3	9
()f. Health education	1	2	3	9
()g. Compliance follow-up, such as visiting clients to directly observe that medications are taken	1	2	3	9
()h. Risk assessment that might lead to a referral for services	1	2	3	9
()i. Cultural consultation to staff	1	2	3	9
()j. Spoken language interpreting	1	2	3	9
()k. Translation of written materials	1	2	3	9

22a. What other core functions are performed by CHWs at your organization?

(PROBE & CLARIFY)_____99. NONE

23. And would you say that most of your CHWs' work, some of their work or none of their work takes place in the following locations... (READ LIST)

	MOST	SOME	NONE	DK
a. In a clinic or hospital	1	2	3	9
b. In homes or in the community	1	2	3	9
c. In other organizations, such as community-based organizations	1	2	3	9
o. In any other places? (SPECIFY) _____	1	2	3	9

24. Approximately how many client or patient contacts are made by your CHWs in a typical month?
_____ contacts/month

25. I'm going to read a list of health topics that may or may not be addressed by your CHWs. For each topic, please tell me whether or not it is currently being addressed.

() a. Maternal care or well-child care	1. YES	2. NO	9. DK
() b. Chronic disease management, such as diabetes or asthma	1. YES	2. NO	9. DK
() c. Education or case management for people with HIV or AIDS	1. YES	2. NO	9. DK
() d. Alcohol, tobacco and other drugs	1. YES	2. NO	9. DK
() e. Infectious disease prevention or management, such as tuberculosis or STIs	1. YES	2. NO	9. DK
() f. Environmental safety, such as pesticide or field protection	1. YES	2. NO	9. DK
() g. How to access primary care, such as how to make appointments	1. YES	2. NO	9. DK
() h. Preventive care, such as cancer screening	1. YES	2. NO	9. DK

25a. What other health topics are addressed by your CHWs?

_____ 99. NONE

26. I'm going to read a list of different races or ethnic backgrounds. For each, please tell me if it is a primary population that is served by your CHWs, a secondary population or if it is not currently served by your CHWs. The first one is...

	PRIMARY	SECONDARY	NOT	DK/REF
a. African	1	2	3	9
b. Black American	1	2	3	9
c. Hispanic or Latino	1	2	3	9
d. Pacific Islander or Native Hawaiian	1	2	3	9
e. Asian	1	2	3	9
f. American Indian or Alaska Native	1	2	3	9
g. White or Caucasian, such as Russian, Bosnian, etc.	1	2	3	9
o. Any other populations? (SPECIFY) _____	1	2	3	9

27. Do any of the primary populations served by your CHWs speak languages other than English as their first language?

- 1. YES > CONTINUE _____
- 2. NO
- 9. DON'T KNOW/REFUSED > GO TO Q29

28. What languages are spoken by these populations? (DO NOT READ LIST. CIRCLE ALL THAT APPLY)

- a. East African, such as Somali, Oromo or Amharic
- b. Spanish
- c. Hmong
- d. Other Asian, such as Cambodian, Lao or Vietnamese
- e. Eastern European, such as Russian or Bosnian
- o. Other (SPECIFY) _____

29. We've asked a lot of questions regarding CHWs. What comments or suggestions would you like to share regarding effectiveness, training needs or barriers to employing CHWs?

(PROBE & CLARIFY) _____

_____ 99. NONE

GO TO Q35

30. Does your organization currently serve bicultural or bilingual individuals or communities?

- 1. YES > CONTINUE _____
- 2. NO
- 9. DON'T KNOW/REFUSED > GO TO Q32

31. Do you use any of the following to serve bicultural or bilingual communities?

(READ LIST. CIRCLE ALL THAT APPLY.)

- a. Interpreters
- b. Social Workers
- c. Bilingual staff
- d. Volunteers
- e. Telephone Language Line, such as the AT&T Language Line

31a. What other resources or people do you use to serve bicultural or bilingual communities?

_____ 99. NONE
GO TO Q33.

32. For what reasons do you not currently serve any bicultural or bilingual communities?

33. How likely is your organization to hire any Community Health Workers in the next 1-3 years? Would you say very likely, somewhat likely or not at all likely?
1. VERY LIKELY > GO TO Q34
 2. SOMEWHAT LIKELY
 3. NOT AT ALL LIKELY > CONTINUE
 9. DON'T KNOW/REFUSED > GO TO Q34

33a. For what reasons are you unlikely to hire any CHWs in the next 1-3 years?

34. What thoughts would you like to share regarding serving bicultural or bilingual communities and/or Community Health Workers?

35. Next I have some questions about interpreters. Interpreters make it possible for two or more individuals who do not share a common language to communicate directly with each other as if they did. By reducing language barriers, the goal of medical interpreters is to improve the cultural competence and effectiveness of the organizations that employ them. Interpreters may work in many health care venues, including hospitals, clinics and home care agencies. Some interpreters are freelancers or contract workers working for outside translation and interpreting agencies while others are hired full or part-time by a health care organization. This survey includes all of these types of interpreters.

36. (Just to check) Not including the people from our discussion about Community Health Workers, does your organization use any interpreters?

1. YES > CONTINUE
2. NO > GO TO Q50
9. DK > GO TO Q50

37. Do you have interpreters on staff that work primarily in the role of interpreter and are employees of your organization?

1. YES > CONTINUE
2. NO
9. DON'T KNOW/REFUSED > GO TO Q39

38. How many interpreters are currently employed at your organization...

- a. Full-time, meaning 32 or more hours per week _____
- b. Part-time, meaning less than 32 hours per week _____

39. Does your organization use . . .
- | | | | |
|---|--------|-------|-------|
| a. An agency that contracts with interpreters | 1. YES | 2. NO | 9. DK |
| b. Freelance interpreters | 1. YES | 2. NO | 9. DK |
- IF NO/DK (2/9) TO ALL IN Q37, Q39A & Q39B, GO TO Q50.

40. Overall, how effective have interpreters been in helping your organization provide service to bicultural or bilingual community members? Please use a 5-point scale where 1 means not at all effective and 5 means extremely effective.

NOT AT ALL				EXTREMELY		DK
1	2	3	4	5		9

41. How likely is your organization to increase the number of interpreters you use in the next 1-3 years? Would you say very likely, somewhat likely or not at all likely?
1. VERY LIKELY
 2. SOMEWHAT LIKELY
 3. NOT AT ALL LIKELY
 9. DON'T KNOW/REFUSED

42. Please tell me whether each of the following is a funding source for hiring and retaining interpreters.
- | | | | |
|---|--------|-------|-------|
| a. Funding from within your organization | 1. YES | 2. NO | 9. DK |
| b. Government grant funds | 1. YES | 2. NO | 9. DK |
| c. Foundations | 1. YES | 2. NO | 9. DK |
| d. Medicare, Medical Assistance, or Insurance reimbursement | 1. YES | 2. NO | 9. DK |
| e. Any other funding sources? | 1. YES | 2. NO | 9. DK |
- (SPECIFY) _____

43. Thinking about all interpreters used, whether on-staff, contracted or freelance, approximately how much is budgeted per month for interpreter services? \$ _____ per month

998. DON'T KNOW 999. REFUSED

44. My next few questions have to do with training for your interpreters. Do you require that interpreters have any formal interpreter training when working with your organization?
1. YES
 2. NO

45. In some states, formal interpreter training programs have been developed that focus on the core competencies interpreters need to demonstrate. How much need, if any, do you see for standardized training of this sort for interpreters in Minnesota? Would you say you see a great deal of need for standardized training, some need or no need at all?

1. GREAT DEAL 2. SOME 3. NO NEED 9. DK

46. How familiar are you with any programs currently available for training interpreters? Would you say you are very familiar, somewhat familiar or not at all familiar with training programs?

1. VERY > CONTINUE
2. SOMEWHAT
3. NOT AT ALL > GO TO Q48
9. DK

47. What interpreter training programs are you familiar with? (PROBE & CLARIFY FULLY.)

48. Approximately how many client or patient contacts are made by interpreters in a typical month?
_____ contacts/month

49. What languages are spoken by any interpreters used by your organization?
(DO NOT READ LIST. CIRCLE ALL THAT APPLY.)

- a. East African, such as Somali, Oromo or Amharic
- b. Spanish
- c. Hmong
- d. Other Asian, such as Cambodian, Lao or Vietnamese
- e. Eastern European, such as Russian or Bosnian
- o. Any Others (SPECIFY) _____

50. What comments regarding effectiveness, training needs or barriers to employing interpreters would you like to share?

99. NONE

51. Now, I have just a couple of questions about your organization to help us classify your responses. Which of the following best describes the region or geographic area that you serve?

Would you say . . . (READ LIST)

1. City
2. County, or > GO TO Q53
3. Multi-county area > CONTINUE
9. DON'T KNOW/REFUSED > GO TO Q53

52. How many counties are included in the multi-county area?

_____ COUNTRIES

53. What county is your organization headquartered in? (WRITE IN COUNTY # FROM CODE SHEET)

54. Approximately how many total patients or clients does your organization serve in a typical year?

55. And, of those, approximately what percent primarily speak a language other than English?

_____ %

56. Thinking about the past five years, would you say that the number of patients or clients that primarily speak a language other than English as increased, decreased or stayed about the same?

1. Increased > CONTINUE
2. Decreased
3. Stayed about the same > GO TO Q59
9. DON'T KNOW/REFUSED

57. By about what percentage would you say the number speaking primarily a language other than English has increased in the past five years?

_____ %

58. In what languages have you seen an increase in the past five years? (DO NOT READ LIST.)

- a. East African, such as Somali, Oromo or Amharic
- b. Spanish
- c. Hmong
- d. Other Asian, such as Cambodian, Lao or Vietnamese
- e. Eastern European, such as Russian or Bosnian
- o. Any others (SPECIFY) _____

59. Lastly, can you think of any other organizations in your area that work with bicultural or bilingual clients or that might have Community Health Workers that we might be able to talk with?

1. YES > CONTINUE

2. NO > GO TO Q61

60. Who is that? (GET AS MUCH OF THIS INFO ABOUT THAT PERSON AS POSSIBLE. IF MORE THAN ONE, WRITE ADDITIONAL CONTACTS ON BACK OF PAGE.)

NAME _____

TITLE _____

ORGANIZATION _____

ADDRESS _____

CITY _____ MN

PHONE NUMBER _____

61. Those are all of the questions I have – I want to thank you very much for your time. As I told you earlier, we will send you a copy of the summary of findings from this study. I just need to verify some information so that we can do that:

NAME _____

TITLE _____

ORGANIZATION _____

ADDRESS _____

CITY _____ MN ZIP CODE _____

We expect to complete the study this summer and to have the report out in early fall. Thank you so much for your time!

Appendix 2: Selected resources

For more information about health care cultural competence, community health workers, and health care interpreters, check out the following resources:

Cultural competence in health care

Center for Cross-Cultural Health, Minneapolis, MN

Regional clearinghouse for information sharing, training and research, to develop culturally competent individuals, organizations, systems and societies. www.crosshealth.com

The Cross Cultural Health Care Program, Seattle, WA

An organization serving as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. www.xculture.org

Diversity Rx

National clearinghouse for information on how to meet the language and cultural needs of minorities, immigrants, refugees, and other diverse populations seeking health care. Web site includes information on model programs and a research agenda on community health workers. www.diversityrx.org

Health Advocates, Minneapolis, MN

Consulting group for research, program coordination, and training on cross-cultural and international health. Special expertise in bilingual/bicultural workers. www.webshells.com/hlthadv/pfolio.html

National Center for Cultural Competence, Washington, D.C.

An organization assisting health and mental health programs to provide culturally and linguistically competent service delivery programs. Offers a Guide to Planning and Implementing Cultural Competence. www.georgetown.edu/research/gucdc/ncc.index.html

Community health workers

American Public Health Association

Community Health Worker Special Interest Group, Washington, D.C.

Special interest group for development of the role of new professionals, community health advisors, and other community-based professionals. Provides a forum to share resources and strategies. Click “Special interest groups.” www.apha.org

Community Health Worker Evaluation Tool Kit

A guide for increasing the quality and quantity of community health worker program evaluations. University of Arizona Rural Health Office, El Paso Satellite. (915) 351-9099.

Community Health Works of San Francisco, San Francisco, CA

Nationally recognized center for training, research and development on first-level community health professionals and interdisciplinary community health teams. Established the first college-sponsored Community Health Worker Certificate program in the United States. www.communityhealthworks.org

Health care interpreting

Certificate in Interpreting, College of Continuing Education, University of Minnesota, Minneapolis, MN

Certificate program that prepares bilingual students to be professional interpreters in health care or legal settings.

www.cce.umn.edu/certificates/interpreting/shtml

National Council on Interpreting in Health Care (NCIHC)

Multidisciplinary organization whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health services for LEP patients. www.ncihc.org

Grantees of the Blue Cross Foundation

Comadres Program, Neighborhood House, St. Paul, MN

A program to reduce the risk of teen pregnancy, HIV/AIDS and other sexually transmitted infections among St. Paul's Latina community. Neighborhood House is a community-based organization providing services to individuals, families and organizations on the West Side of St. Paul. Services include child care, social development, counseling, emergency assistance, senior activities, home-delivered meals, and camping.

www.neighb.org

Lao Assistance Center of Minnesota, Inc., Minneapolis, MN

A mutual assistance association dedicated to increasing the capacity of Minnesota's Lao-American population by responding to community needs with programs and services that promote the well-being of families and children and preserve their cultural heritage.

(612) 374-4967.

PathFinder Program, Multicultural Healthcare Alliance, Rochester, MN

An initiative to train bilingual and bicultural workers to help immigrant community members acquire the skills needed to access health care services. The Multicultural Healthcare Alliance is a partnership of Mayo Clinic, Olmsted County Health Department, and Olmsted Medical Center to improve health care access for immigrant communities of Olmsted County. (507) 285-8360.

Somali Community Resettlement Services, Inc., Rochester, MN

A southeastern Minnesota mutual assistance association helping the Somali immigrant community to assimilate into mainstream society. Services include interpretation, translation, information and referral, orientation for new arrivals, pre- and post-employment support, health education programs, educational training in English as a second language, computer basics, elementary math, and electronic assembly. (507) 252-5888.

Woman to Woman Program, Women's Cancer Resource Center, Minneapolis, MN

A program to promote better health outcomes for African American, Hispanic and Laotian women with breast cancer. The Women's Cancer Resource Center is a grassroots, not-for-profit organization focusing on the needs of women living with cancer and educating the community about cancer prevention.

www.givingvoice.org

Other related resources

Center for Rural Policy and Development, Mankato, MN

A private, not-for-profit research organization dedicated to the study of the social, economic and cultural forces that affect rural Minnesota. www.ruralmn.org

Office of Minority Health, U.S. Department of Health and Human Services, Washington, D.C.

The mission of the Office of Minority Health is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health. www.omhrc.gov

Office of Multicultural and Minority Health, Minnesota Department of Health, St. Paul, MN

The Office of Minority and Multicultural Health exists to focus attention on the disparities in health status among Minnesota's populations of color and American Indians. www.health.state.mn.us

State Demographic Center, Minnesota Planning, St. Paul, MN

The State Demographic Center analyzes and distributes data from state, U.S. Census Bureau and other sources. www.mnplan.state.mn.us