



Health Promotion & Prevention of Health Disparities for Minnesota's Refugee & Immigrant Communities

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Creating Community: Health Policy and Immigrant Integration

Lisa Thakkar, New Americans Policy Project, Illinois Coalition for Immigrant and Refugee Rights

The Illinois Governor's executive order creating a state-level **Office for New Americans** is a successful model for supporting immigrant integration and is being replicated in New Jersey, Washington and Massachusetts.

The U.S. Census Bureau data shows the foreign-born population in Minnesota increased by 30 percent from 2000-2006 and represents 6.6 percent of the population. Immigration has shifted, with immigrants no longer settling in big urban centers as they once did, but are now living in more rural areas. Because immigrants are joining our towns, counties and states, good immigration policy needs to focus on integration at the local level. Good policy should involve non-profits and faith-based organizations, government, and businesses.

The **Illinois Immigrant Policy Project**, in combination with state government, state agencies, and community organizations, studied the tax contributions of immigrants. Three major findings:

1. Immigrants pay over \$7 billion dollars in taxes each year.
2. Immigrants use public benefits almost three times less than nonimmigrants (temporary immigrants).
3. Immigrants are 10.2 percent of population and pay 10.8 percent of the taxes. Sixty-eight percent of immigrants are in the workforce, compared to 62 percent of citizens.

The **Illinois Coalition for Immigrant and Refugee Rights** (ICIRR) was started by 18 established and diverse refugee agencies in the Chicago area. The coalition includes members from faith-based communities, the labor sector, social service organizations, police departments and trade organizations. The coalition offers a variety of programs to immigrants and refugees, including an all-kids healthcare program, assistance with federal identification documents, preschool, in-state college tuition for undocumented students, citizenship applications, and the New Americans Initiative.

The **Executive Order Project** was a collaborative effort of Esther López, Deputy Chief of Staff of the Illinois Department of Labor, Grace Hou, Assistant Secretary for the Illinois Department of Human Services and Josh Hoyt, the Executive Director of ICIRR. This project responded to huge demographic shifts in immigration, and the objective was to create a comprehensive plan for Illinois. The two-year policy process resulted in an executive order signed by the Governor of Illinois in 2005.

The mission of the **Office of New Americans Policy and Advocacy** is to coordinate policies and programs to help newcomers fully assimilate to the state, provide more and better services to the growing number of immigrants living in Illinois, and to study the impact of immigration policy on the state.

Recommendations for success in Minnesota and other states:

- Citizenship and learning English are two issues everyone can support.
- Partnership between the government and communities is key.
- If there is a commitment to make a change you can make the money go far; in Illinois this year their budget is only \$2 million.
- Healthcare: many immigrants come with healthcare backgrounds. *Upwardly Global* helps with job training, certification and placement. <http://www.upwardlyglobal.org/>
- Focus on the economics of immigration more than the human services and education aspects. Find out what immigrants contribute to the community economically.

Minnesota: Opportunities and Challenges

State Senator Linda Berglin
State Representative Jim Abeler

State Senator Mee Moua
State Representative Thomas Huntley

Senator Linda Berglin

The main thing the legislature did last session that will be helpful to immigrants was the creation of **medical homes** in Minnesota Care. Beneficiaries with chronic conditions will have a medical home. This will help improve communications, for example, between doctors and pharmacists about appropriate medications. One of the important aspects about medical homes is helping patients understand their role in the medical care. Medical homes require patient participation to be successful. Today, only 10 percent of people with diabetes in Minnesota are getting what they need for their chronic condition.

Public health improvement grants will be funded next year. It is very important that communities of color be involved in planning for these public health improvement grants. The goal is to reduce obesity and smoking, two of the leading causes of chronic disease. The idea is based on a federal grant received by four Minnesota communities: in Minneapolis, where 75 percent of the students in the school system are from communities of color; in Olmstead County, where 58 percent of the population speaks a language other than English; in Ramsey County, with the largest Hmong population in the nation; and in Wilmer county, with a growing population of Somali immigrants and the third largest Latino population in Minnesota.

In Minneapolis, radio and television shows are offering fitness and nutrition sessions for Somali and other people of color. Among the programs receiving funds from health disparities grants are walking clubs, glucose screening, body mass index measures and blood pressure checks. There is also an effort to engage businesses and factories to offer a change in break and cafeteria food for workers.

We have also provided additional funding to community health centers, a major provider of health care to the refugee/immigrant population, to conduct outreach to increase the number of people enrolled in public programs. We are working to simplify enrollment and re-enrollment, and to improve coordination between public health programs.

As for the future legislative session, we expect the economy will have a big role to play. We left the session last spring expecting another budget deficit and we believe that has gotten worse. We need to be vigilant and concerned about the kinds of budget cuts that might be proposed or considered.

The health care access fund is one way we have increased the number of people with affordable health care coverage. We need to protect this fund from budget cuts.

The issue of interpreter services has come up and it has been contentious. We have public funding and the issue is whether private insurance should be required to cover it. We created a registry for certified interpreters to ensure that we get quality interpreter services. The debate will continue on how we get health care plans to pay for services.

There is a community health worker program that we funded a couple of years ago. We projected a savings in this program, if you're looking for a way to productively cut your budget. Our community health worker program provides services in a patient's own home, helping them to understand protocols they should be following, and helps bridge cultures.

Representative Thomas Huntley

In public health, we are funding a \$47 million initiative over a two-year period starting next July. It is a very strong community based program, funding grants to community health boards. The new statewide program will allow each community to decide on the best way to spend the money, which in many cases directly affects refugee and immigrant communities.

We are very concerned with cost control and building efficiencies into the health care system. The Health Care Transformation Task Force made recommendations to the governor, one being the public health initiative. *Mathematica** predicted that if we did everything in that report we would spend 20 percent less by 2011 than if we did nothing. We were very concerned about cost control, and about half of the savings come from the public health initiatives.

In terms of cost control, Ezekiel Emanuel, director of Bioethics at the National Institutes of Health, says, "*the lack of insurance is a symptom, like a fever is a symptom of disease. If you just treat the symptom you will never cure the disease.*" What he calls the disease is the cost of health care and its inefficient delivery.

Senator Berglin talked about the medical home. The emphasis is to help people manage chronic disease. Fifty percent of health care costs are spent on five diseases: diabetes, coronary heart disease, congestive heart failure, depression and asthma. If you want to look where to save money, asthma is

a good place to start. An inner city clinic in Hartford, Connecticut reduced the spending on kids with asthma by 80 percent by preventing asthma attacks. This kept kids out of the hospital, made sure they were in school, and mothers didn't have to take time off work. There were huge savings. Unfortunately they lost money because they needed to hire a social worker and two translators to call families and find out how their kids were doing. The Medicaid reimbursement system won't pay for the social worker or the translators. We've changed the way we reimburse providers so that they can do the right thing.

The Federally Qualified Health Centers** (FQHC) are doing a great job. We have community measurements in Minnesota that measure what people get in each individual clinic. The ones that scored the best in diabetes were not the ones in the rich suburbs but the ones in the inner cities that are FQHCs. We're trying to duplicate that chronic disease management that they've been using at FQHCs and spread that through our system.

* <http://www.mathematica-mpr.com>

** <http://www.cms.hhs.gov/center/fqhc.asp>

Representative Jim Abeler

I'm a chiropractor in my real life and I live in the systems that the state built. Most of us serve anyone with a state plan who comes in, because we care to serve. But, you can't make a living on it. In most cases, the service reimbursements are below my cost. It's been getting leaner and leaner and tighter and tighter, for almost 30 years now. With pediatric care, and intensive care, and procedures that take more time, providers simply cannot do it. I want to caution you that as we build this system that's based on mechanisms that don't work and doesn't pay its costs, we're going to have some challenges.

Let me read you the first sentence from an article that appeared in today's Pioneer Press, "Doctors are less likely to provide proper medical care to low-income Minnesotans enrolled in state health plans than patients with private insurance." As we talk about expanding Minnesota Care, we have to understand what that does to the market. As policymakers at state and local levels and those working in nonprofits, we need to remember that at some point providers are making their cost plus a little margin, if it becomes cost minus a margin, you can't stay in business. We have to have the right fees.

There are a couple of answers, even in the system we have. There are movements and community meetings about alternative childbirth ideas. There are a lot of ideas out there, innovations, alternative treatments, that can handle some of these chronic conditions we all face. Unfortunately, some of the state plans are not covered very well, where people have to pay a lot of their own costs. There is interesting research about alternative treatments, but often they are not reimbursed. Health care decisions are made not based on quality or outcomes, but about who would lose market share. I hope that you with your expertise will be willing to talk to us, help us see the holes, and help us see better ways.

Senator Mee Moua

Let me give you a case study of what many of you know and our panel understands. I have a 74 year-old mother-in-law who lives with me. She has had two strokes and takes six medications. She suffers from high blood pressure, she's borderline diabetic and suffers from depression. Her physician is a

Hmong-American, her dentist is a Hmong-American, her foot doctor, her pharmacist, her chiropractor are all Hmong-Americans on the east side of St. Paul. They get paid nothing. They don't charge her co-payments for her doctor visits, or for her co-pay on 6 medications, because she can't afford it. The message is that these practitioners working with the most vulnerable citizens can't continue to do this. They can't bill for interpreting services. Information is coming straight from the provider and not from the interpreter who was paid to drive the patient to the doctor's office and paid to interpret. We have a cache of experts in the community and we need to close the loop to bring them in to have a conversation with us, and stop penalizing them. They'll go out of business and then we'll really have a problem on our hands.

Q&A

Q: I feel like I'm in a catch-22. You talk to us as policymakers but policies come from the legislators. We implement policies. If we have this information about where to cut health care costs, about the impact of different distributions of funds, what more can we do to change legislation that can allow us to change policies?

Huntley: Let me give you an example. I was chief author of the "Freedom to Breathe Act," which banned smoking in bars and restaurants. That did not come from legislators or the governor but from the grassroots movement that was already in progress. My advice to you is to make a lot of noise out there, let the public know and let the legislators know. It's much easier for us to pass something with public support. We can know all the intellectual things to do but if there is no public support for it it's not going to happen. It really does start at the grassroots level.

Berglin: The community health workers legislation that we passed a few years ago was an idea that came out of the community health clinics. They were already doing it, even though they weren't getting paid for it, and they had the data to show it produced cost savings and better health outcomes. We could get a fiscal note from the Department of Health and Human Services that the cost savings would pay for it statewide. I'm sure there are other ideas that come from the community that we listen to and are implemented.

Abeler: Get to know the senators and representatives where you live and where you work. What they can help you do is to talk to the right person, the right leaders. Some of these are policy and some are money matters. There is far too little feedback from the hinterlands how things are working. Some of the good ideas don't get implemented. People are afraid to talk. There are speed bumps. There are good ideas. We want every dollar to be useful. Don't be shy. Call us up.

Moua: We don't have an executive branch like Illinois that will help us do the work we need to do. We are working against a force that is not with us. We still get major provisions vetoed and blocked by the executive branch. The reality is that every time we have a budget deficit we cut programs. We can't do all that we need to do until the political momentum changes in this state. Let's not mislead ourselves. Even with good-hearted people and with hardworking legislators, we still can't get things done until political dynamics change. This population is worth investing our resources in, but the political will is not there.

Q: In this conference*, the Joint Commission for Quality Assurance talked about establishing a federal or national model for interpreter certification and training. I referred them to what the

Minnesota legislature had done in courts and health care, and Senator Berglin was instrumental in establishing that. The work has been done, why reinvent the wheel?

Regarding Senator Moua's and Representative Abeler's comments that we aren't reimbursing providers adequately, we have heard that more individuals should do their own self-management and self-care. If there is no money for health care, how can we support and encourage families to take care of themselves?

*Sixth National Conference on Quality Health Care for Culturally Diverse Populations
<http://www.diversityrxconference.org/>

Berglin: The best way is to be very vocal within your own family and communities that you interact with. I don't believe Minnesotans want to see health care cut. I feel on pretty solid ground about that. It doesn't hurt my colleagues or the governor to hear that as well.

Q: In community dental care we have 20,000 patients, most of whom are refugees, immigrants and minorities. Because of the critical access dental plan that the legislature passed, we are able to survive. For 90 percent—18,000 patients—we get paid 50 cents on the dollar. For \$4 million of work we get paid \$2 million and we can't survive. You can't pay the dentists and their assistants. Because of the legislation we are able to serve 13,000 Hmong and many other immigrants. Thank you.

Q: How much is Medicare and Medicaid policy driving what you can and can't do? We are making a much bigger investment in prevention and hope that the benefits are being documented.

Berglin: Medicare is a major player in the system. We can't change what we get in health care until we change what we pay for. As a state, we are not waiting for Medicare to change the way they pay. Instead, at the state level, we are trying to get all the other payers to pay differently. All the other payers will pay for medical homes, pay for outcomes and use the same quality standards. We expect to change the way Medicare pays us because of the benefits we show them. The Minnesota health plans came together to fund the community health care project, which will help us focus on quality and outcomes. Thus, more emphasis is placed on prevention and helping people with chronic conditions. And we will see more of that as result of the legislation that came this year.

Huntley: Every industrial country except the United States has universal coverage and better outcomes. But we have a huge tilt toward specialty care and do not reward primary care. Every other country pays specialists the same as primary care. In the United States, this is based on the 1965 Medicare bill that set up the initial payment rates. For example, cardiologist Doug Wood told the legislature he gets paid four times as much per hour to put in a heart stent as he does to spend time helping patients from needing one in the first place. That's what we're trying to change with medical home and chronic disease management. We have to pay for reimbursement.

Q: There is a huge population in Minnesota that can not get any kind of insurance – the undocumented. People work hard, they get sick, they have accidents and they end up in ER. They cannot get coverage unless the person is pregnant or has an emergency care need. What is the thinking of the legislature?

Huntley: Regarding the undocumented not having insurance, you wouldn't believe how hard we worked just to ensure access to prenatal care for unauthorized immigrants. If there's one thing in preventive care that's been shown to save money it is prenatal care. That pays off. A woman will go to the hospital, deliver that child, that child will be a U.S. citizen, who will have insurance, and be eligible for care. Lack of prenatal care could cause premature birth, which could cost upward of \$200,000.

Q: There are cultural and linguistic challenges for our system in serving this diverse population and in providing health care access. Seven Asian groups started the Minnesota Asian American Health Coalition and started a health summit series. We had a fourth summit last year with Jonathon Watson, Community Health Centers (CHC). The FQHC is a good model of delivering primary care to the Asian populations and other populations. The Asian community is the only major ethnic community without a CHC focused on their community. What can be done to support the Asian providers and linguistically, culturally competent care?

Moua: One of the conversations is that Asian or Latino doctors don't want to think about becoming a community health center. There are resources out there if someone is willing to come in and do a CHC. We need to find ways to get CHCs up and going, and help Hmong, Latino, African doctors manage the accessibility, language and cultural competency issues and help these individuals enhance their ability to do a good job.

Berglin: A word of advice about starting community clinics, because I want you to be successful. Grow in a metropolitan area. We provided bridge funding in Mankato that had no federal funds. They serve all southern Minnesota, no matter what language you speak. They missed getting federal certification by five points. They think next year the application can get over the five-point hump. We have a number of clinics that we need to work with to help them provide services better. We're not likely to get another CHC funded by the federal government.

Promising Practices in Minnesota and Beyond

Participants offered innovative projects addressing the health needs of immigrants and refugees. Ann O'Fallon, Refugee Health Coordinator at the Minnesota Department of Health facilitated the meeting. Cynthia Roat, expert in language access advised the roundtable discussion.

Ann O'Fallon, Facilitator:

I want to start with our success story. I direct the Refugee Health Program at the Minnesota Department of Health and we have one of the best immigrant/refugee health programs in the country. Minnesota has the greatest proportion of refugees and we, as a community, do an excellent job on care and follow-up care. We have a high rate of screening. All colleagues—doctors, clinics, public health clinics—do a great job of screening refugees when they first arrive.

Participant:

I have 29 years working as community health worker (CHW), both domestically and abroad. Several years ago we started a network which allows CHWs from a variety of ethnic backgrounds to hear from speakers they are interested in. We have a strategic planning session coming up to see if the CHW want to spin off and form their own organization or stay with IHV. We work a lot with Somali community. Last year, we launched a Center for Somali Health. A lot of CHW staff are

Somali, and they go into people's homes and educate people about pertinent health issues, including chronic diseases.

Participant:

We help people with the application process for MinnesotaCare and with medical assistance. Most people we talk to are eligible but they can't get through the complex application process. We help them fill out forms and we communicate with county workers on their behalf. It's a very unique coverage program. We also have our own health plan called Portico HealthNet. It's not an HMO but is a community-based plan funded by hospitals. No government money goes into the program. The coverage mainly provides primary and preventive care for individuals who are legal in the state but not eligible for public benefits. Individuals get primary care, specialty care and prescription drug benefits. It's designed to reduce the number of ER visits that would otherwise go unpaid. Care managers are involved to educate immigrants about how health care works and encourage them to use the health care system appropriately.

Participant:

I am with the Upper Midwest Translator and Interpreter Association (www.umtia.org.) Information is posted on the website about the Curriculum Stakeholder Group. The collaborative was established in 2004, and we meet monthly to coordinate how people who are working as interpreters can access additional training. We're also working on getting funding to support training, as well as address the issue of establishing certification for medical interpreters. We're partnering with people at a national level to have a process in place for certification. Also, legislation was passed to develop a statewide roster listing all health care interpreters. The roster identifies where interpreters are, what language they speak and allows us to access a pool of available interpreters throughout the state. Part of the legislation includes developing a plan to identify who has a minimum set of qualifications. The group includes a broad cross section of people including interpreters, agency employees, as well as those of us who hire interpreters.

Participant:

We have a program to improve culturally specific health care and we want to reform the way health care professionals are licensed to ensure providers in clinics speak languages of immigrant population. We received one-time funding from the state to provide scholarships for people to study and pass medical certification exams. Some actually began residency programs. We have had doctors and nurses getting licenses to practice in the United States. We hope for additional funding from the legislature to continue the project. We have funding from the Office of Refugee Resettlement working with foreign professionals to get them integrated for self-sufficiency.

Participant:

In Minnesota, we have a certification process for court interpreters but there is a big difference between legal interpreters and medical interpreters. It's important to pay attention to interpreters in a medical setting. Minnesota will join in with the national process of medical interpreter certification. It costs a lot to develop good and valid and reliable tests for interpreters. It's more important to invest in extending and expanding training for interpreters, in both urban and rural settings. When looking at those who speak native language at home but English outside the home, only 30 percent can pass language screening. Often they don't speak the language well enough to be a medical interpreter.

Participant:

A "Clinic Session" is offered every third Sunday to seniors. Seniors can come and consult with community doctors and based upon their condition they are referred further to free clinics or to physicians they can understand. Consulting sessions help to overcome barriers to health care that are related to religion and language.

Participant:

Westside Community Health Services is 35 years old and was founded by immigrants. Its' role is to provide culturally appropriate care in an affordable manner to those ineligible for public programs and it offers care outside of Medicaid. We are running a pilot project, which is following more than 1,400 patients with diabetes—a big and increasing issue among Latino and Hmong populations. We are looking at a community-based, clinic-based disease management model. The care coordination team includes an RN and CHW, both of whom are bilingual and bicultural. RNs and CHWs interact with the clinical care team, and go to homes and to communities. Care management most often occurs through a phone call from plan providers. Immigrants and refugees, partly because of cultural/language barriers, never make contact with a care coordinator. As the state looks at different models of providing care and looks at different ways to reward providers for working with different populations, we hope that this model can be incorporated and be a more effective tool. We do need new models because the traditional ways of doing things just aren't working. As things get defined under "medical home," we hope that the right components are included and that we take into consideration methods that work for diverse cultures and languages.

Participant:

The highest standards of interpreter certification are found in the courts and legal interpreting field. Individuals certified by the courts are also often used by medical providers. If we are looking for medical interpreter standards, especially on a national level, cost savings are possible, if we learn from the legal interpreting process and its standards. Another point is that progress is being made to establish national cultural competency standards.

Participant:

We need all the resources available to encourage the certification of medical interpreters. The Bush Foundation convened a meeting with national experts on testing. The federal court certification exam and the state court certification exams could serve as vehicles. All of these resources are helpful when establishing exams and standards for medical interpreting. (This participant is a member of the Standards, Training and Certification Committee at the National Council on Interpreting in Health Care <http://www.ncihc.org/mc/page.do>.)

Participant:

It's important to look at the executive branch and how provisions are implemented. Sometimes instruments are developed that are not necessarily appropriate. It is critical that we understand what we are testing, because frequently testing means that we are screening people out, rather than screening them in. One important question has to do with compliance with federal law and the provision of interpreting services in the area of health.

Participant:

The Eliminating Health Disparities Initiative established by the Minnesota Department of Health has been a very successful model for 10 years. The initiative funds many immigrant programs and organizations. It also funded the first Somali survey for adults, which conducted one-to-one

interviews to get the baseline data. It also funds a youth program and Somali exercise programs, and aims to increase access to fresh fruits and vegetables. This approach has been replicated by a lot of other organizations and groups.

Participant:

A friend of mine said that many people here are odd. They eat big portions and then they pay for the gym. Newcomers to America change their way of life and adopt the ways of their new home and do not exercise enough and gain weight. We have to think about a healthy weight and have to consider cooking at home rather than eating out for convenience. There are many language barriers and cultural issues. The Bosnian's Women Network has been successful in getting funding and working with the community on these issues. The community has to be educated on these issues. Newcomers do not know the American system very well – the schools, the health care systems, Medicaid. It takes time to learn and to make life easier for you and your family.

Participant:

We provide many different services. We are a Blue Cross/Blue Shield of Minnesota grantee. Mental health and culturally appropriate care in this field are very important for the Somali and Oromo communities. How can we work on mental health? It is quite stigmatic in their culture to talk about mental health. We provide mental health education. We also work with health institutions to address many different health concerns like nutrition and eating disorders. Soda-pops in schools and school nutrition also is an issue of concern. Every time we discuss these issues with our community we ask: "What did you learn? How does this impact your life?"

Many newcomers have extensive family that lives back home but life in the U.S. is very lonely, which can lead to depression. Often war traumas exist and nobody speaks their language, which contributes to isolation. We try to assist individuals in socializing efforts so that they can speak up about their concerns in their lives and they can become more open to the surrounding community. We are working with several partners on research and surveys around Somali communities, especially mental health, with a lot of success.

Ann O'Fallon

Minnesota is the land of ten thousand lakes but also the land of ten-thousand collaborations. We are people who like to work together for success: on access to health, CHWs, medical homes, education and the great work in the field medical interpreter issues.

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