

Communiversality

Minnesota Community Blueprint to Asian/American and Pacific Islander Health Equity: Indicators for Success

Prepared in partnership with
Minnesota Asian/American Health Coalition

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Executive Summary

In December 2010, the Minnesota Asian/American Health Coalition (“MA/AHC”) published its *Minnesota Community Blueprint to Asian/American & Pacific Islander Health Equity*. The *Blueprint*, in part, aims to optimize the health and well-being of the Asian American and Pacific Islander (“AAPI”) community in Minnesota by drawing attention to four core areas that aspire to improve health equity. The *Blueprint*’s core areas are (1) Community Empowerment, (2) Culturally Relevant Data and Research, (3) Professional Development, and to (4) Strengthen Processes that Reinforce Health Access. To further empower the *Blueprint*, this Project aims to select indicators to measure the community’s performance in these core areas, and to create a foundational structure that will track the specific progress of these indicators. For feasibility purposes, this initial Project focuses on developing indicators for *Blueprint* areas of (1) Community Empowerment and (4) Strengthen Processes that Reinforce Health Access, leaving the remaining areas for future efforts. To develop these indicators, key informant interviews were conducted with select members of the Blueprint Advisory Committee and other community experts, chosen for their unique roles in the health and healthcare community. The suggestions garnered from these interviews were then compiled and organized into indicators in collaboration with the MA/AHC Executive Director.

Methods

I. Literature review of completed blueprint projects for indicator formulation

In efforts to refine the methodology of selecting indicators, twelve Blueprint-type projects conducted in the United States were analyzed. These projects informally fit into three categories: Fully Developed Indicators, Informative with Indicators, Informative without Indicators.

a. Fully Developed Indicators

Health departments and States typically matched their chosen indicators with established measurements, and thus produced primarily empirical indicators. These reports tended to be extensive and detailed. With the respectively greater resources than other organizations undertaking blueprints, these public departments and states were able to associate their data directly to tracking organizations. In fact, most all of the indicators chosen were already tracked by States or other organizations. Thus, these empirical indicators could immediately be studied over time, and indicative of progress even with time frames of less than a year.

b. Informative with Indicators

Other organizations, such as coalitions and research organizations were more apt to produce blueprints with call-for-action indicators, such as policy proposals. Their indicators were primarily chosen by advisory committees that typically focused on indicators with traceable data. These indicators often took form as qualitative accounts of the resulting change in quantitative data. This indicator formulation utilizing a call-to-action format can be applied to blueprints even without established measurements, and presented as an appropriate format for many of the AAPI health equity measures.

c. Informative without Indicators

Many organizations produced blueprints that were primarily informational, with no tracking indicators. These organizations tended to be coalitions, even ones national in scope, creating reports that only indentified problem drivers. These blueprints generally were aimed to inform and to mobilize policy makers. The audiences of these blueprints were broadly focused.

d. Application

The majority of analyzed blueprints utilized committees to choose indicators, regardless of the ultimate indicator formulation. For example, the *Health Equity Index* by the Health Equity Alliance utilized a committee to choose quantitative indicators, coupled with indicators that were qualitative and unmeasured. These latter indicators focused on issues such as day care facilities, public transportation, and food options in particular geographic areas... issues that were not aptly quantifiable. *The Power of We*, a State Health Department blueprint, also utilized a committee to choose indicators. The *Minnesota Milestones 2002*, the most local blueprint examined, used a committee-like body to choose indicators that were almost all linked to preexisting tracking systems. In General, the Blueprints used Advisory Committees to choose goals or indicators that were then evaluated against a set of pre-defined criteria developed by the Advisory Committee. In part, these criterions included: (1) readily available data, (2) suitability of the data, (3) links to one or more health statuses, and (4) cost effectiveness of the indicator. Correspondingly, the Project utilized the Blueprint Committee to formulate indicators.

II. Key Informant Interviews of *Blueprint* Committee and other Community Experts

Advisory Committee members to the *Minnesota Community Blueprint to AAPI Health Equity* and other community experts were chosen by the Executive Director according to their expertise and experience pertaining to the two chosen core areas of the *Blueprint*. The

interviews were structured informally into two parts. First, the experts were asked about their particular specialties and how these areas affect the health equity of the AAPI community. Second, the experts were asked open questions on what they perceive as barriers to AAPI health equity, in any area. The information garnered from these interviews were then compiled and analyzed.

III. Development of Indicators

Indicators were chosen according to the information gathered in interviews, and under two factors: their (1) relationship to the *Blueprint* core areas, and (2) suitability of any available data. During this process, measurable indicators were sought. However, due to lack of research and epidemiologic data for the AAPI community in Minnesota, many indicators consequently were informative only, or recommended policy.

Blueprint Indicators

I. Community Empowerment

a. Increased community representation in decision-making bodies

Number of AAPI graduates from leadership programs. Currently, there no adequate systems in place for the AAPI community to communicate health issues to pertinent decision makers and the State Legislature. As such, the community is in need of leaders stemming from all pertinent areas that are capable of affecting health equity for the AAPI community. Institutions such as the Bush Foundation, Wellstone Action!, and the Minnesota Council of Nonprofits stand as organizations focused on leadership development, and are rich in well-needed expertise. By increasing the number of AAPI graduates from these and other like programs, the AAPI community can better advocate for improved health equity.

The communication gap between the AAPI community and pertinent decision makers leaves the community without influence to planning processes that directly affect their health equity. Further, the lack of already sparse data and legislative accountability to the community impairs future efforts to increase the community's capacity towards equitable health systems. Fortunately, there are many community organizations that have established themselves as salient advocates. As such, more effort should be focused to participate in and supporting these organizations for the ultimate purpose of health equity for the AAPI community. These institutions not only provide advocacy expertise, but feed highly needed leaders into other organizations. By supporting these organizations, the AAPI community can build a voice on health equity issues. Some of these organizations that should be engaged, and are listed below:

The National Association of Asian American Professionals – Minnesota	http://mn.naaap.org
Asian American Student Union	http://www.tc.umn.edu/~asu/about.html
Council on Asian Pacific Minnesotans	http://www.capm.state.mn.us/heritage_leadership.htm
Asian Pacific Partners for Empowerment, Advocacy, and Leadership	http://www.appealforcommunities.org/laamppii
Asian & Pacific Islander Scholarship Fund	http://apiasf.org/
Lao Assistance Center of Minnesota	http://www.laocenter.org
Association of Community Health Organizations	http://www.aapcho.org/site/aapcho/
Vietnamese Social Services of Minnesota	http://www.vssmn.org/
Hmong American Partnership	http://hmong.org/

Number of AAPI champions in elected positions. In the new 2011 state legislative session, there will no longer be any AAPI State elected officials. For inclusion in crucial health related decision making bodies, such as the *Health Care and Human Services Policy and Oversight Committee* in the House, and the Senate’s *Health, Housing and Family Security Committee*, there must be more champions that will support bills backed by the AAPI community that strive towards better health equity.

The community lacks voice in state legislature, where broad health policy is conducted. Beginning in 2011, the AAPI community is losing crucial representation in health related decision making bodies such as the *Health Care and Human Services Policy and Oversight Committee* in the State House, and the Senate's *Health, Housing and Family Security Committee*. However, under Minn. Stat. 3.9226, the Council on Asian Pacific Minnesotans was created in 1985 in part to “ensure Asian Pacific Minnesotans are more incorporated and engaged in the governmental and policymaking process.” We must bolster support for the Council, and support any effort at direct representation in Minnesota State Legislature.

b. Increased health literacy at the family and community level

Number of AAPI community health workers. Community health workers play a vital role in promoting health equity for the AAPI community in Minnesota. Not only do they provide a diverse array of enabling services, but they are positioned to deliver care in a culturally sensitive manner. The AAPI community can increase its own health literacy by empowering and increasing the number of AAPI community health workers that serve in the State. To further this goal, a registry or public database of community health workers and the populations they serve would be greatly beneficial.

Creation of a system or forum for patient feedback to the community. The AAPI community itself is best positioned to gauge its own concerns, including cultural and ethical barriers to health equity. By creating an avenue for AAPI patients to better communicate concerns to community leaders, health equity will be better achieved through the enforcement of specific rights. Community meetings or other forums that allow concerns to be centrally addressed will ensure greater family and community literacy.

c. Increased role of traditional healers in health care organizations

Partnerships between traditional healers and health care organizations. The members of the AAPI community are diverse, with diverse views on the philosophy of health care. Currently, there is little incorporation of traditional views to complement Western medicine. Increasing the role and relationships of traditional healers in health care organizations in Minnesota will better realize health equity for AAPI communities that seek healers outside of the allopathic viewpoint.

According to the American Academy of Acupuncture and Oriental Medicine,¹ almost all referrals to more traditional medical philosophies are from physicians and there are little if any formal relationships with health systems in Minnesota. Most health systems perform acupuncture, which may be reimbursable. But, other therapies such as Traditional Chinese Medicine (TCM) are typically not. However, many health systems and hospitals, such as Children's Hospital in Minneapolis have recognized the importance of incorporating traditional medicine views as a complement to Western medicine.² Others, such as Hennepin County Medical Center, have opened up alternative medicine clinics that stand as positive examples of a complementary system between traditional and Western philosophies.³ Since many in the AAPI community practice and seek treatment in both traditional and Western approaches,⁴ it is important to expand this type of access to other health systems throughout the state.

Number of AAPI providers and medical staff. Medical providers stemming from AAPI backgrounds may naturally present with personal knowledge of culture, language, and other communication methods that may remove some barriers for many AAPI patients. The diverse

¹ <http://www.aaaom.edu/>

² <http://www.childrensmn.org/web/clinicsanddepts/025019.asp>

³ <http://www.hcmc.org/depts/medicine/alternative.htm>

⁴ http://www.csh.umn.edu/prod/groups/ahc/@pub/@ahc/documents/asset/ahc_17580.pdf

AAPI population has equally diverse needs, and requires greater choices in medical practitioners to achieve health equity. Increasing the number of students from AAPI backgrounds in medical education programs will provide patients with more diverse choices.

d. Increased investment of community serving community

Creation of a centralized system of organization for the AAPI community. The growing AAPI community in Minnesota does not have a central advocacy system. With a respectively smaller population as compared to others in the state, advocacy is crucial for the community to achieve greater health equity. Centralized organization will produce more focused outreach, and give credence to efforts in legislative advocacy.

Although the AAPI community is growing rapidly in Minnesota, it is fractioned with no central advocacy system. With better community infrastructure, we will be able to measure our efforts and services, and stand with a more powerful posture to create efficacious partnerships. With centralized organization, there will be more incentive for outside institutions to conduct research, producing more focused outreach. And indeed, a centralized voice would be more salient in legislative advocacy.

Number of beneficial partnership to the AAPI community. The AAPI community should complement its own strengths with beneficial partnerships. By nurturing and establishing relationships with salient organizations, the community's capacity to strive towards better health equity will be bolstered with outside support. Increasing the number of beneficial partnerships will also better connect the AAPI population to the larger Minnesota community, which may ease barriers to advocacy.

II. Strengthen Systems that Reinforce Health Access

a. Enforce compliance of culturally and linguistically appropriate services

Number of AAPI capable healthcare translators and interpreters in outpatient settings.

Language services stand at the forefront of need within a community stemming from multiple non-English based cultures. Within large health systems in the Twin Cities, available language services for the AAPI community surpass that of most other states. However, demand is still high in more suburban and rural areas. By increasing the availability of language services outside of large cities, better health equity can be realized no matter where an AAPI community resides.

Increase in quality of language services through certification, and enforcement of standards.

Currently, translator services are inconsistent, lacking any national or statewide certification requirements. With no binding standards of quality, AAPI patients have suffered from inconsistent service, or even overbilling and fraud. Through required certification, enforcement, and oversight of translator quality, the AAPI community will have a better measure of services they are paying for. As of today, language translators in Minnesota are required to register on the Spoken Language Health Care Interpreter Roster to receive state-funded reimbursement.⁵ However, Roster inclusion neither confirms certification, nor provides an indication of any quality standards.

b. Increase recognition of enabling services

Increased services in financial assistance, obtaining public insurance, case management, and outreach to understand the health system. Minnesota's community organizations provide

⁵ See <http://www.health.state.mn.us/divs/pqc/hci/index.html>

numerous enabling services to the AAPI community. However, many of these services are performed without documentation, and thus go uncompensated. This threatens the continuation of these services in the long run, when organizations run into any financial constraints. By documenting performance to support reimbursement advocacy to decision makers, these organizations can obtain the funding necessary for services to continue, or even expand.

Greater support for community programming. In addition to general health care services, community programming performed by various institutions can fill specific need-gaps for the AAPI community. Institutions such as the University of Minnesota, who create and operate these programs, need support to raise funding, carry out operations, and to promotion of utility. Grass roots and organizational support of community programming will ensure these unique services the AAPI community continue.

c. Increase and Expand the reimbursement structure within the health care system to be more responsive to the health belief of the AAPI communities

Higher reimbursements for translator services from the State of Minnesota. At current rates, reimbursements for interpreters are not enough to induce more work force into the field, even though training programs are available and of high quality. Scholarships have been offered by the University of Minnesota, but have been received with little to no enthusiasm. With the high cost of education and low reimbursement, the number of translators available to the AAPI community is directly affected by this pitfall.

Reimbursement approval for new services. Though a difficult undertaking, the AAPI community can help influence the reimbursement of new services through the combination of advocacy, data collection, and leadership. To do so, requires direct communication and advocacy to the Administrative Uniformity Committee (www.health.state.mn.us/auc).

Conclusion

This Project sought to develop indicators to complement the *Minnesota Community Blueprint to Asian/American & Pacific Islander Health Equity*. Constrained by lack of research data collected on health equity measures for the AAPI community, the Project necessarily employed Key Informant Interviews to gain insight into pertinent health equity Indicators for the *Blueprint's* Core Areas. The interviews revealed Indicators that were, in general, call-to-action indicators that pointed to a focus under each Core Areas that needed future attention. This initial attempt, concentrating only on two of the four Core Areas of the *Blueprint*, sought only to provide a structural approach at future efforts in developing indicators. Hopefully, future endeavors will be able to interview a broader base of experts, and supplement with empirical studies, to develop indicators in full for the entire *Blueprint*, and give the AAPI community in Minnesota a tool to better achieve health equity.

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