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Evaluation and Recommendations for Emergency Communication Strategies to reach Limited English Proficient Populations

Minnesota Department of Health
Report to Public Health and Community Health Agencies

June 2012

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Evaluation and Recommendations for **Emergency Communication Strategies to reach Limited English Proficient Populations**

I. Introduction and Project Background

Between 2000 and 2010, the number of Minnesotans age five and older with limited English proficiency increased from 167,511 to 205,751[1]. In order to better guard the health and well-being of all Minnesotans, emergency communication strategies must be enhanced. The Minnesota Department of Health (MDH) and local public health agencies must strengthen our capacities to inform and educate all Minnesotans which will require strategies to reach individuals with limited English proficiency (LEP) populations as well as the general public.

The MDH Office of Minority and Multicultural Health (OMMH) recognizes the need to assess and improve how Minnesotans with limited English skills receive critical information during health emergencies. With this goal in mind, OMMH conducted a study to document current strategies used to communicate with LEP populations and understand how residents with limited English skills find or receive information. Findings from this study identified ways that Local Public Health agencies can or want to be supported in order to effectively reach limited English proficient populations in their regions. A two-pronged approach was used to 1) understand how emergency health information is disseminated by public health agencies at the state, regional, and local levels; and 2) assess information received by residents with limited English skills.

The study was centered around the following four questions:

1. What are the LEP population demographics by county?
2. What strategies were put in place to reach LEP populations, particularly outside the metro region, during the recent pandemic flu (H1N1) incident?
3. From the perspective of both local public health agencies and LEP residents, how effective were these strategies?
4. Were those strategies institutionalized to be utilized effectively in other or future emergency communication situations?

To begin answering these questions, the OMMH conducted a survey of professionals in health and human services, health education, community based organizations, and emergency outreach and preparedness personnel. With a focus on Greater Minnesota, residents with limited English skills participated in four focus groups and 18 phone interviews. This approach helped to identify and recommend strategies to close the communication gap.

[1] http://www.migrationinformation.org/datahub/state2.cfm?ID=mn

II. Overview of Minnesota's Limited English Proficient Populations

Emergency communication strategies must adapt to our state's increasingly diverse population. One indicator of this demographic shift can be seen in the continual increase in number of children living in linguistically isolated households.[2] From 1990 to 2000, the number of school age children living in linguistically isolated households increased by about 24,000. Half are Asian Pacific Islander households, 30% are Spanish-speaking households, and about 11% likely speak one or more African languages (census data do not disaggregate individual languages). [3] Recent census data from 2000 to 2010 indicates the number of foreign-born, limited English proficient (LEP) population age five and over in Minnesota increased by 40.7 percent[4].

Demographic data was analyzed by county to identify likely targets for focused community-based research. Counties outside the seven-county metro area were prioritized by these criteria:

- Potential for LEP population centers (total numbers) of Asian, black, or Latino residents
- Percentage or density of potential LEP populations (Asian, black, or Latino residents)
- Linguistically isolated State Demographic Center rating
- Immigrant population increase of 15% or more
- Percent of English Language Learners in school districts
- Racially diverse (percent of non-white residents)

Hennepin and Ramsey Counties respectively have the largest LEP populations by total and percentage, followed by many of the counties in the metro area. However, these metro centers also have well-established resources to reach LEP populations. The primary intent of this study is to highlight and improve strategies that may be less established or under-utilized to reach LEP populations in Greater Minnesota. Therefore, excluding the seven county metro region, large or growing potential LEP populations were identified in the following counties. (Appendix 1 shows the percentage of Asian, Black, and Latino residents in each county, noting a handful of counties that have a high percentage of students who primarily speak a language other than English at home.)

- Olmsted County
- Rice County
- Nobles County
- Kandiyohi County
- Stearns County
- Mower County
- St. Louis County
- Clay County

[2] The US Census defines "linguistically isolated" as households where all members, 14 years old and over, have at least some difficulty with English.

[3] Minnesota Demographic Center. 2005. http://www.demography.state.mn.us/DownloadFiles/Children2000Census.pdf

[4] http://www.migrationinformation.org/datahub/state2.cfm?ID=mn

- Lyon County

Brown, Scott, Otter Tail, and Freeborn Counties also had notable growth in potential LEP populations,[5] but did not meet, or were not highly ranked, in one or more of the other criteria.

Forty-nine residents with limited English skills in Olmsted, Rice, St. Louis, and Lyon counties participated in focus groups and phone interviews to provide information about their direct experiences related to information access during health emergencies like H1N1 (Appendix 2 is a table of study participants' county and language).

While these participants represent only a small portion of Minnesota's diverse LEP populations, their experience illustrates important and often-missed perspectives that can improve strategies used to inform and engage LEP populations, particularly those outside Hennepin and Ramsey Counties. In addition to the LEP focus groups and interviews, this study also asked local public health agencies, community based organizations and other emergency preparedness personnel to share their communication and outreach efforts during H1N1 (see Section IV).

III. LEP Residents' Experiences with Emergency Health Messages

It is important to understand the context and conditions of populations with limited English skills. Many, though not all, people with limited English proficiency are foreign-born immigrants or refugees and may have experienced significant hardship prior to and during relocation. With this context, participants in this study alluded to a different sense of what constitutes an emergency. Participants indicated that emergencies must be personal and/or widespread. For instance, H1N1 pandemic did not fully resonate as an emergency for some participants. This presents a particular challenge in communicating a sense of emergency here in Minnesota to populations that have experienced extreme international turmoil. Messages may be better received if aimed at increasing urgency and ease of preventive health measures.

Using the most recent health emergency (H1N1 flu pandemic) as an example, residents with limited English skills were asked what and how they received health information. (Appendix 3 is a template protocol for focus groups and interviews.) Almost all participants heard about H1N1 from a variety of sources. About half of the participants described the H1N1/flu as dangerous, contagious, and deadly. The most mentioned sources were television, ethnic radio, family members, and flyers from community centers such as schools or other social service programs, clinics or stores – particularly those advertising flu shots.

A majority of participants were not able to differentiate between seasonal and pandemic flu, and less than half of all participants received a flu shot. Participants who understood the difference were generally older and made frequent or regular doctors' visits, typically related to chronic illnesses.

[5] Generally, immigrant populations increased by 10-20%.

Roughly, three out of four participants received some health emergency information from ethnic-specific media. Topics seemed to be elevated in priority if it was covered by both mainstream and ethnic media outlets, which was a common remark among participants. Typically, news and events in ethnic media outlets were viewed as having more relevance to most participants. After initial awareness of a health emergency via mainstream TV or newspaper, younger participants in particular reported actively searching online web sources for information in their native language and found more language-specific content from sources outside Minnesota.[6] Of the television programming, only one participant (a Hmong woman from Lyon County) commented that she occasionally watched a health education program in Hmong.[7] She stated that she appreciated that the program was accessible, but did not feel it offered coverage on current events. It was pre-recorded and its content was not immediate or timely news.

Other common channels of health messages included family doctors or regular health providers including school nurses, family members with more English language skills, and workplaces that employ many LEP residents. There was not a consistent source of information across ethnicities or counties. However, aggregate responses suggest that once individuals established a source of information, they continue to expect or rely on that source for other information as the need arises. For example, one participant stated that their school often sent fliers for contagious illnesses at school. She stated that once or twice a year, she would get information about lice in her child's backpack, and only when the school had notable cases. Each lice flyer was the same and therefore, recognizable. Also, it was

COMMUNITY CONTEXT

- ✓ Many people with limited English skills are foreign-born immigrants or refugees who have a different sense of what constitutes an emergency.
- ✓ Most participants received some health emergency information from ethnic-specific media.
- ✓ Once individuals establish a source of information (such as a school nurse, community program, or employer) they continue to expect or rely on that source for other information as the need arises.
- ✓ People with limited English skills are hesitant to ask for more information based on their real or perceived threat of discrimination and prejudice.
- ✓ Translated, written materials are often not immediately useful.
- ✓ Understanding costs, insurance coverage, and navigating paperwork with medical professionals are difficult.
- ✓ Challenges get communicated quickly through word of mouth and can prevent residents from seeking needed resources and taking necessary action.

[6]Sources include: Somali: http://www.mogadishutimes.com/
Minnesota based, African immigrant: http://www.mshale.com/index.cfm
Latino: http://latindispatch.com/category/regions/north-america/united-states/
Minnesota based, Latino: http://www.laprensademn.com/

[7] This program is presumably an Emergency Community Health Outreach (ECHO) program, though the participant did not know the name of the program.

always timely, alerting her to current spread of illnesses. Because she established this as a source of information; she would rely on the school nurse and/or school office for other current health information.

Navigating the health system can be stressful even to native English speakers, but the challenges are acutely felt by people with limited English skills. Regardless of their level of English proficiency, many participants indicated they have low confidence in their English skills and/or accent. People with limited English skills are hesitant to ask for more information based on their real or perceived threat of discrimination and prejudice. Some participants received written information translated in their native language, but particularly for Asian and African participants, this information was not immediately useful for a variety of reasons: the information was too general, they did not read in this particular language/dialect, or they did not read in their native language at all.

Participants commented on additional challenges in getting emergency health information – these were related to H1N1 as well as in other emergencies, such as after a major flood. Understanding costs, insurance coverage, and navigating paperwork were barriers to some participants. Participants perceived that preventive measures would be costly. For most people who mentioned cost, the perceived or potential cost of a flu vaccine prevented them from seeking additional information. The out of pocket cost of the vaccine was a burden particularly for single adults without health insurance. Also, because limited vaccines were issued in order of priority, understanding or applying these criteria was a challenge for multi-generational families. These types of obstacles get communicated quickly (and not always accurately) through word of mouth and can prevent residents from seeking needed resources and taking necessary action.

IV. Public Health Outreach Strategies to LEP Populations

1. *Office of Emergency Preparedness Poll*

The MDH Office of Emergency Preparedness (OEP) oversees eight Public Health, Healthcare and Behavioral Health Regions and Teams. Shortly after the H1N1 pandemic, in February 2010, OEP polled these teams (79 individuals) about their public health outreach strategies. Via weekly email, OEP asked, "What strategies or materials did you use to educate or provide updates about H1N1 to your populations of color/American Indian communities?" Responses (80% response rate) were aggregated by region. It is important to note that the OEP poll is not specific to LEP populations, though some communities of color and American Indian communities may share similar challenges across culture and language.

- Regionally, different communication strategies were used for African, Asian, Latino and Native Indian populations during the H1N1 pandemic. In six of eight regions, different outreach strategies were used to reach two or three target populations.

- All regions (except the Northeast region) used multiple strategies to reach Latino populations. Targeted outreach efforts in the Northeast region were mainly to engage Native American residents.

- Five of eight regions used multiple strategies to reach LEP African populations, and four of eight have strategies for LEP Asian populations. Of the four regional strategies to reach LEP Asian populations, two relied solely on bilingual family members as their only strategy.

2. *Strategies Identified through Office of Minority and Multicultural Health Survey*

Building on this earlier open-ended OEP poll, OMMH surveyed a wide array of health professionals in across Minnesota, including the seven county metro region. Survey recipients included employees of state agencies, local public health agencies, city and county human service agencies, care providers (primary care providers, hospitals, clinics, and treatment centers), and nonprofit agencies. An online survey was sent to approximately 400 unduplicated individuals using pre-existing email distribution lists, directories, and professional networks (Appendix 5 is the online survey). Responding to the online survey about their agency's outreach and communications to residents with limited English skills in their service area, were 318 professionals for an estimated 80 % response rate (Appendix 5 and 6 show survey respondents' agencies and roles). About half (47.5%) of respondents self-identified as employees of local public health agencies.

- 53 % of all survey respondents relied on interpreters or bilingual staff during H1N1. Hospitals and health providers, in particular, rated interpreters and bilingual staff as the most useful outreach strategy. In Greater Minnesota, half of local public health (LPH) agencies used interpreters or bilingual staff to reach LEP populations. Interpreters' responsibilities included making phone calls and being present at mass clinics.

- Among all respondents, the second most frequently used strategy to reach LEP populations was use of pre-existing (MDH and Center for Disease Control) translated materials (48%). While about half of all respondents used pre-existing translated materials, very few respondents rated this strategy as most useful (about 1/3 of health providers, hospitals and clinics).

- Other frequently used strategies were providing internal staff and/or key partners with information and referral resources (34%) and referring people to ECHO resources (34%).

Respondents from local public health, hospitals, and primary care providers relied on outreach through community programs, schools, or clinics. Similarly, community based agencies noted that having a strong relationship with a local public health agency or a local hospital/clinic has

helped their agencies be prepared for an emergency. It is important to note, however, that there was no mention or documentation of whether or not individuals followed through on those referrals or whether the referred agencies had applicable services. .

- 11 % (46 broad-based and ethnic-specific organizations) of nonprofit respondents (a majority serving the metro region) reported they did not use any of the listed strategies because they "did not have enough resources to address this issue with limited English populations."
- In Greater Minnesota, one out of three LPH agencies refer people to ECHO resources compared to LPH agencies in Hennepin and Ramsey Counties, of which half refer people to ECHO. Of community based agencies responding, 13% (both metro and Greater Minnesota) referred people to ECHO resources.

3. *Opportunities for Growth and Capacity Building*

Of all survey respondents, 58 % did not have different communication strategies for Latino, Asian, or African (or diverse ethnicities within these categories) residents with limited English skills in their service area. This is even more alarming when local agencies are not aware of the presence and diversity of LEP populations in their service area.

- Of respondents who identified as Local Public Health agency staff (LPH), outside Ramsey and Hennepin Counties, 15% replied that during the H1N1 emergency, strategies to inform or educate people with limited English skills were "Not Applicable" to their community because "community members can be reached in English," including one of the nine counties that met this study's criteria for large potential LEP populations.
- Of local public health respondents outside Ramsey and Hennepin Counties 5% indicated that "we did not have enough resources to address this issue with limited English populations," which includes six of the thirteen counties this study identified as having large or notable potential LEP populations.

IV. Communication Gaps | Findings

1. *Effectiveness of Translated Materials*

Selecting from a menu of choices, translated materials were the most often noted form of technical assistance across all responding service agencies. During the H1N1 pandemic, 32 % of all survey respondents created or translated printed materials into other languages. Not surprisingly, the most language-specific outreach during the H1N1 pandemic occurred with Spanish-speaking populations.

Of LPH agency respondents, 34% ranked "Translation of print materials such as posters, flyers & factsheets" as the technical assistance they would find most useful in order to increase their ability to inform and communicate with non-English speakers during future health emergencies.

Ethnic community based organizations specifically commented that translated materials were useful if the information was timely. For example, respondents indicated that there was often a delay in receiving language-specific information if they received any at all. Community-based organizations may or may not have the capacity to translate materials provided in English, and sometimes if they did, they later received translated materials that duplicated their efforts.

Translated materials was rated by agencies as most useful and also most requested form of technical assistance among health, community outreach and emergency preparedness professionals. The most common form of "translated materials" mentioned by LEP focus group and interview participants were flyers sent by schools and other community programs. Translated information is particularly useful when it gives specific instructions or directions for prevention (where to go, when needed) following general information to raise awareness. It must be noted, however, that many of the focus group and interview participants, like many individuals with limited English skills, are not able to read in their native language and heavily rely on oral communication or visuals. Translated materials with visual cues help LEP populations to seek additional information, resources, or interpretation.

2. Using a Mix of Media

Of all health, community outreach and emergency preparedness professionals responding 35% "refer people to ECHO resources." However, in a follow-up question, almost no additional information was provided to describe which ECHO resources were referred by these agencies, or, if and how individual

TRANSLATED MATERIALS

"Ready-made information would be terrific, as it will save time in getting the word out to have something that can easily be used rather than having multiple agencies working on time-consuming translations".
- Community-based agency respondent

- ✓ However, many of individuals with limited English skills are not able to read in their native language and heavily rely on oral communication or visuals.
- ✓ Community based agencies may use translated materials in conjunction with verbal explanation of the information presented.
- ✓ Translated materials may be a visual cue for LEP populations to take additional actions or seek specific resources.
- ✓ Translated materials are useful to community-based agencies if the information is timely.

"As a home visitor, in 99% of the Hmong household that I visit, they have a radio tuned to the Hmong MN station. That is where they get their news."

- Community health worker

residents with limited English skills then accessed these resources. In contrast, none of the residents identified ECHO as a source of information during emergencies.

Of all health, community outreach and emergency preparedness professionals responding 12% used ethnic media or multi-lingual press releases. Ethnic media was used in the Metro region for African, Asian and Latino residents, and in the Southeast region for Latino residents. LEP focus group participants in Greater Minnesota reported actively seeking health and emergency information from ethnic media outlets. Rural LEP populations stay connected to their ethnic community through culturally-specific or language-specific media (mainly available in print and radio) for news and information. Language-specific print media is limited due to frequency of printing, timeliness, and literacy, though visual cues (often in advertisements) can be helpful. Additionally, mainstream sources with multi-lingual programming, such as BBC Somalia, Voice of America or KFAI Radio, provide ongoing coverage relevant to many LEP populations in their native language.[8]

3. Community Outreach through Bilingual Staff and Interpreters

Use of bilingual staff/interpreters was the most common strategy employed among health, community outreach and emergency preparedness professionals and highly rated as most useful. However, many respondents made a distinction between bilingual staff and interpreters. Bilingual staff members provide multiple functions that increase agency capacity for outreach, on an on-going and emergency basis. Bilingual staff who are consistently employed and have integrated functions are more able to provide important, non-emergency resources and build trust among residents.

Agencies, primarily LPH, without consistent bilingual staff had mixed results using contracted or short-term interpreters. Especially in time-sensitive situations, interpreters may not be readily available. It is particularly difficult to find interpreters for less-common languages or LEP residents in less densely populated regions. Outsourced interpreters may include broad interpreter and multilingual services, such as the membership based online resource, Multilingual Resource Exchange,[9] however, these types of services were not specifically mentioned by respondents. Health care professionals surveyed did not feel that a directory and guide to using interpreters would be useful. Additional resources are listed at the end of this document.

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[8] Media resources: BBC Somalia: http://www.bbc.co.uk/somali/
Hmong: http://www.shrdo.com/ and http://hmongradioam690.com/AboutUs/about_us.html
Voice of America: http://www.voanews.com/english/news/
Twin Cities based community radio: http://www.kfai.org/
Pan-ethnic radio: http://kpnp1600.com/

[9] Based in Minnesota, the Exchange is a partnership formed to exchange information and resources about health communication and to share multilingual health materials. http://www.health-exchange.net/about.html

4. Outreach Partnerships

Survey participants were asked about what kind of technical assistance would be most useful to them. The second highest rated technical assistance need was "establishing and sustaining partnership with ethnic-led agencies, community elders & leaders" with 18 % of LPH agencies indicating this was most useful. Interestingly, ethnic-based agencies also rated this technical assistance need the highest compared to other types of assistance. A directory or guide to using interpreters was generally rated as least useful across all respondents and agency types.

Outreach through community programs was the top most useful strategy rated by local public health agencies. Conversely, nonprofit agencies did not rate “establishing and sustaining partnerships” very high. Partnerships with organizations, elders, or key leaders were used to connect with African, Asian and Latino populations, but not consistently across all regions. Of nonprofit agencies responding (ethnic and broad-based) 11% said that they did not have enough resources to assist LEP residents. Focus group participants commented that rural ethnic agencies need help to be more connected to each other and to residents.

EMERGENCY COMMUNICATION GAPS

- ✓ Written translated materials are needed, but also are limited in effectiveness with orally-based cultures.
- ✓ Delay in producing or distributing translated materials significantly reduces its effectiveness for emergency communication.
- ✓ Ethnic-specific and relevant media sources are a primary source of news and information for LEP populations, which is currently underutilized for emergency health communications to these target audiences.
- ✓ Bilingual staff (as opposed to temporary workers) are most effective during emergency health situations because of their value during non-emergencies in establishing the agencies that they work for as reliable sources of information.
- ✓ Outreach partnerships, particularly rural ethnic agencies, need help to be more connected to each other and to residents.

LEP Participants' Suggestions by Race/Ethnicity

African	*Latino*	*Asian*
• Use approaches that account for diversity within "African" community – e.g. no common language among African immigrants • Identify two or three most reliable and trusted communication sources/outlets • With Somali community, getting critical information to Adult Education Centers, Public Health (WIC programs), BBC Somalia and Voice of America which air through the internet several times a day in Somali language could be valuable asset. Many focus group participants considered them as trusted source of information. • With Kenyan community, participants strongly felt that if the information is only available through the internet, then it is not as important as when someone calls them or talks to them and explains things -the pros and cons. • With Sudanese community, participants reported having strong connection with faith-based /churches and identified them as trusted sources of information.	• Use texting as a method to get emergency info out in many languages – "everyone has a cell phone" • Using the same outlets, coordinate with partners to provide ongoing relevant info, such as jobs and immigration in addition to health and emergency info • Develop community relationships among and between Latino organizations and residents • Facilitate key leadership , church leadership and coalitions access to health information • Provide information about emergency situations such as what to do when sirens blare.	• Establish phone trees so key community contacts can quickly disseminate information • Information must be targeted to families not individuals so it is relevant to more people, increases likelihood of information being shared • Increase use of ethnic media, both locally and regionally, via print and radio • Detailed information (specific action steps and prevention measures) is better conveyed in brief school flyers or letters, following mainstream news (mainly TV) • Information received and discussed at workplaces and/or from employers increases likelihood of taking action (employers who offer more info or incentive for flu vaccine, also provide info about H1N1)

V. Public Health System Coordination

The public health system can be seen as hierarchal, with federal, state, regional, and local government agencies. For-profit health providers and not-for-profit health and human service agencies are also part of the system, operating with related but separate structures. This multi-faceted network of public health officials, direct service providers, and complementary human service programs is complex to navigate, even for tenured public health workers. Even so, 89.5 % of all survey respondents, which included many of these agencies, felt they received an adequate amount of information and overall communication during the H1N1 pandemic.

Regionally, different emergency health communication strategies are used for different target populations. There is room for improvement, as 58 % of individual respondents in the OMMH survey indicated there was no differentiation in strategies at the local agency level. Each local agency appears to rely on one primary emergency communication strategy to reach for all LEP populations in its service area. Specific attention is needed to strengthen community ties, interagency cooperation, and cross-cultural communication. Attention to special populations often falls on a select few agencies, divisions, or positions. This special attention can create silos or token initiatives that hinder these programs' ability to fully utilize available resources. Ongoing partnerships must be developed and maintained among various agencies/programs serving LEP residents in order to provide consistent messaging.

An integrated, yet individualized, approach to working with the different community groups is needed. Each county and each ethnic community are unique, and resources need to be flexible enough to adapt to these situations. For example, in required emergency preparedness plans, LPH should include emergency communications to LEP populations. Strategies should be tailored to local and regional LEP populations and integrated with broader emergency communication strategies. Review and assessment of these strategies should be a critical item in public health certification.

In keeping with the Department of Health's role of

POLICY RECOMMENDATIONS

1. Local health departments need to identify and develop relationships with formal and informal leaders of LEP populations in their communities.
2. Emergency messages should be available in languages that effectively reach the population at risk, potentially requiring multiple formats and delivery systems. Materials for likely Minnesota hazards should be prepared before the incident.
3. Organizations that serve LEP populations should be engaged as partners in preparing and delivering messages before and during an emergency.
4. Resources for rapid translation/interpretation for statewide and localized emergency messages should be identified and Memorandums of Understanding developed to facilitate service delivery during an emergency.
5. LEP focused materials for a statewide incident should be developed by MDH.
6. LEP focused materials for a localized incident should be developed by MDH and Local Health Departments in partnership.
7. The MDH Website should have translated materials that are readily accessible to LEP populations during an emergency.

guidance first and direct service second, it is clear that leveraging relationships, empowering community leaders, and enlisting the help of partners in the effort will provide the maximum impact with limited resources.

During H1N1, a working group was convened to include a cross-section of MDH participation, as well as representatives from Department of Human Services, Local Public Health and a range of non-profit organizations who do provide direct service to the target audiences.

The working group recommended and subsequently planned a state-wide community forum. The forum was held on May 5, 2009, with 53 attendees representing 43 different organizations. The goal of the forum provided information and emergency planning resources for those who might be missed by communication outreach through mainstream media. Another goal was to identify target populations, and communication challenges on a local level and highlight the role of local Public Health. Initiatives like this are making inroads in identifying and creating effective strategies. This type of interdepartmental, interagency approach will increase effectiveness of emergency communication not only to LEP populations, but also create a more cohesive infrastructure for public health.

VI. Recommendations to Public Health Agencies

1. Strengthen Multi-lingual Media Network in Greater MN

LEP populations in Greater Minnesota are a willing audience for multi-lingual media. Many households make special efforts to stay informed through ethnic-specific media, particularly print, radio and internet sources that are timely. Public health use of multi-lingual media resources in Greater Minnesota will strengthen this as a reliable source of information for many LEP populations.

- Increase availability of timely, translated print materials to ethnic media outlets
- Include regional radio programs and national websites that are accessible and culturally relevant in public service announcement distribution and press releases
- Stay current with multi-lingual programming, pre-recorded announcements for cable access networks or TV public service announcements must be timely and relevant
- Use texting system and use other social networks to alert and inform community
- Prioritize ethnic media in any purchased advertising campaigns (this financial support will help to build capacity and more effectively support communication goals)

2. *Increase Community Resources and Health Education*

Twenty-five percent of recommendations from survey respondents for additional resources (not technical assistance) to reach LEP populations were about increasing use of community health workers and health educators within ethnic communities. Similarly, focus group and interview participants indicated the need for culturally sensitive health education.

- Increase the number and usage of community health workers and outreach programs, whether internally staffed or utilized through external partners.
- Provide assistance to develop leadership capacity with and among LEP residents and local organizations.

COMMUNITY HEALTH WORKERS

- ✓ We need more bilingual health care workers trained as professionals employed in our [LPH] organization.
- ✓ Community health workers play a vital role in organizing information sessions at various locations where ethnic communities are concentrated.
- ✓ Community Health Workers and public health nurses who represent the ethnic communities of our local area are educating members

3. *Maintain Community Relationships*

LEP populations are growing in rural areas, although these populations remain less dense compared to metro region. Partnerships with organizations, elders, or key leaders were used to connect with African, Asian and Latino populations, but not consistently across all regions. Focus group and interview participants commented that rural ethnic agencies need help to be more connected to each other and to residents. This was repeated by 11 % of nonprofit agencies (ethnic and broad-based) who indicated their agency did not have enough resources to assist LEP residents.

Notably, an LPH respondent in a region without a high LEP population commented, “This experience [health communications response during the H1N1 pandemic] has brought awareness to our agency regarding outreach to and engaging the entire population. We will need to be mindful of changing demographics and adjust our strategies in the future if demographics have changed.”

- Education and awareness outreach must be ongoing, bi-lingual and well-equipped with multiple types of news and information.
- Build relationships with residents from diverse communities to better understand and frame relevant news to dynamic LEP populations.

VII. Coordination Between MDH Divisions

A critical element of communications planning is ensuring that people and entities who are not accustomed to responding to health crises understand the actions and priorities required to prepare for and respond to a health emergency.

Emergency job functions might be integrated across divisions such as: Office of Emergency Preparedness (OEP), Office of Minority and Multicultural Health (OMMH), Immunization, Tuberculosis, and International Health (ITIH) Refugee Health Division, Infectious Disease Epidemiology, Prevention and Control (IDEPC). For example, these personnel may be more intentionally utilized across divisions as:

- Just in time training team leaders
- LEP communications coordinator
- DOC Public Information Officer

Representatives of these divisions should work together to ensure clear, effective and coordinated risk communication, locally and regionally, before and during an emergency. This includes identifying credible spokespersons at all levels of government and through community channels to effectively coordinate and communicate helpful, informative messages in a timely manner.

VIII. Additional Resources

Minnesota Department of Health Resources

2012 Health Resources Directory for Diverse Cultural Communities
http://www.health.state.mn.us/divs/idepc/refugee/directory.html

2012 DIVERSE COMMUNITY MEDIA DIRECTORY: Local Community Press, Radio, and TV Programs in Minnesota
Hard copies by contacting the MDH Refugee Health Program at 651-201-5414 (Twin Cities) or 877-676-5414.
http://www.health.state.mn.us/divs/idepc/refugee/ethnicmedia.pdf

2010 Mutual Assistance Association – Community-based Organizations Directory
Hard copies by contacting the MDH Refugee Health Program at 651-201-5414 (Twin Cities) or 877-676-5414. Http://www.health.state.mn.us/divs/idepc/refugee/index.html

Public Health Resources

CIDRAP U of M
http://www.cidrap.umn.edu/cidrap/index.html

Countryside Public Health website:
http://countrysidepublichealth.org/

SCHSAC REPORT:
http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/reports/docs/2011emergency_finalreport.pdf

Rand Health Resource List
http://www.rand.org/health/projects/special-needs-populations-mapping/promising-practices/resources.html#lep

FEMA Blog
http://blog.fema.gov/2012/04/engaging-latino-communities-in.html

Translation, Multi-lingual Services

Multilingual Resource Exchange
www.health-exchange.net

Adult Education Outreach Partners

Minnesota Adult Basic Education networks by region
http://mnabe.themlc.org/Statewide_Map.html

Planning Tools

The ECHO Emergency Operations Plan is available:
http://www.echominnesota.org/sites/default/files/Signed%20ECHO%20Emergency%20Operations%20Plan%20EOP%20BOD%20Approved%20112310_0.pdf

ECHO Field Operations Guide:
http://www.echominnesota.org/sites/default/files/Signed%20ECHO%20Field%20Operations%20Guide%20FOG%20BOD%20Approved%20112310.pdf

ECHO TOOL KIT: http://www.echominnesota.org/webinar-communicating-without-english

Emergency Managers Tool Kit: Meeting the Needs of Latino Communities
http://www.nclr.org/index.php/publications/emergency_managers_tool_kit_meeting_the_needs_of_latino_communities/

Appendix 1: Minnesota population by race and Hispanic origin for counties

2010 Census Redistricting Data (Public Law 94-171) Summary File

NOTE: For information on confidentiality protection, nonsampling error, and definitions, see:
http://www.census.gov/prod/cen2010/pl94-171.pdf

Geographic area			Race								
County FIPS Code	County	Total population	One race total	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino (of any race)
	Minnesota	5,303,925	5,178,780	4,524,062	274,412	60,916	214,234	2,156	103,000	125,145	250,258
1	Aitkin County	16,202	15,993	15,494	57	390	27	4	21	209	151
3	Anoka County	330,844	322,323	287,802	14,503	2,257	12,868	104	4,789	8,521	12,020
5	Becker County	32,504	31,532	28,720	138	2,455	125	7	87	972	398
7	Beltrami County	44,442	43,065	33,359	262	9,004	309	18	113	1,377	676
9	Benton County	38,451	37,836	36,348	749	159	425	4	151	615	632
11	Big Stone County	5,269	5,227	5,175	11	22	4	0	15	42	41
13	Blue Earth County	64,013	62,988	59,400	1,741	178	1,249	22	398	1,025	1,586
15	Brown County	25,893	25,710	25,245	61	21	153	2	228	183	860
17	Carlton County	35,386	34,531	31,727	498	2,086	160	4	56	855	484
19	Carver County	91,042	89,606	84,450	1,124	208	2,478	15	1,331	1,436	3,515
21	Cass County	28,567	27,940	24,534	61	3,196	88	3	58	627	340
23	Chippewa County	12,441	12,287	11,632	65	119	57	97	317	154	611
25	Chisago County	53,887	53,217	51,621	645	324	478	10	139	670	835
27	Clay County	58,999	57,724	54,684	842	803	846	21	528	1,275	2,056
29	Clearwater County	8,695	8,430	7,579	30	782	21	1	17	265	120
31	Cook County	5,176	5,065	4,559	17	446	27	3	13	111	58
33	Cottonwood County	11,687	11,539	10,773	87	27	317	17	318	148	720
35	Crow Wing County	62,500	61,592	60,368	313	526	232	16	137	908	652
37	Dakota County	398,552	387,078	339,499	18,709	1,647	17,451	216	9,556	11,474	23,966
39	Dodge County	20,087	19,814	19,294	60	54	90	4	312	273	915

41	Douglas County	36,009	35,682	35,186	150	105	164	4	73	327	341
43	Faribault County	14,553	14,419	14,042	47	62	43	0	225	134	817
45	Fillmore County	20,866	20,693	20,497	49	22	71	0	54	173	207
47	Freeborn County	31,255	30,737	29,121	231	68	238	18	1,061	518	2,750
49	Goodhue County	46,183	45,464	43,684	445	533	274	17	511	719	1,342
51	Grant County	6,018	5,949	5,864	19	9	14	1	42	69	94
53	Hennepin County	1,152,425	1,114,976	856,834	136,262	10,591	71,905	506	38,878	37,449	77,676
55	Houston County	19,027	18,807	18,570	101	33	89	2	12	220	132
57	Hubbard County	20,428	20,063	19,314	48	557	50	2	92	365	327
59	Isanti County	37,816	37,200	36,319	245	174	309	19	134	616	582
61	Itasca County	45,058	44,135	42,195	144	1,568	142	12	74	923	417
63	Jackson County	10,266	10,162	9,830	47	24	140	1	120	104	277
65	Kanabec County	16,239	15,989	15,754	55	90	53	3	34	250	214
67	Kandiyohi County	42,239	41,732	39,206	984	130	172	19	1,221	507	4,710
69	Kittson County	4,552	4,527	4,484	11	4	16	0	12	25	69
71	Koochiching County	13,311	13,054	12,593	78	311	44	3	25	257	147
73	Lac qui Parle County	7,259	7,198	7,087	17	17	29	3	45	61	108
75	Lake County	10,866	10,729	10,616	16	51	31	0	15	137	80
77	Lake of the Woods Cou	4,045	3,962	3,874	14	28	33	0	13	83	35
79	Le Sueur County	27,703	27,394	26,443	94	81	161	5	610	309	1,444
81	Lincoln County	5,896	5,851	5,777	8	9	14	0	43	45	72
83	Lyon County	25,857	25,455	23,360	587	114	679	7	708	402	1,541
85	McLeod County	36,651	36,290	35,159	199	101	267	17	547	361	1,811
87	Mahnomen County	5,413	4,946	2,713	11	2,215	3	1	3	467	99
89	Marshall County	9,439	9,358	9,119	26	43	19	3	148	81	337
91	Martin County	20,840	20,652	20,142	64	59	104	6	277	188	744
93	Meeker County	23,300	23,128	22,663	77	44	59	13	272	172	767
95	Mille Lacs County	26,097	25,614	23,778	97	1,571	83	7	78	483	377
97	Morrison County	33,198	32,839	32,426	131	66	101	11	104	359	402
99	Mower County	39,163	38,435	35,495	818	97	649	40	1,336	728	4,138
101	Murray County	8,725	8,654	8,435	25	11	78	2	103	71	242
103	Nicollet County	32,727	32,261	30,666	667	99	431	1	397	466	1,226
105	Nobles County	21,378	20,984	16,206	743	111	1,168	10	2,746	394	4,820
107	Norman County	6,852	6,694	6,455	13	109	25	0	92	158	276

109	Olmsted County	144,248	141,067	123,605	6,870	353	7,806	65	2,368	3,181	6,081
111	Otter Tail County	57,303	56,604	55,080	430	279	271	34	510	699	1,490
113	Pennington County	13,930	13,681	13,067	192	213	87	1	121	249	380
115	Pine County	29,750	29,192	27,347	597	921	131	8	188	558	723
117	Pipestone County	9,596	9,416	8,975	56	100	69	0	216	180	355
119	Polk County	31,600	30,935	29,495	270	453	218	2	497	665	1,720
121	Pope County	10,995	10,898	10,766	38	24	39	2	29	97	95
123	Ramsey County	508,640	491,084	356,547	56,170	4,043	59,301	247	14,776	17,556	36,483
125	Red Lake County	4,089	4,029	3,934	8	52	4	4	27	60	101
127	Redwood County	16,059	15,744	14,305	75	796	507	2	59	315	335
129	Renville County	15,730	15,565	15,014	44	91	54	6	356	165	1,046
131	Rice County	64,142	62,979	57,275	2,072	300	1,314	40	1,978	1,163	5,122
133	Rock County	9,687	9,568	9,365	59	34	53	1	56	119	197
135	Roseau County	15,629	15,419	14,767	39	201	392	3	17	210	116
137	St. Louis County	200,226	195,711	186,212	2,739	4,477	1,774	64	445	4,515	2,409
139	Scott County	129,928	126,990	112,212	3,376	1,072	7,347	97	2,886	2,938	5,771
141	Sherburne County	88,499	86,999	83,211	1,689	439	1,131	18	511	1,500	1,941
143	Sibley County	15,226	15,046	14,430	48	30	85	2	451	180	1,098
145	Stearns County	150,642	148,307	138,262	4,658	473	2,982	61	1,871	2,335	4,190
147	Steele County	36,576	36,066	34,038	1,013	86	281	8	640	510	2,282
149	Stevens County	9,726	9,555	9,110	76	89	146	5	129	171	337
151	Swift County	9,783	9,691	9,453	49	36	21	3	129	92	350
153	Todd County	24,895	24,571	23,727	94	87	103	44	516	324	1,288
155	Traverse County	3,558	3,518	3,352	13	139	4	1	9	40	50
157	Wabasha County	21,676	21,461	21,000	80	38	97	1	245	215	592
159	Wadena County	13,843	13,632	13,380	111	65	36	0	40	211	176
161	Waseca County	19,136	18,844	17,933	380	148	128	5	250	292	985
163	Washington County	238,136	233,127	209,012	8,579	1,088	12,071	77	2,300	5,009	8,127
165	Watonwan County	11,211	11,079	9,740	82	48	89	2	1,118	132	2,338
167	Wilkin County	6,576	6,505	6,381	15	64	18	0	27	71	130
169	Winona County	51,461	50,860	48,573	650	133	1,101	2	401	601	1,244
171	Wright County	124,700	122,794	118,518	1,328	419	1,478	44	1,007	1,906	3,052
173	Yellow Medicine Coun	10,438	10,313	9,806	16	314	33	6	138	125	397

Source: U.S. Census Bureau, 2010 Census.
2010 Census Redistricting Data (Public Law 94-171) Summary File, Tables P1 and P2

Appendix 2: Study participants by language and county

County	Language(s)	Gender	Total
Olmstead	Spanish	Female (4) Male (2)	6
Olmstead	Somali Arabic Dinka Swahili Luhyia	Female (5) Male (4)	9
Rice	Somali	Female (6) Male (3)	9
St. Louis	Spanish Russian Arabic Korean Hindi Punjabi	Female (5) Male (2)	7
Lyon	Hmong Lao Spanish Karen	Female (11) Male (7)	18
		TOTAL	**49**

Appendix 3: Protocol template for focus groups

Emergency Health Communications with Communities with Limited English Proficiency

FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Welcome, thank you for agreeing to share your time and thoughts with us for the next hour. Please help yourself to food and drinks.

We are Sida and Anab and we work with the MN Department of Health – Office of Minority and Multicultural Health. We want to know about how you get information about health emergencies so different health agencies can be better prepared make sure you get the information you need. We are talking with 3-4 other groups across the state, too.

OVERVIEW of AGENDA & TOPIC

- Hand out *individual questionnaire/sign-in forms*. Everyone should have one of their own. Please fill in your first and last name on this form and what language(s) you speak, and if you are male or female.
- We will collect these forms at the end of the hour. We need them back in order to give you the gift cards.
- Underneath the space for your name are the questions we will be talking about. These are the same questions that are posted on the walls. If you would like, you can write a few notes down on this form to help answer the questions.
- We will be talking about each question as a group, and [XXX] will be taking notes on the papers posted on the wall. So you don't have to take notes if you don't want to. Please let me know if there is anything else we should add to the notes as we write down what you are all saying.
- Also, if you don't understand anything, please let us [or one of the teachers] know and we will explain.
- We have plenty of time to talk about each question, so we will take our time to make sure everyone has a chance to talk and listen to each other.
- We are all wearing name tags, but it would be helpful if we could go around and briefly say our names so we know how to pronounce your name.

If the group is large, we may need to work in smaller groups to make sure everyone understands each question. If needed, write a word or phrase in response on the questionnaire. After explaining each question, as a full group, everyone share their ideas and we will list all on a poster paper.

MAIN QUESTIONS (only those bolded are on the questionnaire) and Probing Questions

1. **Did you hear about the flu emergency H1N1?**
    a) How did you get this information?
    b) How did you feel after you got this information?
    c) Did you get a flu shot? Why or why not?

2. **Where do you get information about emergencies that affect your community?**
    a) How often do you get this information or look for this kind of information?
    b) What ways are most reliable, easiest, trusted for you to get information?
    c) Of all the things we discussed, what is the most important way to you?

3. **How do you decide if the information is important and relevant to you and your family?**
    a) How often do you hear or receive a message before it seems important?
    b) What do you need to know before you will do something about it?

4. **What are your concerns or barriers to receiving health information and messages?**
    a) For example, not sure who in your family the information is most important for?
    b) For example, not sure who to ask if you have questions?
    c) Is there anything we didn't talk about that you think is important to know about getting emergency health information?

That is the end of our questions. Thank you again for talking with us. Please make sure to return your form to [xxxx] and she will give you a gift card.

COLLECT INDIVIDUAL PARTICIPANT FORMS

Appendix 4: Online Survey Questionnaire

PHER LPH-CBO survey

Thank you for participating in this brief survey about communicating with limited English proficient persons during health emergencies.

Please answer each question completely. Your responses will be compiled with other respondents across the state. Any identifying contact information will not be shared publicly. Findings from this study will be shared on the OMMH website and disseminated to partners across the state.

If you have questions or encounter problems with the survey, please email
Sida Ly-Xiong (Sida.Ly-Xiong@state.mn.us)
or Anab Gulaid (Anab.Gulaid@state.mn.us)

(End of Page 1)

1. Please check the **ONE** or **TWO** statements that best describe your job function, duties, or role.
Please read all the answer choices before responding.

- ❑ Other, please describe _____
- ❑ I supervise or provide health services to a general population which may or may not include people with limited English skills.
- ❑ I supervise or provide health services specifically to people with limited English skills.
- ❑ I supervise or provide a one or more direct human services (for example, job training, adult education, counseling, youth and family programs) to people with limited English skills.
- ❑ My primary function is outreach, information and referral to communities with limited English skills.
- ❑ My primary function is communications to a general population which may or may not include people with limited English skills.
- ❑ My job duties include emergency preparedness planning and response.

If none of the above statements apply to you, please forward this survey to others in your agency who fit one or more of the above job functions and stop here.

---

2. Which of the following categories best describes your agency?

- ❍ State health agency
- ❍ Local public health agency
- ❍ Other city or county human service office
- ❍ Ethnic-specific community based nonprofit
- ❍ Broad-based nonprofit service agency
- ❍ Primary care provider or clinic
- ❍ Hospital, treatment center or other health facility
- ❍ Other, please specify _____

3. What specific counties does your agency serve? Check all that apply.

- ❑ ALL - Statewide
- ❑ Aitkin County
- ❑ Anoka County
- ❑ Becker County
- ❑ Beltrami County
- ❑ Benton County
- ❑ Blue Earth County
- ❑ Big Stone County
- ❑ Brown County
- ❑ Carlton County
- ❑ Carver County
- ❑ Cass County
- ❑ Chippewa County
- ❑ Chisago County
- ❑ Clay County
- ❑ Clearwater County
- ❑ Cook County
- ❑ Cottonwood County
- ❑ Crow Wing County
- ❑ Dakota County
- ❑ Dodge County
- ❑ Douglas County
- ❑ Faribault County
- ❑ Fillmore County
- ❑ Freeborn County
- ❑ Goodhue County
- ❑ Grant County
- ❑ Hennepin County
- ❑ Houston County
- ❑ Hubbard County
- ❑ Isanti County
- ❑ Itasca County
- ❑ Jackson County
- ❑ Kanabec County
- ❑ Kandiyohi County
- ❑ Kittson County
- ❑ Koochiching County
- ❑ Lac qui Parle County
- ❑ Lake County

- ❑ Lake of the Woods County
- ❑ Le Sueur County
- ❑ Lincoln County
- ❑ Lyon County
- ❑ Mahnomen County
- ❑ Marshall County
- ❑ Martin County
- ❑ McLeod County
- ❑ Meeker County
- ❑ Mille Lacs County
- ❑ Morrison County
- ❑ Mower County
- ❑ Murray County
- ❑ Nicollet County
- ❑ Nobles County
- ❑ Norman County
- ❑ Olmsted County
- ❑ Otter Tail County
- ❑ Pennington County
- ❑ Pine County
- ❑ Pipestone County
- ❑ Polk County
- ❑ Pope County
- ❑ Ramsey County
- ❑ Red Lake County
- ❑ Redwood County
- ❑ Renville County
- ❑ Rice County
- ❑ Rock County
- ❑ Roseau County
- ❑ Scott County
- ❑ Sherburne County
- ❑ Sibley County
- ❑ St. Louis County
- ❑ Stearns County
- ❑ Steele County
- ❑ Stevens County
- ❑ Swift County
- ❑ Todd County
- ❑ Traverse County
- ❑ Wabasha County
- ❑ Wadena County
- ❑ Waseca County
- ❑ Washington County
- ❑ Watonwan County
- ❑ Wilkin County
- ❑ Winona County
- ❑ Wright County
- ❑ Yellow Medicine County

4. Which of these languages, if any, are spoken in your service area in addition to English? Check all that apply:

- ❑ Amharic
- ❑ Arabic
- ❑ Burmese
- ❑ Chinese (Mandarin)
- ❑ Hindi
- ❑ Hmong
- ❑ Karen
- ❑ Khmer
- ❑ Korean
- ❑ Lao
- ❑ Nepali
- ❑ Oromo

❑ Russian ❑ Spanish ❑ Thai

❑ Somali ❑ Tagalog ❑ Vietnamese

❑ My agency is ethnic-specific and primarily speaks: _____

❑ Other, please specify _____

(End of Page 3)

5. How much information and communication did your agency receive about the H1N1 flu
emergency?

- ❍ Adequate amount of information and communication overall.
- ❍ Too much information - some information was not relevant for our agency.
- ❍ Not enough information.

6. What partners or external resources does your agency primarily rely on to stay informed
about potential or current health emergencies in your region?

- ❑ Minnesota Department of Health
- ❑ Center for Disease Control
- ❑ Ethnic-specific community based nonprofit
- ❑ Broad-based nonprofit service agency
- ❑ Local public health agency
- ❑ Other city or county human service office
- ❑ Primary care provider or clinic
- ❑ Hospital, treatment center or other health facility
- ❑ General media
- ❑ Ethnic media
- ❑ ECHO Minnesota
- ❑ Informal networks, word of mouth
- ❑ Other, please specify _____

7. Regarding the H1N1 Flu emergency (approximately October 2010 through March 2011),
what, if any strategies did your agency use to inform or educate peoplelimited English skills?
Please check all that apply.

- ❑ Not Applicable, our community members can be reached in English.
- ❑ None, we did not have enough resources to address this issue with limited English populations.
- ❑ Ethnic specific or multi-lingual media releases (newspapers, radio, TV)
- ❑ Interpreters and/or bi-lingual staff
- ❑ Outreach through community programs, schools, or medical facilities; please specify _____
- ❑ Set up temporary clinics in schools or other community sites
- ❑ Email blasts to residents and neighborhood organizations
- ❑ Providing internal staff and/or key partners (visiting nurses, social workers) with information/referral resources
- ❑ Engaging community meetings, presentations/forums
- ❑ Informal networks, word of mouth
- ❑ Creating or translating printed materials into other languages
- ❑ Referring people to ECHO resources
- ❑ Use of other pre-existing translated materials (MDH, CDC)
- ❑ Other, please specify _____

7 A. Of the strategies you selected, please describe the specific activities, resources, or partners that were most useful.

_____

_____

_____

8. Did your agency use different communication strategies for different ethnicities?

- ❍ Yes
- ❍ No
- ❍ Not applicable

8 A. If you answered YES to Question 8 above, please describe what unique or different
strategies were used for each ethnic community.

_____

_____

_____

9. Please rank the technical assistance that your agency would find most useful in order to increase your ability to inform and communicate with non-English speakers during future health emergencies?

1= MOST Useful; 4= LEAST Useful

	1	2	3	4	5
Translation of print materials such as posters, flyers & factsheets	❍	❍	❍	❍	❍
Establishing and sustaining partnership with ethnic-led agencies, community elders & leaders	❍	❍	❍	❍	❍
Access to existing ethnic media (TV, radio, newspaper, website)	❍	❍	❍	❍	❍
Directory and guide to using interpreters	❍	❍	❍	❍	❍
Establishing and sustaining partnership with health care agencies, clinics or other health facilities	❍	❍	❍	❍	❍

9 A. What other technical assistance does your agency need?

Please specify: _____

Please specify: _____

10. What else do you think is needed in order to ensure that people with limited English
skills are informed during a health emergency?

_____

_____

_____

We would like to follow up with a select sample of respondents for a possible short phone interview. If you willing to be contacted, please provide the requested information. This will not affect your agency's confidentiality in our overall data analysis.

Name _____

Position title _____

Agency _____

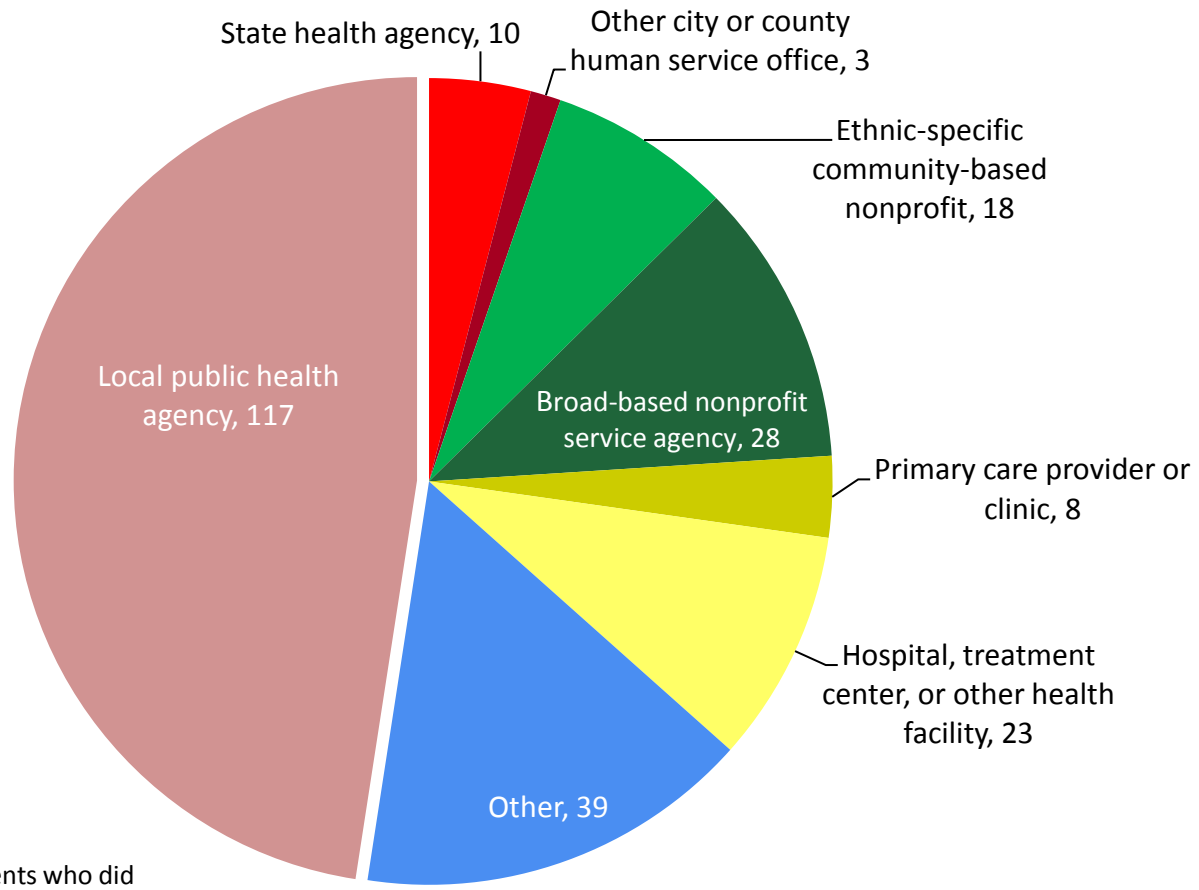
Phone _____

Email _____

Thank you for your insight and participation in this survey.

(End of Page 7)

Survey Respondent Agencies



* Does not include 19 respondents who did not select an agency type.

Survey Respondent Roles

Response	Chart	ALL Frequency	Count
I supervise or provide health services to a general population which may or may not include people with limited English skills.		27.5%	71
I supervise or provide health services specifically to people with limited English skills.		7.4%	19
I supervise or provide a one or more direct human services (for example, job training, adult education, counseling, youth and family programs) to people with limited English skills.		14.3%	37
My primary function is outreach, information and referral to communities with limited English skills.		14.3%	37
My primary function is communications to a general population which may or may not include people with limited English skills.		26.0%	67
My job duties include emergency preparedness planning and response.		45.7%	118
Other, please describe		8.5%	22
	Valid Responses		258
	Total Responses		280