Promising Practices in Domestic Health Orientation
RHTAC webinar
July 11, 2012

Operator: Good day, ladies and gentlemen. Thank you for standing by and welcome to the Promising Practices in a Domestic Health Orientation Webinar. During the presentation, all participants will be in a listen-only mode. If you'd like to ask a question during the presentation, please use the chat feature located in the lower left corner of your screen.

If you need to reach an operator at any time, please press star 0. As a reminder, this conference is being recorded on Wednesday, July 11, 2012. I would now like to turn the conference over to Jennifer Cochran. Please go ahead.

Jennifer Cochran: Great, thank you. And hello to everybody. I want to welcome you to our presentation today on Promising Practices in Domestic Health Orientation. As the operator said, my name's Jennifer Cochran and I'm project director for RHTAC, the Refugee Health Technical Assistance Center, which is a project that's administered by the Refugee and Immigrant Health Program at the Massachusetts Department of Public Health.

I want to acknowledge and thank the Office of Refugee Resettlement at the U.S. Department of Health and Human Services for their funding of the Technical Assistance Center. Their support makes today's webinar possible. Thank you.

As the operator mentioned, we are Web broadcasting. So please listen to the Webinar over your computer speakers or headphones. If you need a call-in number, you can chat with the Chairperson or I see she's actually posted the dial-in number as well.

So our objectives for today really build on the presentation that was done in December 2011, a Webinar that was organized by the Cultural Orientation

Resource Center and RHTAC on the Refugee Health Orientation Continuum, with both the overseas and domestic perspectives.

There was a lot of interest at that time in a follow-up Webinar that would explore domestic practices further. We are really pleased that today's Webinar has been organized in partnership with the Health Education Committee of the Association of Refugee Health Coordinators or ARHC. The Committee is doing just tremendous work and we are so appreciative of this collaboration.

So our objectives for today are to present a brief review of the current methods used for carrying out domestic health orientation, to describe examples of some really nice and innovative health orientation strategies and to promote ideas for future collaboration and educational opportunities.

The structure for the next hour and a half is here. We'll have four presenters speaking in total for about an hour and we'll follow that by a question and answer session. Please type your questions in the chat box at any time during the presentation. So we'll be organizing these. And while we may not get to all of them during the Webinar, we hope to touch on most of them.

Please visit our Web site, www.refugeehealthta.org. And it's there that we will post the recording, the transcript and the slides from today's presentation. There will also be a Q&A document if we don't get to all the questions live today and some additional resources related to today's presentation.

Please keep in mind that, you know, it takes a couple of days to get the recording and transcript and slides up. And the other documents may take a little bit longer. So please do check back regularly. And I'm going to put in a plug here too for if you go onto the TA Web site homepage, you can sign up for an RSS feed and then you should get a notification as these things are posted there.

Our email address is also here, refugeehealthta@jsi.com, and feel free to email us after the Webinar if you have any questions. So our presenters

today are listed here. We have four great presenters. I'm actually going to - Liz Edghill's going to present first and I'm going to introduce her in a few minutes.

She'll be followed by Lauren Schroeder and Lauren's the well-being promotion program coordinator at the International Rescue Committee or IRC in Tucson, Arizona. And before coming to IRC Tucson, she worked with CommuniCare Clinics in West Sacramento, California as an HIV/AIDS health educator for at-risk youth and adults and incarcerated youths and adults.

Her work at the clinic led her to join the Peace Corps, where she served as a community health volunteer building a capacity of community health workers in rural Zambia for two years. And Lauren's going to be speaking on the well-being promotion program at IRC in Tucson.

She'll be followed by Marla Lipscomb. Marla's currently working at Saint Alphonsus CARE, the Culturally Appropriate Resources and Education Maternal and Child Health Program. She provides trauma counseling, additional support to women during pregnancy and postpartum, as well as group psychoeducation throughout their prenatal care.

In partnership with a diverse group of women who serve as Health Advisors for the CARE Clinic, Marla is working to develop CARE's Domestic Violence and Sexual Abuse Prevention, Resources and Education Program. She also provides community orientations on mental health to all new refugee arrivals at Boise's English Language Center and that will be the focus of her presentation today.

After Marla, Leslie Hortel, who is in Colorado, will be speaking. Leslie is a health educator at the Refugee Health Clinic in Denver. She has been providing health orientation and education to refugees for three years. She is also currently pursuing a Certificate in Global Public Health. And Leslie's going to be talking about the Health Passport Tool that's in use at the Denver, Colorado Refugee Health Clinic.

So all important is the evaluation. The evaluation forms will pop up in your window as you leave the Webinar. So please do stay logged in until the end of the Webinar, because that's what will trigger the evaluation form to come up. We strongly encourage people to use the evaluation, give us your thoughts. We read every one of them and hopefully think about our next Webinar accordingly.

So before we start today's presentation, those who have been on our Webinars before know we sometimes like to see like who's in our virtual room out here. So I'd like you to take a minute. It's not a trick question, just what kind of organization are you in? I'll give you a minute to fill it out. Are you in a healthcare setting, in public health setting, resettlement agency, community-based organization, a faith-based organization or something else?

I'm going to give you another couple of seconds. Most people seem to have figured it out. And this will be - it's helpful to the speakers to know too. So about a third are in resettlement, and a quarter in public health and 14 percent or so in healthcare settings. So a very nice mix, an important mix of people to have on the call. I think as we go through, that will be evidence.

So then we have another question for you and that's what's your job role within the setting where you're working? Are you providing clinical care, administration, case management or social work, community education, community engagement, a lot more in the community engagement planning side, patient education, program support, education, academics.

And I know sometimes people feel like, oh, I do a lot of these. Just pick the one that you feel like you're going to relate to today. All right. So let's see who's here. Again, a very nice mix and although a lot of people said something other than what we've listed there. So you can see a pretty nice mix between in the medical care administration case management, a lot in the other. We may explore that as we go.

So, great, well with that, I'm going to jump right into the whole Webinar for today. So let me start by introducing Liz Edghill and it's really my pleasure to

do so. Liz is a nurse and the refugee health educator coordinator at Family Health Centers - Americana, a Federally qualified community health center in Louisville, Kentucky.

She served as a health education volunteer with the Peace Corps in Guyana, South America from 1999 to 2002, and she's been working domestically in refugee health and health literacy since 2008. I also want to mention that Liz co-chairs the Health Education Committee for the Association of Refugee Health Coordinators and has helped to plan today's Webinar. So, thank you, and I'm going to turn it over to Leslie, I mean, sorry, Liz.

Liz Edghill: That's okay. Leslie's our other capable co-chair. Thank you, Jennifer, for the introduction. So basically in December, we presented just a summary of the various types of health orientations that tend to occur domestically, because we didn't have a lot of time. So we weren't able to focus on example programs or innovative strategy or best practices.

So today we're happy to have that opportunity to present a more in-depth Webinar on domestic health orientations. For continuity's sake and for by way of introduction to the topic, though, I'll sort of recap just the basics of domestic health orientation.

So the big picture is that it varies a lot, much like the varying programs overseas. It's hard to truly label what is a domestic health orientation. Some resettlement agencies have simple discussions or a handout about insurance cards or calling 9-1-1 for emergencies, while others may have lengthy orientations or designated health coordinators on staff.

In some states or programs, domestic refugee health screening providers are responsible for providing health education content to refugee clients. Orientations vary from just a few minutes up to maybe three hours or ongoing.

There are, I think I went too far, hold on. There are varying groups who also provide orientation to refugee clients. It could be resettlement agencies, case

managers or health coordinators. Sometimes it's done through the ESL classes or ESL centers, through refugee health clinics, community health care providers, community health workers, partner agencies.

There are some models where resident programs or medical students are involved. And then of course there are mixed models. And the orientation materials and methods vary. They could be intake meetings with families or clients at the resettlement agency. It could be small group teaching or learning sessions, maybe by ethnic population and language.

It could be large group teaching with learning sessions, maybe through multiple interpreters at the same time. It could be manuals that are given handouts and there are some folks who use the USCRI translated documents that are available. It could be translations or documents created in house or health handouts, health binders.

It could be field trips, group sessions. The options are endless. So we have a poll question here. Just should think about who provides refugee health orientations in your community. And this is a check all that apply, so we can just kind of see how varied it is.

So it looks like a lot is coming through the resettlement agencies and refugee health clinics. So I'll give it a few more seconds for folks to respond. The community healthcare providers, partner agents. So the orientation themes also vary. Some general health orientations may focus on preventive care, which is new to many of our refugee clients or how to access care in the very complex US healthcare system.

Some orientations are based on the health needs and level of previous exposure to western medicine. So that's sort of tailored education content based on the population. Others may be based on certain key topics, like HIV or TB or hygiene or bedbugs or another endless variety of topics.

When we were preparing for that Webinar in December, we sent out a little informal survey through the Association of Refugee Health Coordinators and

Health Education Committee members. And came up with this very, very vast list of the topics that are addressed in refugee health orientations, what to expect at the refugee health assessment, insurance, the healthcare system overview, using 9-1-1, preventive topics, immunization.

Family planning is addressed in some places, not addressed in others. Mental health is addressed in some and not others. Nutrition, specific health issues that a client maybe experience. A lot of this is client driven. Domestic violence, hand washing, medication management.

And the timing also varies. I hope you're seeing the theme here. It varies, it varies, it varies. A few days after arrival is when some folks are going through these orientations. Some of them it's a little later down, a few months after arrival. And some places it's done several times, kind of by different providing agencies or through different mediums.

So there are some challenges in presenting high-quality orientations. There's the overall lack of time in a given day for our staff and for our clients. It's difficult to reach everyone. The complexity of the U.S. healthcare system cannot be undermined. Frequent changes in the healthcare system also make it a challenge.

There are variations in services across the state and that makes sharing best practices or handout or materials at the national level fairly difficult. And it's also challenging for the overseas providers, orientation providers to be able to help start this process.

There is a lack of primary care resources at the local level. So there's sometimes a mismatch between the advice that we give folks and the actual reality of their situation. Limited insurance coverage, especially in the dental and vision that we know of, is pretty strong in a lot of places. Transportation is sometimes not addressed and that's really one of the most pressing practical needs that refugee clients have.

And it's also hard to reach clients when they have other perceive pressing needs and priorities, especially early in the resettlement period when they're taking in so much. It's also a challenge to know whether our efforts are useful. Is it just information dissemination? Is it just information that we're giving that's going in one ear and out the other?

We're often missing the evaluation piece. So it's hard to tell we - many of us invest a lot of time in this. We're using quality translations and custom materials and we're still not sure what the impact is. The refugees are from various places with different languages and cultures and its different exposures to western medicine. It's very difficult given all these other challenges to tailor a good presentation or orientation for folks.

And then there's limited financial and staff resources. Caseworkers are doing more than they technically have to. Clinic staff are doing more than they technically have to. And, yet, still there are gaps and the clients are patients who fall between the cracks.

Other considerations that we've talked about are information sharing and making sure that information follows refugee clients as they navigate throughout the healthcare system. Orienting community health providers to best practices and refugee care. Empowering refugees. One of the ways we can do that is by improving their health literacy level, but of course health literacy is a challenge among our American born population as well.

Pursuing best practices, trying to find out really what are the best methods and mediums for maximum learning and comprehension. So that's why we're here today. We hope to highlight a few of these more innovative health orientation strategies. We'll be talking about the Well-Being Promotion Program at the International Rescue Center in Tucson.

We'll be talking about the Mental Health and Wellness Orientation Program out of Boise, Idaho's English Language Center, and a Health Passport Tool that was created in Colorado along with some results from their refugee focus group discussions that they had. So we're going to start. I'm going to pass it

on to Lauren Schroeder from the Well-Being Promotion Program at the International Committee in Tucson.

Lauren Schroeder: All right, great, thank you. Good morning and good afternoon to everyone. Let me preface by saying our Well-Being Promotion Program is not our standalone health orientation program. We do offer other health orientation services upon arrival and at six months through our case managers.

So this is a broader program but does incorporate health orientation topics. And so the program is looking at health in the more holistic perspective and really looking at well-being and everything that well-being encompasses.

And I like to refer back to the World Health Organization's definition of well-being, which states that well-being is a state in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.

And we know that kind overarching everything in a refugee's experience in the U.S. are their prior experience in and their conditions in and their status in their home country, refugee camp or second country. And they face a lot of barriers once coming to the U.S. to well-being.

So just a little poll before I go into too much about the program. I'd like to know how familiar are you with what's called the community health worker model? Do you work with community health workers, CHW's, or have you been one? Are you just very familiar with the model, heard of the model but don't know the details or not familiar with the model at all?

All right. So it looks like we're across the board, varying. So I'll go into a little detail about it. There will also be some resources posted on the RHTAC Web site. So this program is based on the community health worker model. And it began in 2008, when we began to realize that women weren't fully participating in some of the resettlement activities and the resettlement process.

And this was due to kind of gender inequities in their own culture, having less and less educated and less confident than their male counterparts and making them less equipped than the refugee men when adjusting to American society. And so this program was created to help kind of bring women more into the discussion and involved in the resettlement process.

And so a little background on the community health worker model. The American Public Health Association defines the CHW as the front line public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

This trusting relationship enables the CHW to serve as a liaison link intermediary between health, social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education and formal counseling, social support and advocacy.

In addition to the American Public Health Association, the CDC and the Robert Wood Johnson Foundation have all endorsed the CHW models in means to address glaring health and social inequities that exist among minority and low socioeconomic populations in the U.S.

And so this program specifically is not a health intervention program. It is an educational, referral and advocacy program. And so, we utilize well-being promoters who are refugee women themselves and they go on home visits to newly arriving refugee women. And I'll explain more on that.

We also do community trainings. So community organizations within Tucson who serve the greater Tucson community, but also happen to be serving refugees, we provide refugee 101 educations. So helping them identify who

refugees are, some of the challenges they face, how they come to Tucson and why they're in the U.S. and that sort of education.

And then we also have provided health and community connection fairs. So, we have health providers come and we do a refugee health fair and then we do a more general community-based, community education connection fair.

So one more poll question. Internationally, where are community health worker programs being utilized, Nepal, Kenya, Pakistan, Haiti or all of the above? Great. So we have lots of answers coming in, and generally overwhelmingly, it is all of the above.

And so one reason this is a great model to be used here in the U.S. is that because it has been used all over, a lot of the refugees who are coming in to Tucson and to the U.S. already familiar with community health workers. So having someone come to their home and provide educational visits is something that they're familiar with and isn't an unusual concept.

All right. So the well-being promoters are, that I use are an incredible group of women. We currently have eight promoters. Three are Nepali speaking, two Arabic speaking, two Somali speaking and one Swahili speaker. And this captures about 84% of arriving refugee women and their families who are coming into Tucson. So this really reflects the population that we have in Tucson.

For our program, they are IRC employees. Within the community health worker model, they are, community health workers are, sometimes volunteers in the community. Sometimes they get stipends. Sometimes they're also hourly employees. So it really does vary, but for us they are hourly employees and they work about 20 to 40 hours a month, so not per week, but a month.

They're all refugee women. They are bilingual and literate in their native language and English. They show an interest in becoming resources for and leaders within their community. They have had prior experience in community

organizing and/or in public health within their home country or their refugee camp.

They're generally passionate about women's and children's issues. And they show strong intercultural communications skills. And because they're refugees themselves, and they've all had to at least live in Tucson for about two years, they have knowledge of the local area health and human service network. The promoters go through a number of hours of training.

Once they're hired, we do about 40 hours of education. And this includes going over different modules and curriculum that we have for the program, going over community resources, the referral processes for some of these resources, home visitation practices, such as case noting, how often they'll see participants, resiliency and boundary setting and then they'll go through shadowing veteran promoters.

We have noticed that existing evidence-based CHW or promotora curriculum often targets, at least in the Southwest, has targeted vulnerable Spanish speaking or African American populations only. And they're based on Western approaches that do not take in account the distinct cultural differences and experiences of refugee ethnic groups.

So in response to this, a majority of our curriculums and trainings used in the program have been created in-house or adapted from existing curriculum. So we've made it more appropriate for our population.

They also receive three hours a month of continuing education and professional development training and so this will go over any new health topics that we need, that have come up in the community, any new organizations or services that are happening in the community, go over updates, check-in, that sort of thing.

Additionally, they meet with meet-up for one to two hours a month of case note review to go over kind of their service notes that they're doing during the home visits. And then, they receive ongoing monitoring of their home visits.

So myself or the program assistant will be going out with them on their home visits.

So as we call them, promoters or community health workers, have many roles. One of them, and these are quotes from my promoters on the screen that you see as how they see themselves. So they act as a bridge between the people's culture and that of the professionals within the community.

They're cultural mediators and they do also provide interpretation services sometimes. They're a social support. They're not - excuse me. They're not trained counselors, but they do often end up providing informal counseling. They are educators. They disseminate culturally appropriate information education around health and other general topics.

They are advocates for individual and community needs, community capacity building, empowerment through collective efforts and resources mobilization and assurance. They do - they help assure people get the services they need and they increase access to health services, link and negotiate services for people in need, and assist with services navigation and they provide referrals.

So the main function of the program is providing these educational home visits. So when a new woman and her family arrives into Tucson, they are greeted by a promoter. We try to see them within the first week of their arrival, and then they'll receive one home visit per week for the first 30 days they're in Tucson.

And then from months two through six, they'll receive two visits per month, and months seven through 12 as they're starting to get a bit more adjusted, they receive one visit per month. So the topics that we're covering in the first six months, kind of focusing on what we see as some of the survival kills - skills.

And so for those, that first visit is often around apartment living and home safety and public safety, how to cross your street, locking your front door, using electrical outlets, appliances in the home, that sort of thing, and then

moving into personal and home hygiene, and very quickly going into systems navigation, understanding your DES benefits.

So that includes Medicaid, food stamps. Then the education system, and then public transportation, riding the bus, bicycles, if they have them.

Then we go into financial literacy, a self-advocacy curriculum, focusing on knowing and understanding their rights and responsibilities, what accommodations they need, how to effectively assert themselves in the U.S., about whether they speak English or don't speak English, how to effectively communicate through interpreters and then constantly making referrals.

The second six months is going to focus more on actual health topics. So once, they're kind of learned to navigate systems on their own, the promoters help them understand their Medicaid card, how to set up doctor's appointments, how to take public transportation to their doctor's appointments, that sort of thing.

Then they'll focus more on some health topics. And those will include physical health topics, family planning, maternal and child health. We have new curriculums for mental health, family parenting issues, self-advocacy can - an ongoing discussion and community referral.

So challenges for the program is this is one program to serve many ethnicities. And so developing curriculum, trying to develop culturally competent curriculum for a varying number of ethnicities can be a challenge, and so it really does rely on the promoters to be the ones who are the liaisons to make the information appropriate.

And they're - and all the curriculums that we develop, all the promoters are involved in creating that curriculum and the topics that are, how they are going to be discussed, what topics are going to be discussed, how they'll be used in the homes. We'll test them with them. And so they're actively involved to kind of help overcome that challenge.

But we have found that you can't just pull out a curriculum that someone else has used and try to apply it to this program. There are varied education levels within my promoters and within, obviously, the participants. So the promoters, some of my promoters have, one has a, is working on a master's degree and others are, just have their high school diplomas.

And so there's varying education levels with that. And then also the participants, some aren't even literate in their own language, some have, you know, a master's degree themselves. Then there's scheduling conflicts with trying to get in and see the clients when they have so many doctor's appointments and school appointments and appointments with their case managers and DES appointments.

And then there's, the promoters aren't working full time, so a lot of them have second jobs, and so they have their own scheduling conflicts. Transportation is always an issue. Some of the promoters have cars, some are taking the bus.

And then referrals to community organizations can be difficult in the sense that a lot, some of our agencies right now have waiting lists and they can't get clients into those organizations. Some of the organizations say they serve refugees, but have no means for interpretation.

And then there's always unrealistic expectations of the promoters because they speak the same language, they share the same culture. They have similar experiences. Some of them were in the refugee camps together. There's this kind of - the participants often rely on the promoters a bit too much because the promoters are not their case managers.

We do do, you know, evaluation is always important. We do a post, then pre-evaluation survey. And, sorry, whoops, put this back one more. And so, this is administered by the promoters at the end of the - when they see the client's route one year, so at the end of the one year.

And we do post, then pre because we have limited resources and capacities so - and the pre-post tests weren't going over well with, you know, too much paperwork. They didn't - it wasn't being translated very well, and so this way we have the participants reflect on what they did know and what they know now after the program.

And we've seen increases in knowledge and understanding on where to get resources, what to do if there's an emergency, health education and financial systems in Tucson and the resettlement process.

And then they've also seen - we've also seen increases in confidence in their ability to adjust to life in Tucson and the ability to help others access resources and support. And then, I'm going to end just with two client quotes and then I'll discuss the funding for the program.

This is from an Iraqi client and this is the pictures of our promoter, (Bushra), who said, "I was so happy to find somebody who spoke my same language, shared my same culture and guided me from my arrival. I now feel confident."

And the last quote, "I learned so many good informations and knowledge from the home visits because you covered most all the basic informations that we need to survive in life here. I know the uses of bus pass, food stamps, Access, and Access is the Arizona Medicaid System.

I know the value of money, safety in the apartment, to reapply to the DES after six months and the importances of ESL school. I also learned to make doctor appointment and reschedule the appointment and I know to take my baby to the doctor for well-check. I can get the things I need from the resources." That's from our - one of our Bhutanese participants.

And so funding, it's always a challenge. Currently we are funded under an ORR grant, a preferred communities grant, our Arizona Refugee Settlement Program, we have a contract with them. We have foundation grants, local, Southern Arizona Women's Foundation and then a state, the Arizona First

Things First Grant. And so we do have a variety of funding resources from federal, state and local foundations.

And I'll close with that. And the last quote, "Nowadays, I know a little more and have a hope of surviving in Tucson and also getting some courage to move around the city and see new things." So, thank you.

Jennifer Cochran: All right. Thank you so much, Lauren. I've seen some questions coming in and we will have a question and answer section at the end. So, we'll get back to some of those. And we're going to move on to Marla Lipscomb, who's going to talk about the Mental Health and Wellness Orientation program in Boise, Idaho.

Marla Lipscomb: Great, thanks. Hello, my name is Marla Lipscomb and I'm a counselor and clinical social worker at Saint Alphonsus CARE/Maternal Child Health Program in Boise, Idaho. And I'm thankful to have the opportunity to talk about providing mental health orientations to refugee populations.

This is a critical topic to be covered during both initial orientations, as well as follow-up orientations as stages of resettlement progress. The orientation that I'll be discussing is one that is given to all new arrivals during their initial week-long orientation that's offered at Boise English's - Boise English Language Center.

It's also presented at St. Alphonsus CARE Clinic during group pre-natal appointments as part of the cycle of education that's provided. With recurring mental health orientations for refugee populations, it can be helpful to use these three factors at your foundation when you develop your orientation. One of the greatest challenges that we often face when talking about mental health, is the pervasive stigma that exists across cultures.

If we're not careful about our approach in the words that we choose, we can further exacerbate the stigma. When working with populations who have extensive compound trauma histories, it is critical that every orientation utilize

trauma informed practice to decrease potential triggering of survivor stress and fear responses.

And this is particularly important when talking about mental health. It is also extremely important that the orientation is culturally sensitive, in order that the information being shared is relevant and meaningful for the participants.

As we go through these slides, you may notice how these three guiding factors are deeply interconnected and shape every aspect of the orientation. When seeking to overcome the stigma associated with mental health, it's important to understand the power that both fear and shame can hold and collect of its communities with extensive trauma histories.

Throughout the world, there is often no concept of a spectrum of disorders. When talking about stigma, one Somali Bantu elder reflected you are either crazy or not crazy. There is no in between. And this creates a significant fear of being labeled and bringing shame not only on the individual who might need services, but also the family, the extended family and the community.

Avoiding shame is often a high cultural value among the diverse populations who are resettled and the shared concept of shame fuels the stigma. We will discuss ways that the use of a narrative approach can help to normalize symptoms and decrease the stigma associated with mental health.

Cultural and linguistic considerations are also extremely important. Often times, orientations are presented to a culturally and linguistically diverse audience, not just a single ethnic group. This can pose a challenge as each culture has their own unique beliefs about mental health and appropriate ways to talk about mental health.

Also, presenters must be very careful not to use mental health vocabulary when presenting, as these words can be very culturally bound. Mental health vocabulary often lacks cultural meaning, poses challenges for interpretation and can increase the stigma if the interpreter is unsure how to interpret words that are being used.

Also, the interpreter's own personal bias can have a significant impact on interpretation and increase the stigma. This creates a need for engaging community health workers from their respective ethnic and linguistic communities, as well as interpreters to discuss mental health and explore the stigma associated with it.

Providers and presenters are in need of feedback and advice to better adapt mental health orientation for their communities. The mental health orientation that is provided in Boise, Idaho has been presented to a diverse group of health advisors who serve as community health workers, as well as a focus group of medical interpreters.

The following slides will reflect their feedback and influence on strengthening mental health orientations. Mental health orientations can trigger significant stress and fear responses for survivors of trauma if the orientation does not reflect trauma informed practice.

And this is important for both the participants as well as the interpreters who often have their own trauma stories. If the interpreters are triggered, they will have a very difficult time remaining present throughout the orientation, due to having to manage their own symptoms.

Five aspects of trauma informed practice that can be very helpful when providing orientations are being aware of potential triggers throughout the orientation, restoring power and control to the survivor, knowing what to expect to happen next, restoring dignity and respect to the survivor and creating safety and building trust.

As we discuss the orientation, you will see ways that each of these guiding practices of trauma informed care are utilized. One of the greatest challenges when talking about mental health is knowing how to best introduce a mental health worker without increasing the stigma of the services being discussed.

Also, many of the resettlement communities come from cultures that place a high value on the role of introductions. If a mental health worker is not adequately introduced by a facilitator, it might cause the audience to question whether or not this presenter or worker is worthy of respect, which might result in increasing the stigma of mental health.

We do not use the term mental health worker or psychologist or psychiatrist due to potential fear and stigma that are associated with these terms. Through complication and feedback from the focus groups, it was recommended to use the term counselor or social worker.

Counselor may be a new term which can help to decrease stigma since it may not have a previous negative connotation. And the term social worker was also recommended as it's familiar for many of the populations and often carries the meaning of someone who can help you overcome problems that you are facing.

On this slide, there is an example provided of how a facilitator of an orientation might introduce a service provider who's going to talk about mental health. And one of the resources that we will post on the Web site will be additional examples of ways mental health workers can introduce themselves and explain their role further.

As a presenter, it can help to further establish safety and build trust, by then greeting each interpreter and acknowledging their language group. Of course, be mindful of culturally appropriate eye contact and ways of greeting. Welcoming everyone and expressing honor and gratitude for the time you will share together can help to further restore dignity and respect to them as survivors.

A final consideration before beginning a mental health orientation is to give permission for them to leave the room if they need to at any time during the orientation, to get a drink, use the bathroom or go outside and let them know that they are welcome to return to the orientation.

This is really important to help restore power and control to them as survivors and to know that they have a way out if their fear or stress response is triggered during the orientation.

After investing valuable time on introductions, I then transition into a narrative approach to the orientation. Many of the cultures that have resettled have strong storytelling and narrative traditions. For some, dramas may have been a very effective and common way of providing education in their country of origin or host country.

And the narrative approach can help to reduce stigma as it normalizes experiences and symptoms that survivors may have. It also can be a culturally appropriate way to talk about mental health, as it is indirect. This indirect approach also reduces potential triggers for their fear response.

The metaphorical story that I share tells a story about an invisible bag that each of us carry that is filled with a large heavy rock every time something bad happens to ourselves, our family or our community. This story also discusses the impact that carrying a bag of heavy rocks can have on a person's health.

It emphasizes the somatic impact of trauma and ways that trauma is stored in the body. It also emphasizes ways that resettlement stressors can impact a person's health. As we share this metaphorical story, participants from each language group often nod their heads in agreement and identify with the story that is being shared.

This approach to talking about mental health was strongly affirmed and encouraged by both of the focus groups. A copy of this narrative will be a made available on the Web site to - for participants to review further if you're interested in using this kind of approach.

And one thing I'll note before we move on to the next slide, is I'd like to discuss the use of the word trauma. The word trauma can create linguistic challenges for interpreters as it may not have a direct translation. So I try not

to use the word trauma when talking about mental health, but instead refer to bad things that may have happened in the past.

While using the metaphorical story, I share about the ways that - the rocks can impact a person's health. And while referring to the bag, we review together health problems that can occur.

On this slide there's a list of health problems that survivors may experience. And we do not use terms such as somatic, depression, anxiety or PTSD as these terms can increase stigma, as well as cause unnecessary challenges for interpreters to provide meaning for meaning for interpretation when mental health jargon is used.

When talking about the symptoms, we emphasize the normal response to trauma and loss as well as seek to install hope in the healing process. And we also talk about ways that these symptoms can get worse over time and impact the family system and employment.

This can help participants by encouraging to access services with a counselor early in the resettlement if they're experiencing any of these symptoms. After discussing symptoms and health problems that can occur due to the heavy bag of rocks, we transition together to talk about children and the family system.

Ideally this would be a separate one to two hour orientation altogether, incorporate some brief dialog on this topic because of ways that mental health and well-being is deeply connected to the family system. We discuss the impact of trauma on children, such as ways that children can become stressed or saddened if their parents are suffering from bad things that have happened in the past.

We also discuss the impact of early childhood traumatic memories. For example, across many cultures, there's a belief that if the child was young when the bad event happened, that they will not be affected by it when they

are older. We talk about ways that the child, no matter how small they were, can still remember what happened even if they cannot talk about it.

We discuss other ways that the child may show that they are still being affected by the bad things that happened to themselves or their family by reviewing signs and symptoms that may be unique to children that parents can look for, such as re-enactment playing of the bad thing that happened, nightmares without recognizable content.

We also spend time talking about behavior problems or changes in personality as signs of trauma. We provide an example during the orientation that often occurs in the school setting where perhaps a newly arrived parent might be called into the principal's office due to the child "misbehaving."

This can create significant shame for the parent, child and community and results en passé for the child even being punished at home. We discuss that the child's behaviors does not mean that they are a bad child, but that their child is in need of help to heal from the things that have happened in the past.

We really seek during the mental health orientation to strengthen the parent's trauma lens as they work with their children during the first several years of resettlement. Also the end part - this part of the orientation, we discuss the impact of acculturation on the family system. We discuss ways that language acquisition and acculturation can shift roles within the family. We also always affirm the role of parents in their child's well-being.

At the bottom of this slide, you'll see a quote. And this is just an example of something that I always share with parents during the mental health orientations. By sharing this we can help to further restore dignity and respect to them, not only as survivors, but also as parents, which is really important during mental health orientation.

As part of trauma informed practice, we try to then shift our focus from the past to the present as the orientation is half-way over to help survivors begin to contain any intrusive thoughts related to their past history or trauma. We

discuss ways that stress in America can cause more heavy rocks to be added to a person's bag, which can cause a person's health to worsen.

We invite each person to think about things that may have been difficult since they arrived to America and to share them with their language group. Their interpreter is instructed to then share with the larger group.

As the presenter, I make sure to let the audience know that I'll be writing all of the responses so that the interpreters can share with the larger group. We want to make sure that they feel validated in their thoughts and feelings and in - by encouraging their voices - their voice as a survivor.

Usually, once one person shares with their language group, everyone begins to share. And a very lengthy list of stressors and difficulties experienced is created within a few minutes. In doing this group activity, you can feel the shared experiences of resettlement across the diverse ethnic and linguistic groups that are represented in the orientation.

We also discuss the impact of the various stages of resettlement, normalized feelings of moving from hope to despair throughout the first year, as well as affirm ways that counselors or social workers can provide increased support during resettlement.

After discussing stressors, we transition to focusing on strengths of resettlement that they are hopeful about. We use the same model of participants sharing with their interpreter and their interpreter then sharing with the larger group. A list is also quickly made as a shared group.

This can be a helpful way to further assist participants in containing any intrusive thoughts they might be experiencing. It also can provide an opportunity for the participants to move in and out from feelings of despair to feelings of hope as a collective group. Participants focus much of this discussion on their hope for their children and their families.

Oftentimes towards the end of the orientation, several participants will begin to ask their interpreters, so how do we see a counselor, who pays for this service, how will we get to the appointments, who will be my interpreter? And it's extremely important to reserve time to talk about what counseling services are and to process a referral in accessing these services.

Make sure they explain these services without using mental health jargon. And examples of ways to explain these services in further detail will also be provided as additional resource on the Web site. One of the most important topics identified by the focus groups was making sure that participants know that they have the right to request an interpreter that they trust when receiving counseling services.

This is critical for trust, rapport, safety and healing to occur in the clinical setting. Also make sure to describe the referral process and the ways that they can talk with their family doctor about the impact of their past and current stressors on their health.

It's also very important to discuss issues related to Medicaid such as coverage and transport. Many will not access mental health services before their Medicaid coverage ends, which can create a lot of challenges to receiving assistance.

So it can be helpful both to encourage them to access new health services before their Medicaid coverage ends, which of course requires us to provide these mental health orientation early on in the resettlement process, but also it can be really helpful to provide options for uninsured patients during the mental health orientation in case they choose to access mental health after their Medicaid coverage has ended.

And just as the introduction is critical for establishing safety in building rapport with participants, it's also equally important to make sure that you have a very good closing to further strengthen rapport and restore dignity and respect to survivors.

Here in this last slide, we've provided an example of a closing that's often given during our mental health orientation. And we feel that it's really important for participants to feel respected and cared for by someone who is talking about mental health services as they may represent the only example of a mental health worker to new arrivals.

New arrivals receive such an incredible amount of information, that it's often impossible for them to retain all the new information provided during orientations. However, although they might not remember every word that was spoken, they will remember how they felt with you as a presenter while you were with them.

And this is perhaps the most critical aspect of providing a mental health orientation to refugee populations, because if they do not trust and feel comfortable with you as a person, and feel like you are someone they could eventually share their story, they likely will not disclose symptoms to their medical provider and agree to see a counselor or a social worker.

So the mental health orientation is critical to creating safety for them to access these services. We always make sure to stand at the door, wait and greet each participant as they leave for their break in between orientation topics and also make sure that all of the participants know that I'll be available in a designated room if anyone has additional questions or comments to share.

And often there will be one or two individuals who ask to speak with me after the orientation and, when appropriate, I receive permission to then coordinate with the resettlement case manager and primary care provider to make sure that they receive additional follow up.

Just in closing, one of the hopes of our mental health orientation program here in Boise, Idaho is to also conduct follow-up community-based mental health orientations through community health workers with the respective ethnic and linguistic communities throughout the stages of resettlement as

well as extending beyond the first year. So, with that, I'll close and going to pass this on to Leslie.

Jennifer Cochran: Okay. Our last presenter will be Leslie Hortel from Colorado. She's going to talk about their health passport tools and the result of their refugee focus groups.

Leslie Hortel: Thank you. So my name is Leslie Hortel and I am a health educator at the Lowry Refugee Health Clinic. We provide a public health screening, referrals and health education to approximately 90 percent of the refugees arriving to Colorado at our clinic.

And so today I will be discussing two topics. The first will be on our results from several focus groups we conducted earlier this year regarding health education for newly arrived refugees. And the second will be on the health passport tool we have developed here in Colorado.

So about two years ago, we greatly expanded the health education efforts offered to newly arrived refugees, including opening a resource center where most of our education takes place. So initially all services that were offered were developed based on the needs seen by our providers and our refugee staff. But now that our resource center has been in existence for a while, we wanted to evaluate and get refugee insight on our current services offered.

So in order to do this, we held a series of focus groups with refugee participants and the goals of the focus groups were to assess what types of health education information are the most important to newly-arrived refugees, specifically in three categories, including accessing healthcare, health issues and preventative health topics.

We also wanted to see how refugees learn best, and so specifically through what types of delivery methods. And last, we wanted to do an assessment of the health passport, which I'll be discussing later, to find out how clients specifically were using it, what parts have been the most useful, if anything should be added or what parts should be removed or changed.

So for the focus groups, our participants were recruited from the existing walk-in resource center. Their average time spent in the U.S. was between one and two years and we had 23 females and 16 males. And we studied four different ethnic groups, the Keren, Burmese, Bhutanese and Eritrean. And we chose these groups because they represent our current largest arrivals groups.

We developed a methodology for the focus group in conjunction with several professors from local universities who have done past research with refugees. We chose the focus group method because it allows for verbal dialog as opposed to written surveys, which is more appropriate for our multilingual, low literacy population.

And focus groups are also less threatening than formal interviews and can yield better discussion. Each ethnic group met two times, each for about 90 minutes.

They were led by trained focus group facilitators in the native language of the participants and then a second bilingual staff person took notes on the conversation and then two of our refugee health clinic staff members at the resource center took observational notes and notes on anything said in English.

And so then at the end of each session, the facilitator, note-taker and refugee staff members convened to recap information. And so obviously there are several limitations in this method, but we didn't have the funds to have everything taped and transcribed and so we felt this could be the best method to still yield very positive results.

So I just now want to discuss how we did the focus groups. On the first day, the participants came and took part in several sticker activities, which allowed them to choose what they felt were the most important topics to learn about as newly-arrived refugees in the three specific categories.

So each time the activity was performed, the participants were posed with a scenario. And the scenario was your friend has just arrived in the United States. What are the three most important things you think they need to know about health access or health issues or preventative health?

Participants then made their choices by placing a sticker on the three posters they thought were most important and then after each category, we had a discussion about why certain topics were chosen, what their experiences had been with these topics, where they had received their most useful information on the topics and anything else that they would like to contribute.

And the picture in the upper left-hand corner, you can see our facilitator giving a description of each of the topics and there are about eight to 12 topics in each category for participants to choose from. And each topic had the word in English and the language of the group and there was a picture to describe the topic.

So as for our results, regarding accessing healthcare, our participants stated that communicating with my doctor was the number one topic newly-arrived refugees need education on. And as you can see, that's of particular concern when first arriving in the United States.

Participants often expressed difficulty understanding phone interpreters, especially if the interpreter speaks a different dialect and the Bhutanese often tell us that they often have a very difficult time with phone interpreters because the interpreters are most often from Nepal and speak with a much more complex language than they are familiar with.

Our participants suggested that education could be done to teach newly-arrived refugees how to ask for another interpreter if they are having a difficult time understanding or how to ask the interpreter and/or provider to reexplain if they aren't understanding.

And then our participants also noted that new refugees need to know that they will always have access to some form of interpretation when they see a medical provider, otherwise they might be afraid to access healthcare.

Also health insurance was a priority topic area chosen. And many of our participants expressed fear in taking care if they don't have insurance due to the possibility of receiving medical bills. And often this fear exists even if they just don't know if their Medicaid is currently active or not and they don't know how to find that information out.

They also expressed a lot of difficulty in reapplying for medical insurance if their situation changes due to pregnancy or a loss of job and the difficulty in transitioning to a non-Medicaid insurance or discount program after their Medicaid eligibility ends.

And then our next highest category was what to bring to medical appointments. And participants said this very important for newly-arrived refugees because if you don't bring the correct documents, you won't be seen at the clinic. And they said that different clinics require different documentation so people need to be able to learn what to bring to their specific family doctor location.

And then last, participants said newly-arrived refugees need education in how to make appointments due to the fact especially that phone systems are difficult and many clinics won't accept walk-ins to be able to make their appointments.

All right. So as far as health issues, participants said newly-arrived refugees need education on both vision and dental services, and I think this is often because these services are not covered by Medicaid, especially here in Colorado. Almost all participants expressed having dental issues. So both preventative care and treatment options should be a priority topic area.

Also participants said newly-arrived refugees need education on mental health, specifically regarding how to cope with the high levels of stress and

worry associated with arriving and transitioning in the U.S. And they also associated their stress with a lot of headaches and lack of sleep. And then last, bedbugs and TB, specifically understanding latent TB are important for refugees to know about.

For preventative health, participants discussed a need to educate new refugees about the importance of exercise in maintaining a healthy weight. They also stated that nutrition was important because refugees do not know how to cook with "American Foods," and that many people live in a food desert where the closest places to shop are family dollar stores or 7-11.

And they also stressed the importance of drinking water, and I think that's very specific to Colorado, but drinking water is important for everyone. And last, participants said refugees should learn about immunizations so that their families can be protected from diseases that many of them have experienced. And they talked about learning how to deal with stress, once again, so I think we can see that this is an important topic to newly-arrived refugees.

So after we participated in the sticker activities, we concluded that day. And then participants returned either two days later for some groups and for some groups it was a week later. And they participated in two more activities.

And so the first was a card sort to choose the best and worst methods of learning health information. And then the second was a sticker activity to evaluate our health passport.

So for the card sort, participants put photos of a variety of educational delivery methods in order from the best way for them to learn to the worst. And so as you can see from the results, small groups were the most common preferred method to learn health information. And I really think this supports a lot of our community health worker models.

Three out of our four groups said this was because in a lot of, in small groups you can confirm understanding with other people in the group and gain confidence to ask questions to the doctor or teacher if there is a lack of

understanding. And this is often not done if you're being spoken to individually.

Health navigation or one on one and audio visual information were also preferred methods. And for those of the people that said that audio visual or DVDs were not preferred, it's typically because they do not have a DVD player at home, but when asked if it was made available or if they could be watching something in a clinic, then people did agree that it was a good method, especially if they could rewatch parts that need to be clarified.

Print documents are useful for those who are literate. And they decided that internet is the least preferred method, because people do not know how to use the internet.

All right. So I'm going to switch gears for a moment to talk about our health passport that we use in Colorado and then finish up by showing how we evaluated the passport in the focus groups.

So our health passport is really a very simple tool. But it's given to each refugee, individual or family after their refugee screening. And we are able to do that because we screened such a large portion of the refugees coming to Colorado. We have been able to give them also to our northern and Southern Colorado Partners and we've made them specific to those locations.

It acts as both an organizational and resource tool for health access and follow up. And it's customized for each family or individual based upon their follow-up health needs and their primary care provider location. And it's made up in the flexible three-ring binder so the documents easily fit inside and they include the pocket folder dividers and a business card holder.

And we recommend to families that they bring the notebook with them every time they see a medical provider. So we go through each page of the notebook with family members so they understand what is inside and how it's to be used.

And on the first page there is a demographic page which people can use if they are having a difficult time communicating their address, telephone number, date of birth or language information to clerical staff at their primary care clinic.

And we find this information can be difficult to communicate for patients and, even if the follow-up health facility is using an interpreter. And then next we document all of the follow-up appointments we have scheduled for the family and place it on one page so they don't forget these appointments. And we have seen that some people will stick these to the refrigerator or at least have one place to come back to and review.

We provide information about the primary care provider and dentists that they will be going to for ongoing care. And this includes a picture of the location so that they have an idea of what the building looks like. And we also included a detailed bus route which we write out and explain in the easiest terms possible so that the clients can try to make the bus route on their own.

And we provide toothbrushes and dental education information that we received from our state's preventive dental care department. And we place the immunization records inside the passport. And then we have a large resource section which has been translated to the patient's language.

And this section includes information on common medical phrases, instructions on how to make an appointment, mental health information, WIC information, went to call 911, information about Medicaid and applying for the green card, some dental information and other important phone numbers such as nonemergency police and transportation.

And if anyone's interested in seeing these pages in detail, I will be happy to share them with you. We have been trying to make them as non-Colorado specific as possible so that they can be shared with other states or where there is Colorado-specific information it could be easily replaced with your information.

So during our focus groups, we wanted to see how people were using the health passports. We've frequently seen people carrying them around and bringing them to our office, but we weren't sure exactly which resource pages were most useful, which parts were not being used all and if there were any suggestions for additions or changes.

We gave each participant in the focus group then a copy of the health passport and had them sticker with either a smile or a frown each part. And a smile meant that they liked it or had used this part of the passport in the past and a frown meant that it was not useful, confusing or needed changes.

And we found that all groups liked receiving the passport and that helped them keep documents safe, organized and in one location. We had very few people say that they had never used it. So that was good results. They reported taking it with them to ongoing medical appointments.

They say that some physicians do refer to previous documents, which can help sort out if a patient is being seen by multiple providers or at multiple locations which is a problem we've had in the past.

It helps patients understand when their upcoming appointments are, where to go and they especially really like having a photo of the building they will be going to. And the most resource pages are being used by a literate family member or friend, even if all family members aren't literate.

Some of the things we're looking to change are adding more photos due to lack of literacy, reducing the amount of writing on some of the pages to make them as clear and concise as possible and increasing the education by our staff that it's provided to refugees and especially on the resource section and how each page can be used, increasing the print size.

And then many people wanted us to change the size of the passport so that it can easily fit into someone's purse, but we have been going back and forth on that just because most documents are 8 1/2 by 11. And so I think we're really have to think about what the purpose of it is and how it should be used.

So this brings me to the end of my presentation. I think evaluating our services or practices can be one of the most difficult things that we have to do and I think Liz noted this at the very beginning, but it's important to ensure we're reaching the population we service with their buy in.

So this is what our focus groups were kind of our first attempt to do. Thank you very much for your time and if anyone has any further questions, please do not hesitate to contact me.

Jennifer Cochran: Great. This is Jennifer. And I'm going to have Liz join me now to kind of pose some questions. There have been a number of questions that are coming through and I am going to let Leslie catch her breath. Because there were a few about more information on the health passport. But I'm going to back up to an earlier question that came in around the community health worker models.

Actually, let me also just say again thank you to each of the presenters. I think there was a lot of information that you gave to us.

So, and this is really for around the IRC program and, you know, I think there are a lot of different community health worker models that are out here and programs and the question that came is how does the community health worker program then integrate with refugee resettlement agencies, or in this case this is an IRC-based program as well as the healthcare system? I don't know if...

Liz Edghill: I'm on the line.

Jennifer Cochran: Do you want to take that?

Lauren Schroeder: So our program is within the IRC. So we're housed in one of the refugee resettlement reorganizations. The grants, we always write our grants to serve all refugees in Tucson regardless of which organization they came through

and we have three in Tucson, Lutheran and Social Services and Catholic Community Services are here as well.

So we see all newly-arriving women as they come in. And so I'll get referrals from the case managers to send a promoter there, if we have a promoter who speaks - who shares the same language and ethnicity with them. And within, we're not as integrated into the actual healthcare model, as some other community health worker programs are.

Like some community health workers are based in actual clinics and do more patient advocacy and navigation type services. And that's not where we are at, though our promoters do work with the newly-arriving women to help them understand, you know, how do you speak with your doctor? How do you ask for translators? How do you ask for different translators? How do you schedule appointments?

So more working with them specifically around navigation. In Arizona, we can use Medicaid program offers taxis to take Medicaid patients to their appointments. And so, but you have to call and go through a series of prompts to get these taxis. So how do you do that?

And so it's, so for us, integrating as a health care system with the promoters is more about helping kind of having a friend or a mentor show you how to work through our very complex system that we have here and which clinics there are and where they're located and that. Does that help? Does that answer your question?

Jennifer Cochran: Well, I hope so. They're muted now. There's a follow-up question here too, though, about the community health worker program. And that is do you find that through the women you are able to reach refugee men as well?

Lauren Schroeder: Sure, and a lot of cases, if the men are home, they'll sit in, they'll be with their wife or sister or aunt or whatnot. And so while it's directly a woman-to-woman program, but it's not limited to that. And so we'll often be, or sometimes if the husband is the one who can speak English, he might be the

one who can call the taxi for the clinic. So then the promoter will help kind of help him through that.

And so, while it's directly women-to-women, it also goes into the whole family.

Jennifer Cochran: Great. Before I move to the next question, I want to step back for a minute and let everyone on today's Webinar know that on the Refugee Health TA Web site, so it's again refugee health, actually it's right up here, refugeehealthta.org, there is also an area called community dialog, and at this time under community dialog, if you click on that, you'll see there's a health orientation dialog that's up and running.

And you are welcome, encouraged, strongly encouraged to jump in with comments on that as well and continue this conversation there. This is, you know, it's like a chat function. You don't have to register. But do offer up ideas about community orientation and pose questions to people beyond just our presenters who are here today. Again, I encourage you to go there.

I have a question that's come in that I think is really for Lauren, I'm sorry, for Marla and Leslie, because Lauren covered how her program is funded in Tucson. And so that's for the others, for Marla and for Leslie, how are your programs funded? How have you been able to put together some of the work that you've been doing?

Marla Lipscomb: This is Marla and I can go ahead and answer for our program. For the mental health orientation that I provide at the Boise's English Language Center, it's a partnership here in Boise supported by Idaho Office of Refugees and all three resettlement agencies, IRC World Relief Agency for New Americans. All of their new arrivals attend this week-long orientation at the English Language Center.

So the providers that come in participate in the orientation are providers across the community from specialty areas and it's all in kind. So we just provide that time as part of just a community response to orientation.

Jennifer Cochran: Can I ask a follow up for you again? This is Jennifer.

Marla Lipscomb: Sure.

Jennifer Cochran: And that is how long the mental health orientation is?

Marla Lipscomb: So currently at the English Language Center, it's around an hour. Sometimes it goes over. Often it goes over. So ideally, I would love to have like a two-hour mental health orientation, I think would be the ideal time with a break halfway in between, and then to come back and have the second hour be more focused on resettlement stressors, strings, coping mechanisms. I think that would strengthen the model even more.

Leslie Hortel: And then this is Leslie, and our resource center and all education programs are funded through an OR preventative health grant. And then we have a lot of in kind donations for some of the materials for the health passport and I think that's it.

Marla Lipscomb: I was just going to add also one of the goals for our program here in Boise is to roll out more of a community health worker program with health orientations as part of the program. So we do have some grant funding both through St. Alphonsus Hospital through our foundation grant, and then also a grant that's going to help fund some health advisor community health worker programs.

So that's hopefully going to help fund some more community-based mental health orientations that will be an ongoing process throughout the stages of resettlement.

Jennifer Cochran: Great. Leslie, there have been lots of questions about how to access a copy of that passport tool. Is that online anywhere? Can it be...

Leslie Hortel: Sure, actually, it's not online anywhere that I know of and because we just did our focus groups in February, we're in the process of making some updates, the ones that I discussed. So as soon as we're done updating them and then

we'll have to get some things retranslated, I'll be happy to post them and I'm not sure if I can do that on the RHTAC site, Jennifer?

Jennifer Cochran: Sure, sure, sure, yeah.

Leslie Hortel: Okay. So I'll post them on the RHTAC site with the current Webinar.

Jennifer Cochran: There's also questions about if the health passport is in English only or if there are translations that are done?

Leslie Hortel: It's been translated to our top ten languages, Swahili, Burmese, Somali, Nepal, Amharic, Arabic and Keren, I think I might have, and French. So we do have it in those languages.

And I also wanted, there was one question also about privacy issues. So I wanted to talk quickly about that too. And we do ask families if they would like their binder to be together or if they would like separate ones. And most I've only very few families said that they would like separate ones. And the only personal information that we put in there is their immunization record, which we also get permission to put in there.

So that is the only information that's shared. Otherwise, if there's any sensitive information, someone brought up like HIV status or if someone has a mental health concern or domestic violence, none of that information we put into the passport.

And so it's actually like a very general book when they walk away with it, and then we just let them know that it's their choice what type of medical records that they'd like to put in their for organizational purposes.

Jennifer Cochran: Leslie, there was also a question about who puts the passport together.

Leslie Hortel: Well, we have student volunteers from a local high school. They're like a volunteer committee that come in and put the general passport group

together. And so we just provide snacks and beverages for them and they will come put together hundreds of them at a time.

And then myself and my coworker who are the two health educators in our clinic, we individualize them on a weekly basis for the clients that we're seeing. So it's part of our job role.

Jennifer Cochran: Great. Let's see. I'm looking through the questions are coming. So keep - we have another five minutes or so to take questions. I'm going to go back to, there are, again, a couple of the community health worker questions were around community health workers in refugee home countries, community health workers in camps, and Lauren, if you had any comments.

I think you touched on this a little bit when you opened your talk, but if you had any more information on community health workers or what they may be called in camps. I know that there were some people go by different job titles here as well as overseas.

Lauren Schroeder: Yes, there's lots of different names for them. They have been using the camps. And sometimes they're called lay health workers and along the border in Spanish-speaking countries, they're usually promotoro de salud. They're home educators, home health educators. They go by many titles. But they are used all over the world and in refugee camps.

And I think, I believe one of the resources that will get posted on the RHTAC Web site that I gave is a report by the World Health Organization on the use of community health workers all over the world. So that can give a little more insight on where they're being used and kind of in what capacity they're being used. Yes.

Jennifer Cochran: Great. And in camps too, they're sometimes specialized. There may be...

Lauren Schroeder: Yes, so...

Jennifer Cochran: ...a health worker who's specializing in maternal child health...

Lauren Schroeder: Prenatal care or, right. Sometimes there - or water and sanitation. Yes, sometimes it's not - sometimes it's on a variety of health topics, it's one specific health topic that needs to get - whether it's around water and sanitation or a lot of, yes, prenatal health, well child, baby weighing and that sort of thing. So sometimes it will be a targeted health initiative rather than a general one.

Jennifer Cochran: And are you often looking for people who've been in those roles to become community health workers?

Lauren Schroeder: Yes. If they have, actually, I think about half of my current promoters were doing some - were doing some sort of kind of health work or community health work in the camps that they were in. And so that's great. There's, some people say that you can't make a health worker, that a health worker is born, a community health worker. So you kind of look for those traits in people.

Jennifer Cochran: Good. A question that just came in, it's continuing in this theme. And so it's from someone who says, I'm with a resettlement organization that will likely begin a new outreach and education program in the fall. I think the idea of building a promoter network seems essential, but other than that, what do you consider to be a necessary first step, or several first steps, of starting a program like this?

Lauren Schroeder: I'd say, you know, start with the what role you want the promoters or educators, whatever your title is going to be, what you would like them to be and do you want to target a specific health topic? Do you want them to be more navigators? Do you kind of what role do you see them in?

We do have them in a pretty general kind of well-being role and a lot of it focuses on systems navigation and self-advocacy, which then goes into the health forum and then see who you - what ethnic groups do you need represented, because, you know, we can't cover all of them that come in, but, you know, our main groups.

And then, you know, look for funding sources, if they're going to be funded. Traditionally, a lot of community health workers are actually volunteer or start out as volunteers. So that is one option and then once you're a little more established, looking into funding options around that.

And then where, who's going to do training, where you're going to do the training for them, and what support they'll need once you have it going, what kind of staff you need to support them once they're in the field in the roles they're doing.

But I'd say definitely start with - also then identifying who the promoters would be and when we do that we often go to the mutual assistants associations, see who the community leaders are, who are the trusted members in the community, and going through identification through those sources within the community.

Jennifer Cochran: Great, thank you. I think I'm ready to pose one more question that's here. And it's, maybe I'm going to give it to Liz. I don't know. It was really great to hear both Lauren and Leslie talk about evaluation.

But, I don't know, Liz, if you know about other health orientation programs that have been evaluated, how evaluation is done, or are other countries that have a large resettlement populations doing health orientation as well and how are we cross learning with those?

Liz Edghill: Well, I wish that I had an answer. I've been looking at that same question and trying to think of a good answer. But I think that that's one of the reasons we wanted Leslie to actually present today about the focus groups that they did, because that was such a unique way and important way to evaluate what they were already trying to do and to get feedback on what refugees really perceive as the most important topics.

I really love the idea just of the question your friend has just arrived in the U.S., what are the three most important topics they need to know about as a way of shaping.

So we've had this question come up and I'm not sure that there are a whole lot of folks who've done formal evaluations and I hope that I'm wrong and that somebody out there in the audience has done this also and will share with us maybe via the RHTAC discussion that goes on after this Webinar.

But it is, you know, if I listed it under one of the challenges of providing health orientations. I think when time becomes so limited, like I find myself for example doing a general health orientation at the resettlement agencies here in Louisville and it can easily go to an hour and a half.

And that's a long time for folks that have already had ESL classes or are in the middle of their ESL day and are probably being carted around to Social Security offices and other places. And so there's that whole question of retention and what they're able to absorb and then do I want to give up time to do a formal evaluation within each orientation which would probably be ideal.

But that being said, everyone's always saying, will you cover this in health orientation? Or we're seeing this all the time. Will you add that in? And so the list gets kind of endless. So I encourage any folks out there who have done the evaluation piece or who have some ideas about it or seen any research to please add that on our discussion board.

Jennifer Cochran: Great, thank you. So I think with that, we will again thank our presenters from today, Liz Edghill, Lauren Schroeder, Marla Lipscomb and Leslie Hortel. Thank you so much for your presentations, for taking questions. I think you've given many of us so much to think about in terms of strategies and approaches to health orientation domestically.

Again, I want you to consider going back onto the refugeehealthta.org to also look at the December orientation Webinar if you didn't join that one live. That

is posted there as well. And we thank our colleagues at the Cultural Orientation Resource Center for their work putting together that Webinar.

And again I would like to thank the Office of Refugee Resettlement for their support in making today's Webinar happen. Thank you very much. Stay in touch. And do join that community dialog as well.

Leslie Hortel: Thank you.

Operator: Thank you, ladies and gentlemen, that does conclude the Webinar for today. We thank you all for your participation and we ask that you please disconnect your lines. Thank you and have a good day.

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