REFUGEE HEALTH
TECHNICAL ASSISTANCE CENTER

WELCOME

You are attending the webinar

Making CLAS Happen

Wednesday June 18, 2012
12:00-1:30pm EDT

presentation will begin shortly

Access Code: 6166957

For assistance please call ReadyTalk customer support: 800-843-9166

Webinar Overview

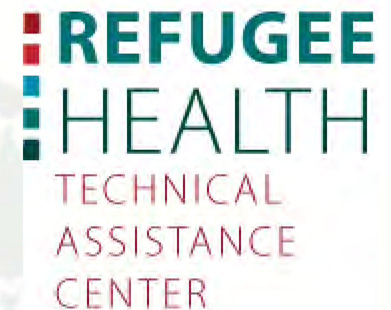
- Presentations (60 minutes)
- Q&A via Chat Window (15 minutes)
- Slides, webinar recording, Question and Answers, and additional resources will be posted to http://refugeehealthta.org after the webinar
- Email refugeehealthta@jsi.com if you have any questions after the webinar

Co-Sponsors

Refugee Health Technical Assistance Center (RHTAC), funded by HHS, Administration for Children and Families, Office of Refugee Resettlement (ORR)

Multicultural AIDS Coalition, supported by the New England AIDS Education and Training Center (NEAETC) Minority AIDS Initiative, funded by HHS, Health Resources and Services Administration, and sponsored regionally by Commonwealth Medicine, UMASS Medical School, Worcester, MA

Massachusetts Department of Public Health, Office of Health Equity, with support from HHS, Office of Minority Health



Objectives

1. Summarize the six areas of action in the Making CLAS Happen Manual.
2. Explore the impact of biases, stereotypes, prejudices, xenophobia and racism on policies, practices, and norms within a clinical setting.
3. Identify key reasons for implementing culturally and linguistically appropriate services (CLAS) from service, financial and legal perspectives.
4. Identify successful strategies for implementing the CLAS standards in clinical settings.

Presenters

- **Georgia Simpson May:** *Making CLAS Happen*
- **Dr. Eric Hardt:** *Culturally Competent Health Care: Some Thoughts for Providers*
- **Dr. Mothusi Chilume:** *Providing Culturally and Linguistically Appropriate Services: Case Study*
- **Sue Schlotterbeck:** *CLAS and Health Literacy at Edward M. Kennedy Community Health Center*
- **Barbara Nealon:** *CLAS and Community Partnerships*

Continuing Education Credits

- MASSACHUSETTS ONLY. This is an educational program directed to practicing professionals. Attendees should only claim credit commensurate with the extent of their participation in the activity.
- **Policy on Faculty and Provider Disclosure:** It is the policy of the University of Massachusetts Medical School to ensure fair balance, independence, objectivity and scientific rigor in all activities. All faculty participating in CME activities sponsored by the University of Massachusetts Medical School are required to present evidence-based data, identify and reference off-label product use and disclose all relevant financial relationships with those supporting the activity or others whose products or services are discussed. Faculty disclosure will be provided in the activity materials.

Evaluation

- Appears in your internet browser after webinar ends (please stay logged in!)
- Also available via email if you logged in from your RHTAC invitation
- Required for MA professionals receiving CME or CE for nurses and social workers.
- Strongly encouraged for everyone – we learn from the evaluations!

THANK YOU!

Making CLAS Happen

The Federal Culturally and Linguistically Appropriate Services (CLAS) Standards

Presented by Georgia Simpson May
Director, Office of Health Equity
Massachusetts Department of Public Health

This Presentation

One → **How did we get here?**

- *The 1985 Heckler Report*
- *Unequal Treatment*-Institute of Medicine, *2002*
- *Unnatural Causes: Is Inequality Making Us Sick? California Newsreel –2008*

Two → **Defining cultural and linguistic competence**

Three → **Why CLAS?**

Four → **The CLAS Standards**

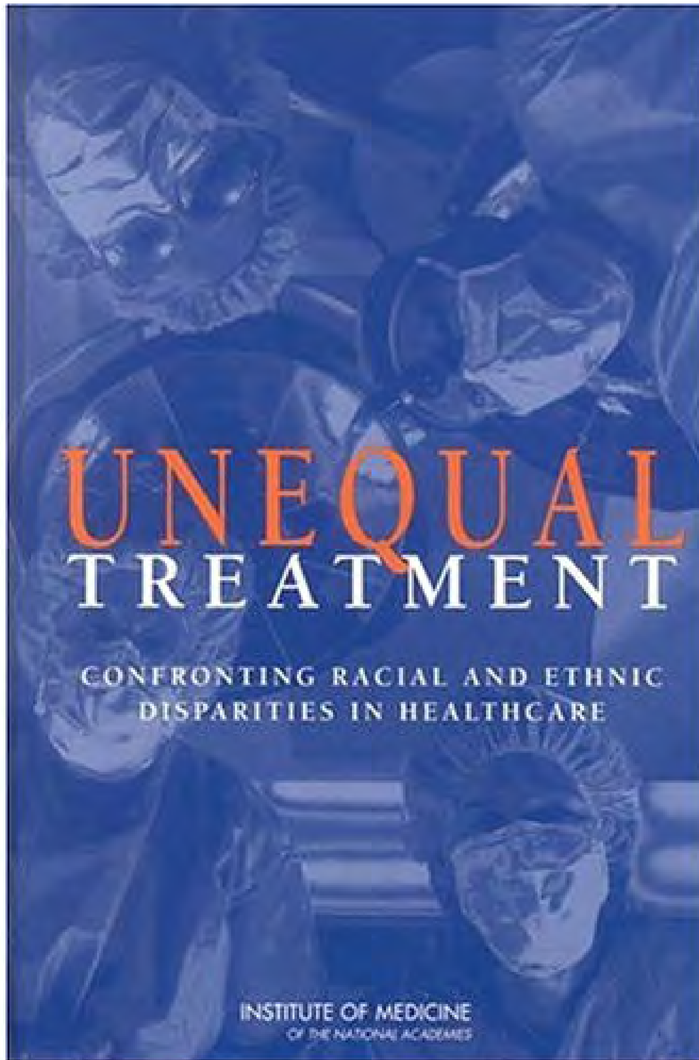
Five → **Got CLAS?** *Making CLAS Happen* – an MDPH Office of Health Equity resource to delivering appropriate services

The 1985 Heckler Report

"Perspectives in Disease Prevention and Health Promotion Report of the Secretary's Task Force on Black and Minority Health"

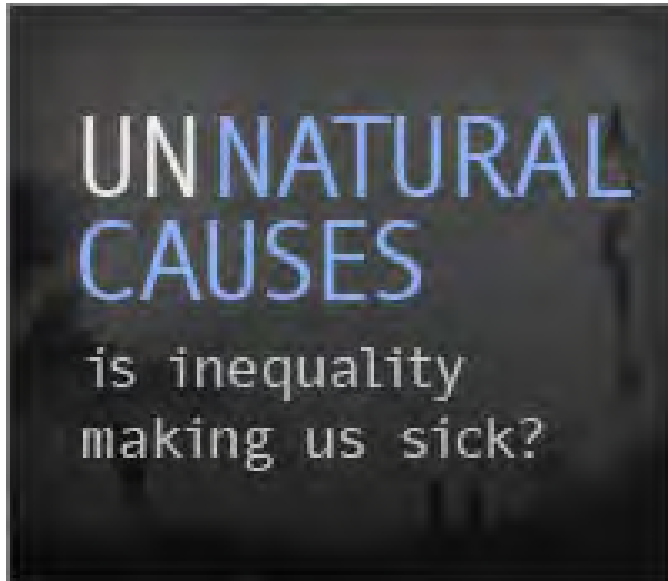
(CDC, Morbidity and Mortality Weekly, February 28, 1986 / 35(8);109-12)

Institutes of Medicine



U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services.

But why?



California Newsreel, 2008

- How can class and racism disrupt our physiology?
- Through what channels might inequities in housing, wealthy, jobs, and education, along with a lack of power and control over one's life, translate into bad health?
- What is it about our poor neighborhoods, especially neglected neighborhoods of color, that is so deadly?
- How are the behavioral choices we make (such as diet and exercise) constrained by the choices we have?

Cultural and linguistic competence…

giving it meaning

(Adapted from Cross, 1989)

"Is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."

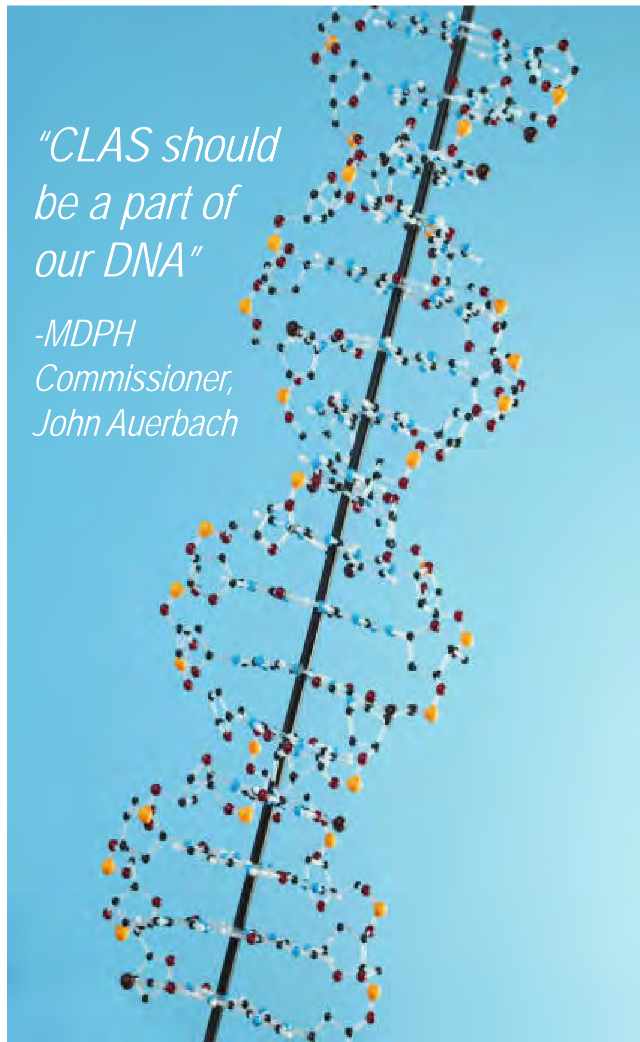
'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Why CLAS Standards?

- Contribute to the elimination of health disparities and to promote health equity
- Make services more responsive to the individual needs of people
- Inclusive of all cultures, but designed to address the needs of racial, ethnic, and linguistic population groups

Why Integrate CLAS Standards?



- There are significant racial and ethnic health disparities that we must eliminate
- Federal mandates
- Opportunity for Continuous Quality Improvement (CQI)

The 14 CLAS Standards…*At A Glance*

Three Categories

Mandates	Guidelines	Recommendations
Current Federal requirements for all recipients of Federal funds	Activities recommended by OMH for adoption as mandates by Federal, State and National accrediting agencies	Suggested by OMH for voluntary adoption by health care organizations

Three Themes

Culturally Competent Care	Language Access Services	Organizational Supports for Cultural Competence
Standards 1 – 3	Standards 4 – 7	Standards 8 – 14

Culturally Competent Practice

Standards 1 – 3 (Guidelines)

1. Respectful care compatible with cultural health beliefs
2. Strategies to recruit, retain and promote a diverse staff
3. Ongoing training on culturally and linguistically appropriate service delivery

Language Access

Standards 4 – 7 (Mandates)

4. Language assistance services, including staff and interpreter services
5. Written offers to provide Language Access
6. Trained interpreters provided – not family and friends
7. Easily understood materials and signage

Organizational Supports

Standards 8 – 14 (Guidelines)

8. Written strategic plans
9. Ongoing CLAS Self-Assessments
10. Race, ethnicity, and language data in health records
11. Demographic, cultural and epidemiologic profiles of the community
12. Partnerships with communities
13. Grievance policies in place
14. Public notice about CLAS advancements (recommendation)

Making CLAS Happen: Six Areas for Action

Making CLAS Happen aims to guide agencies of all sizes as they put CLAS standards into action.

Making CLAS Happen

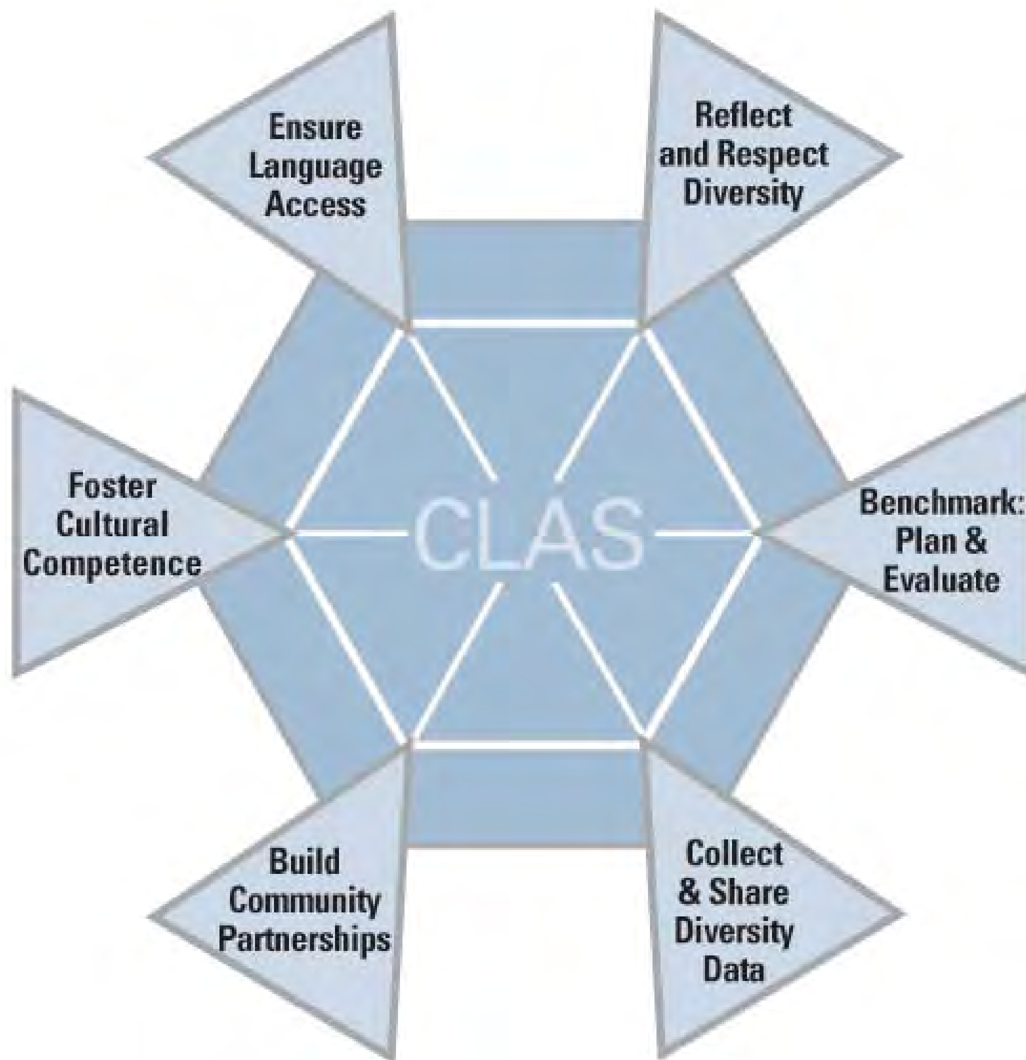
Six Areas for Action

A Guide to Providing *Culturally* and *Linguistically Appropriate Services* (CLAS) in a Variety of Public Health Settings

Massachusetts Department of Public Health—Office of Health Equity

September 2009

Six Areas for Action



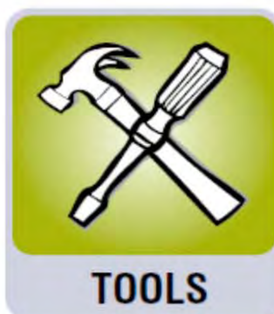
Offers a model for developing a strategic approach to becoming *CLASier.*

Presents CLAS challenges and solutions.

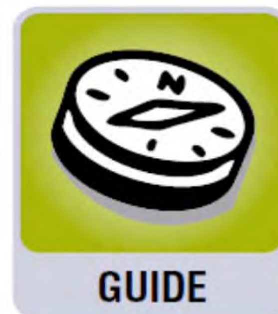
Provides useful information on collecting race, ethnicity, and language data.

To quickly find information, look for the following common elements, and their icons, in each chapter:

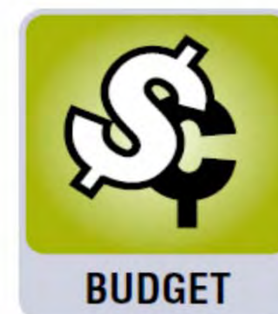
Laws
State and federal laws and guidelines for culturally competent services



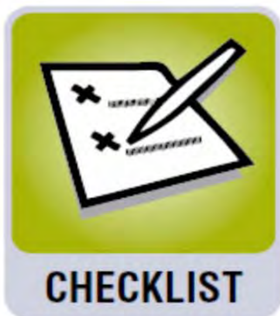
Tools
Templates, helpful links and resources; found at the end of each chapter



Guide
A step-by-step approach to improving cultural competence in each area of action

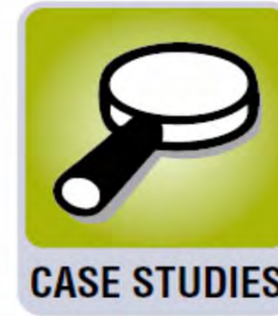


Budget
Strategies to meet growing CLAS requirements with limited resources



Checklist
Suggested ways to meet CLAS-related Request for Response (RFR) and contract requirements

Field Lessons
Ideas and best practices in culturally competent services from Massachusetts public health professionals



Case Studies
Highlights of practical applications of CLAS standards by Massachusetts agencies

Making CLAS Happen: Six Areas for Action

The CLAS Standards moving forward

CLAS Standards Enhancement Initiative

US DHHS, OMH

	National CLAS Standards 2000	National CLAS Standards 2012
Goal	To decrease health care disparities and make practices more culturally and linguistically appropriate	To advance health equity, improve quality and help eliminate health and health care disparities.
Culture	Defined in terms of racial, ethnic and linguistic groups	Defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics
Audience	Health care organizations	Health and health care organizations
Health	Definition of health was implicit	Explicit definition of health to include physical, mental, social and spiritual well-being
Recipients	Patients and consumers	Individuals and groups

- MDPH Office of Health Equity - *Making CLAS Happen*
  http://www.mass.gov/dph/healthequity and go to "Quick Links"
- U.S. OMH CLAS Executive Summary
  http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf
- 1985 Heckler Report
  http://www.cdc.gov/minorityhealth/reports.html#Heckler
- Institute of Medicine of the National Academies
  http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx
- California Newsreel, Unnatural Causes
  http://www.unnaturalcauses.org/
- Think Cultural Health
  www.thinkculturalhealth.hhs.gov

Culturally Competent Health Care: Some Thoughts for Providers

Eric Hardt MD eric.hardt@bmc.org
Associate Professor of Medicine, BUSM
Geriatrics Section, Boston Medical Center
Medical Consultant to Interpreter services, BMC

Why Do Providers Contribute to Disparities and What Can Be Done?

- **Strange juxtaposition of egalitarian attitudes and discriminatory behavior**

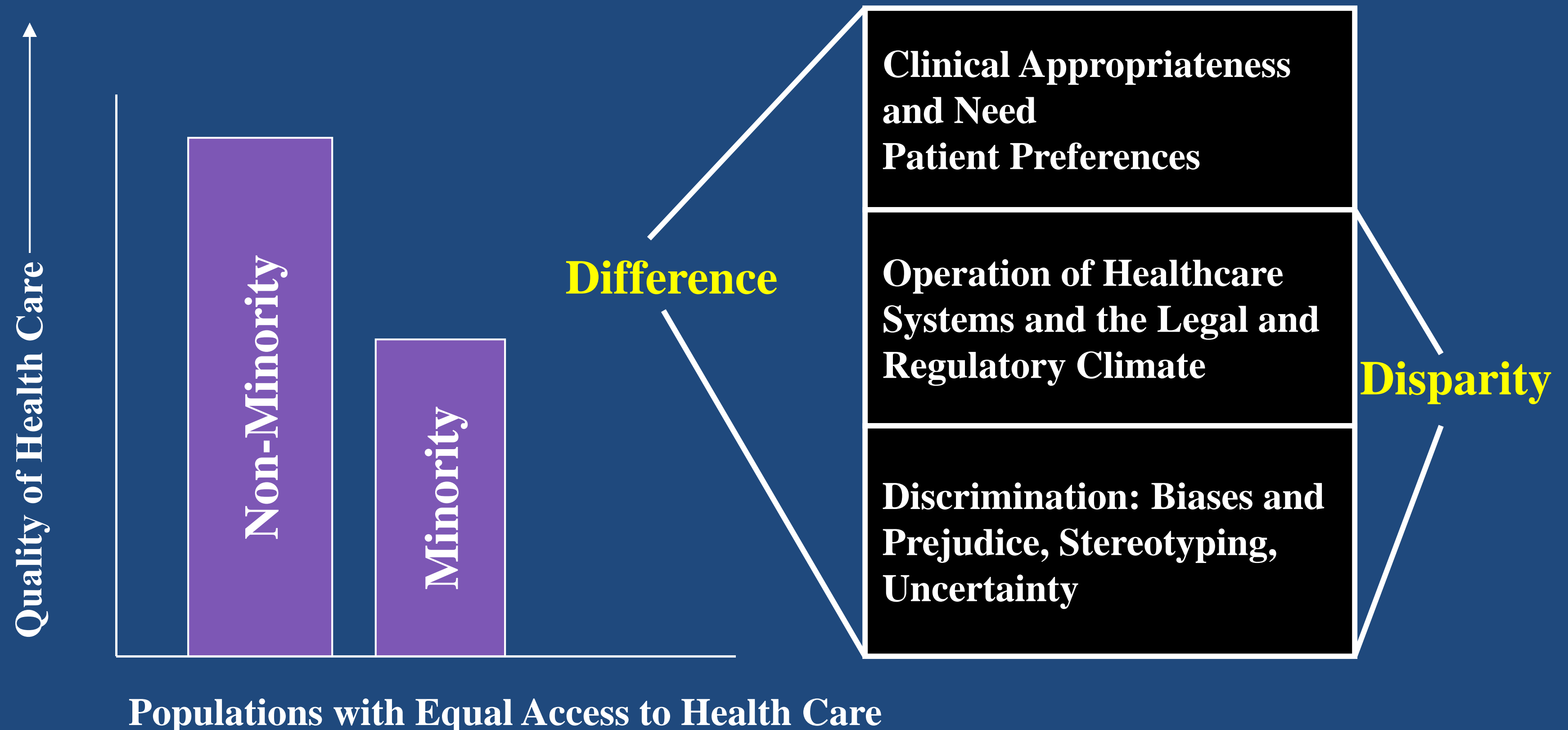
- **Unintentional disconnect between provider's desire to provide equal treatment and actual clinical decisions influenced by race/ethnicity/SES**

- **Automatic, subconscious thoughts and feelings can take over when we are busy, tired, anxious, or under pressure**

Diana Burgess, Steven Fu, Michelle Van Ryn. Jour Gen Int Med 2004; 19: 1154-9.

Potential Reasons for Disparities in Health and Health Care

Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care



Source: Gomes, C. and McGuire T.G. 2001. Identifying the sources of racial and ethnic disparities in health care use. Unpublished manuscript cited in: IOM,. 2002. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Smedley, B., A. Stith and A. Nelson, eds. Washington DC: National Academy Press

Milton Bennet's Model of Cultural Competence

- DENIAL: deny differences, promotes social isolation
- DEFENSE: acknowledges differences, threatened by them
- MINIMIZATION: trivializes differences; similar means "like me"
- ACCEPTANCE: differences recognized, valued, respected
- ADAPTATION: skills in communicating across differences, can take on the other's point of view, stand in others' shoes
- INTEGRATION: values a variety of cultures, integrates aspects of own culture with those of others, defines behaviors and values in contract to and in accordance with other cultures

Bennet M, Int J Cult Relations 1986

Cultural Self-Awareness

- <u>Consider own ethnic, racial, religious, cultural roots</u>; enumerate the positives and negatives
- <u>Explore personal bias, stereotypes, assumptions</u>; recall own experiences with difference/discrimination
- <u>Examine personal cultural nooks and crannies</u> [family, sex, religion, food, hygiene, health, death, money, education, emotion, etc.] until they begin to reveal their unique and arbitrary features
- <u>Commit to contact with and study of other cultures</u>; don't be afraid to talk about it

E Hardt 2000

IOM Classification of Root Causes of Racial/Ethnic Disparities

- **Health System-Level Factors:** issues related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited English proficiency.

- **Care-Process Variables:** These include issues related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication.

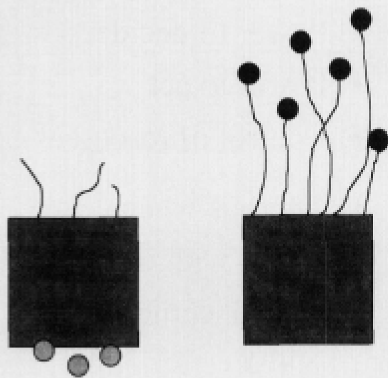
- **Patient-Level Variables:** These include patient's mistrust, poor adherence to treatment, and delays in seeking care.

Institute of Medicine Report on Unequal Treatment 2002

Levels of Racism: A Theoretic Framework and a Gardener's Tale

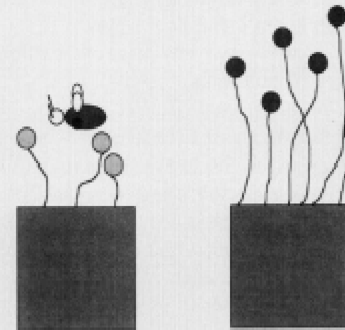
Camara Phyllis Jones, MD, MPH, PhD

Personally mediated racism



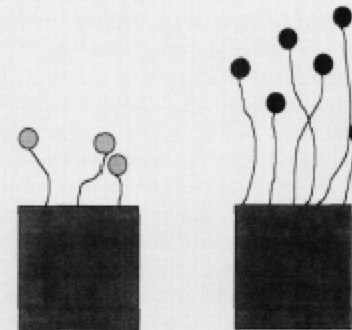
- Intentional
- Unintentional
- Acts of commission
- Acts of omission
- Maintains structural barriers
- Condoned by societal norms

Internalized racism



- Reflects systems of privilege
- Reflects societal values
- Erodes individual sense of value
- Undermines collective action

Institutionalized racism



- Initial historical insult
- Structural barriers
- Inaction in face of need
- Societal norms
- Biological determinism
- Unearned privilege

Jones CP. AJPH 2000

Key Issues of Race for American Health Care Providers

- Special case of white-on-black racism despite many other varieties of racism [NA, API, Hispanic]; US system operates to create power differential for whites
- Race is a taboo topic despite omnipresent prejudice, bias, stereotyping, and discrimination
- Issues active for all types of professional and non-professional staff
- Emotional reactions to issues: e.g. guilt and fear for whites, anger and embarrassment for blacks
- Widespread denial: “ I’m not a racist, but…”, “I’m black and I’ve been successful…”

E Hardt 2005

Trends in Opiate Prescribing by Race/Ethnicity for Pts in US EDs

- 156,729 ED visits with pain 1993-2005
- White pts more likely to receive opioids than non-whites for all levels of pain
- Differential prescribing by race/ethnicity was evident for all types of pain visits, more pronounced with increasing severity, and was detectable for long bone fractures and nephrolithiasis as well as among children

Pletcher et al JAMA 2008

Possible explanations

- Black patients feel pain less [biological difference]
- Black patients are less likely to ask for pain meds [cultural values, internalized racism]
- Doctors have more trouble recognizing pain in Black patients [cultural incompetence]
- Doctors are subconsciously more reluctant to prescribe opiates to Black patients because they are Black [paternalism, personal racism]

E Hardt 2008

"We Don't Carry That"--Failure of Pharmacies in Nonwhite Neighborhoods to Stock Opioids

- 72 % of pharmacies in white [> 80% white] neighborhoods had adequate supplies,

  vs. 25 % in nonwhite [< 40% white] neighborhoods

- 2/3 of the pharmacies with no opioids in stock at all were in nonwhite neighborhoods

Morrison RS et al NEJM 342: 1023-26, 2000

Can patient coaching reduce racial/ethnic disparities in cancer pain control?

- Minority patients with cancer experience worse control of their pain than do their white counterparts.
-
- 67 cancer PTs, including 15 minorities, with moderate pain, randomly assigned to experimental or control . Control group received standardized information on controlling pain.
- Experimental PTs received a 20-minute individualized education and coaching session to increase knowledge of pain self-management, to address personal misconceptions about pain Rx, and to rehearse an individually scripted PT-MD dialog about pain control.

Kalauokalani D et al. Pain Med 2007: 8[1]; 17-24

Can patient coaching reduce racial/ethnic disparities in cancer pain control?

- Results: At enrollment, minority PTs had more pain than whites (6.0 vs 5.0, P = 0.05).
- At follow-up, minorities in the control group continued to have more pain (6.4 vs 4.7, P = 0.01), in the experimental group, disparities were eliminated (4.0 vs 4.3, P = 0.71). The effect of the intervention on reducing disparities was significant (P = 0.04).
- Conclusions. Patient coaching offers promise as a means of reducing racial/ethnic disparities in pain control. Larger studies are needed to validate these findings and to explore possible mechanisms

Kalauokalani D et al. Pain Med 2007: 8[1]; 17-24

We Have Health Care Disparities Related to Language Barriers

Satisfaction

Access

Utilization of Health Care

Quality of Care

Costs

Cross-cultural Issues in Bilingual Medical Interviews

- Cross-cultural issues active in all encounters, but
- Presence of language differences [“barriers”] may indicate the presence of more obvious cultural differences **AND/OR**
- Presence of language differences may make the explanation/understanding/resolution of these differences more challenging

E. HARDT 2004

Roles for Medical Interpreters in Relation to Cultural Issues

- Conduit which the culturally competent provider may use as a technical tool to explore differences in health related beliefs and behaviors
- Expanded role that includes explanation of features of medical and of patient culture and brokerage of relationships between patient and provider
- IN EITHER CASE THE PRIMARY RESPONSIBILITY OF THE INTERPRETER IS TO FAITHFUL TRANSMISSION OF MESSAGES

E. HARDT 2004

Title VI of the 1964 Civil Rights Act Language = National Origin

- **Federal courts and agencies have interpreted discrimination by national origin to include language.**
- **No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance**

PROVIDERS MAY NOT:

- Provide service to LEP clients that are more limited in the scope or that are lower in quality than those provided to other persons
- Subject a LEP client to unreasonable delays in the provision of services
- Limit participation in program or activity on the basis of English proficiency
- Provide services to LEP persons that are not as effective as those provided to others
- Require a LEP client to provide and interpreter or to pay for the services of an interpreter

OCR

Guidelines for the Bilingual Medical Interview

- **Always use an interpreter unless fluent in the patient's language, ideally a trained professional rather than an *ad hoc* interpreter.**
- **Try to match the individual interpreter to the individual patient and clinical setting. Reassure regarding confidentiality.**
- **Avoid technical terms, jargon, lengthy explanations without breaks, ambiguity, abstraction, figures of speech, and indefinites phrases.**
- **Use clear statements planned in advance with language appropriate for the interpreter and plan to spend as much as twice the usual time.**

Guidelines for the Bilingual Medical Interview

- Be prepared to obtain information via narrative or conversational modes rather than through Western-style inquiry.
- Ask the interpreter to comment on non-verbal elements, the fullness of the patient's understanding, and any culturally sensitive issues.
- Learn basic language and common health-related practices and beliefs of patient groups regularly encountered.

Eric J. Hardt MD, adapted with permission from Putsch RW, JAMA 1985; 254: 3344-3348. Copyright 1985, American Medical Association

Remember

- **Individual variation within groups is often more important than variations between groups. Avoid stereotyping.**
- **Take extra time to listen to a patient about differences in point of view; try to get into his/her shoes. Our point of view is not the only valid one.**
- **Take language differences seriously and deal with them effectively. It's the law.**
- **Take personal responsibility for eliminating disparities based on race, ethnicity, religious traditions, language, and other differences.**

E Hardt 2007

Questions???
Email me at eric.hardt@bmc.org

Providing Culturally and Linguistically Appropriate Services: Case Study

Mothusi Chilume, MD, AAHIVS
Family and HIV Medicine
Whittier Street Health Center
Roxbury, MA

Case Study

- You are a provider working in a community health center in Roxbury, MA
- The community health center serves a mostly minority population from the neighborhood
- The clinic also provides care for a large immigrant population from countries such as Somalia, Uganda and Ethiopia

- You are the only provider working in the clinic's Urgent Care one Saturday afternoon
- RJ is a 38 year old male who is an immigrant from Ethiopia
- He can understand and speak some English, but is more comfortable communicating in his native language, Amharic

Case Study

- **What is the most appropriate way to proceed now?**
  - **A. Cancel visit and reschedule when someone who speaks Amharic at the clinic is available**
  - B. Use a certified interpreter through the language line available at your clinic
  - C. Refer him to another clinic where there are more Amharic speaking members of staff

- You offer RJ to conduct the exam with the assistance of the phone interpreting system which is available at your clinic

- He tells you that he prefers to use his friend, who is a certified interpreter instead

Case Study

- RJ reports that he has been having bilateral ear pain for a few months
- The pain has been getting worse in the last 2 weeks, and now he has trouble hearing from his left ear.
- He reports he is otherwise healthy and denies any other illnesses or taking any medications

- RJ vitals are all within normal limits

- Examination of his ears reveals significant bilateral cerumen impaction

Case Study

- As you prepare to conclude the visit, RJ discloses to you that he is HIV positive
- He desires to switch his care from the large clinic where he is currently getting care to a smaller clinic such as yours
- He is worried that his HIV positive status will be found out by someone from the large local Ethiopian community that go to his clinic

- RJ reveals that he was diagnosed with HIV in 2006, soon after arriving from his native country

- He has never been on medications due to being in denial about his diagnosis

- He has not disclosed his diagnosis to any family members. Only his friend who is interpreting for him knows about his diagnosis

- RJ is worried that if his diagnosis were to be discovered by members of his community it would destroy his status as a respected elder

Addressing RJs perception of stigma will play an important role in providing quality care for him

A. True

B. False

- **Conclusion**

CLAS and Health Literacy
at
Edward M. Kennedy Community Health Center

Sue Schlotterbeck
Director, Cultural and Language Services
Edward M. Kennedy Community Health Center
Worcester, MA

sue.schlotterbeck@kennedychc.org
www.kennedychc.org

"At Edward M. Kennedy Community Health Center, we help people live healthier lives."

EDWARD M. KENNEDY
Community Health Center

- Edward M. Kennedy Community Health Center in Worcester, MA
- We provide over 139,000 visits per year to over 24,000 patients
- Our staff speak 37 languages and come from 40 countries
- 77% of our staff are bilingual, of which 16% are trilingual
- Our patients speak 93 languages

2002 – committee to improve health equity and cultural competence
2010- subcommittee to address health literacy

Elements of a successful committee:

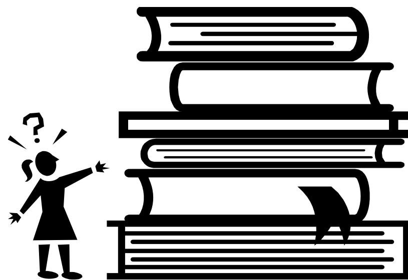
- Provider Champion(s)
- Diverse Team
- Work Plan
- Pilot Ideas (PDSA cycle)
- Communicate

EDWARD M. KENNEDY
Community Health Center

What is Health Literacy?

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Institute of Medicine, Consensus Report, *Health Literacy: Prescription to End Confusion.* 2004



Who Is At Risk?

90 million Americans
Few are truly illiterate, nearly half are at a disadvantage when it comes to the literacy demands of the 21st century. (National Center for Education Statistics, US Dept Education, National Assessment 2003)

9 out of 10 adults may lack the skills needed to manage their health and prevent illness. (National Assessment of Adult Literacy)

This includes many of *us* when we are sick or getting new information.

EDWARD M. KENNEDY
Community Health Center

EMKCHC Health Literacy Initiative

What we did:

- ❑ Assessed our practice
- ❑ Established priorities
- ❑ Increased staff awareness (newsletter articles, discussions)
- ❑ Improved our environment, spoken and written communication
- ❑ Integrated health literacy into policies and procedures
- ❑ Measured our success

EDWARD M. KENNEDY
Community Health Center

Health Literacy is a National Priority

- **CLAS Standards**
- **Patient Centered Medical Home (PCMH)**
- Healthy People 2020
- One of 11 Top Patient Safety Practices (AHRQ)
- Affordable Care Act (ACA)
- American College of Physicians Ethics Manual
- National Action Plan to Improve Health Literacy
- National Partnership for Action to End Health Disparities
- HRSA guidelines for announcing funding opportunities

CLAS standards contribute to the elimination of racial and ethnic health disparities. CLAS standards which relate to health literacy:

Standard 1*

Health care organizations should ensure that patients/consumers receive from all staff member's effective, **understandable,** and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 7**

Health care organizations must make available **easily understood** patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

***Offer care clients can understand.**

****Make available easily understood patient related materials and signage.**

Patient Centered Medical Home (PCMH)

NCQA* PCMH Standards relating to CLAS and Health Literacy. Examples:

PCMH Standard 1- Enhance Access and Continuity
Element F- Culturally and Linguistically Appropriate Services (CLAS)
Element G7- The Practice Team- training and designating care team members in communication skills

PCMH Standard 3- Plan and Manage Care
Element D- Medication Management
4. Assesses patient/family understanding of medications…

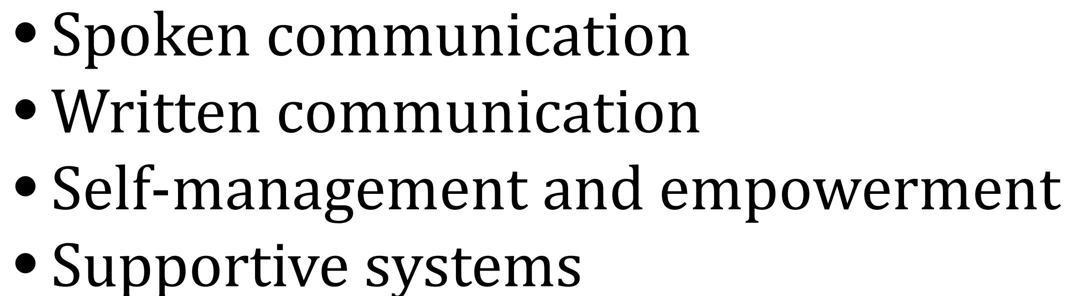
*NCQA- National Committee for Quality Assurance, standards to receive recognition as a PCMH

EDWARD M. KENNEDY
Community Health Center

Assessment

AHRQ Assessment, Provider Assessment, Health Environment Activity

Agency for Healthcare Research and Quality (AHRQ) Health Literacy Toolkit Health Literacy Assessment
http://www.ahrq.gov/qual/literacy/



49 Questions:

- Spoken communication
- Written communication
- Self-management and empowerment
- Supportive systems

EDWARD M. KENNEDY
Community Health Center

Provider Survey

What issues come up time after time in helping your patients understand and follow through on their treatment plan?

What causes you the most aggravation every day in your interaction with patients that relates to spoken and written communication?

2 components of health literacy:

- Literacy of individuals
- Literacy demands and expectations of health systems

Health Environment Activity Packet “First Impressions and A Walking Interview” by Rima E. Rudd
www.hsph.harvard.edu/healthliteracy

This exercise helps us to consider how to reduce literacy demands to better serve patients and clients.

AHRQ Health Literacy Universal Precautions Toolkit

20 tools to:

- **Start on the Path to Improvement**
- **Improve Spoken Communication**
- **Improve Self-Management and Empowerment**
- **Improve Written Communication**
- **Improve Supportive Systems**

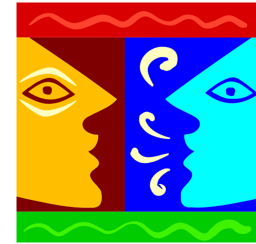
Tool 1: Form a Team
Tool 2: Assess Your Practice
Tool 3: Raise Awareness
Tool 5: The Teach-Back Method
Tool 11: Design Easy-to-Read Material
Tool 12: Use Health Education Material Effectively
Tool 13: Welcome Patients: Helpful Attitude, Signs, and More
Tool 14: Encourage Questions

EDWARD M. KENNEDY
Community Health Center

Examples of “Teach Back” include:

a. “Tell me what I just told you.”
b. “Did you understand what I told you?”
c. “I want to be sure I explained everything clearly. Can you please explain it back to me to be sure I did?”
d. “Do you have any questions?”
e. All of the above

EDWARD M. KENNEDY
Community Health Center



Spoken Communication: “Teach Back”

- Confirms patient’s understanding of what provider has ‘explained’ in a non-shaming way

- Ask patient to repeat in their own words what they need to know or do

- Opportunity to check for understanding, and re-teach if necessary

Example: “Instructions can be confusing. I want to be sure I was clear in how I explained this medicine. Can you tell me what it is for and how you will take it?”

EDWARD M. KENNEDY
Community Health Center

"Teach Back" Pilot

- Pilot use of "Teach Back" with 5-7 patients
- Recorded results on evaluation log
- Shared results with Health Literacy Subcommittee
- Expanded use of "Teach Back" and find "buddies" to also use "Teach Back"

EDWARD M. KENNEDY
Community Health Center

Health Literacy Committee:

- Presentations and Discussions
- Newsletter Articles
- Quality Care Committee
- Developed and updated policies
  - Culturally Responsive Care Policy
  - Patient Education Policy
  - Limited English Proficiency Policy
  - Interpreter Services Procedures
  - Procedures for Translating Documents
  - Patient Communication Policy
- Added Health Literacy and “Teach Back” to required online patient safety training
- Staff feedback

EDWARD M. KENNEDY
Community Health Center

Evaluation:

October 2011 (N=67)

- 61% staff using “teach back”
- 78% staff who use “teach back” report “teach back” changed the way they communicate with their patients

May 2012 (N=105 Question 1 and N=102 Question 2)

- 91 % staff using “teach back”
- 88% staff report using “teach back” has increased patients participation in their care

Written Communication

Health Research Services Administration (HRSA) and Center for Disease Control (CDC) guidelines and resources:

- Plain Language
- 6th grade level or below
- 12 point font or larger
- Ragged rather than justified right margins
- Sentence case rather than all CAPS
- Limit to 3-5 major points

More ways to improve communication

Do not ask yes/no questions like :

- Do you understand?
- Do you have any questions?

Ask:

- What questions do you have?

EDWARD M. KENNEDY
Community Health Center

Health Literacy Resources

AHRQ- health literacy toolkit
http://www.ahrq.gov/qual/literacy

AMA Foundation- health literacy toolkit
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our programs/public-health/health-literacy-program/health-literacy-kit.shtml

Pharmacies: Is Our Pharmacy Meeting Patients' Needs?
http://www.ahrq.gov/qual/pharmlit/index.html

American Academy of Pediatrics Culturally Effective Care Toolkit
http://practice.aap.org/content.aspx?aid=2997

Health Environment Activity Packet "First Impressions and A Walking Interview" by Rima E. Rudd
www.hsph.harvard.edu/healthliteracy

EDWARD M. KENNEDY
Community Health Center

Health Literacy Resources

Quick Guide to Health Literacy
http://www.health.gov/communication/literacy/quickguide/Quickguide.pdf

National Action Plan to Improve Health Literacy
http://www.health.gov/communication/hlactionplan

Center of Disease Control (CDC) Information on Health Literacy
http://www.cdc.gov/healthliteracy

Harvard School of Public Health (HSPH) Information on Health Literacy
http://www.hsph.harvard.edu/healthliteracy

North Caroline Program on Health Literacy
http://nchealthliteracy.org/index.html

Health Literacy Resources

Free Online Courses with CMEs or CEUs

HRSA online course with free CEU's www.hrsa.gov/healthliteracy

The interactive training course, "Unified Health Communication: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency," aims to raise the quality of provider-patient interactions by teaching providers and their staff how to gauge and respond to their patients' health literacy, cultural background, and language skills. The course's five modules take five hours to complete. Up to five free CMEs/CEUs are available to participants who successfully complete the course.

CDC online course with free CEU, CME, CPE, CNE
http://www2a.cdc.gov/TCEOnline/registration/detailpage.asp?res_id=2074

Building Community Partnerships

Barbara Nealon,LSW

Director of Social Service &

Multicultural Services

Heywood Hospital

Partner with Community Organizations

Connect with community organizations, seek joint funding and build and/or join community boards and coalitions

Examples:

- Build relationships with key organizations in your community.
- Reach out to grassroots organizations to share your goals such as: community based organizations, refugee assistance programs, community health agencies, youth and family organizations, faith-based organizations, local schools and universities.
- If you have little to no resources you may need to go beyond your service area to bring those resources into your community.

You Don’t Have To Reinvent The Wheel!

As long as you have initiative, you can make a difference!

There are many resources available to help you.

Here’s some examples to take action now!

Making CLAS Happen
Six Areas for Action

A Guide for Providing Culturally and Linguistically Appropriate Services {CLAS} in a variety of Public Health Settings provided by the Massachusetts Department of Public Health-Office of Health Equity
Published December 2008

*www.**mass**.gov/eohhs/docs/**dph**/health-equity/**clas**-intro.doc*

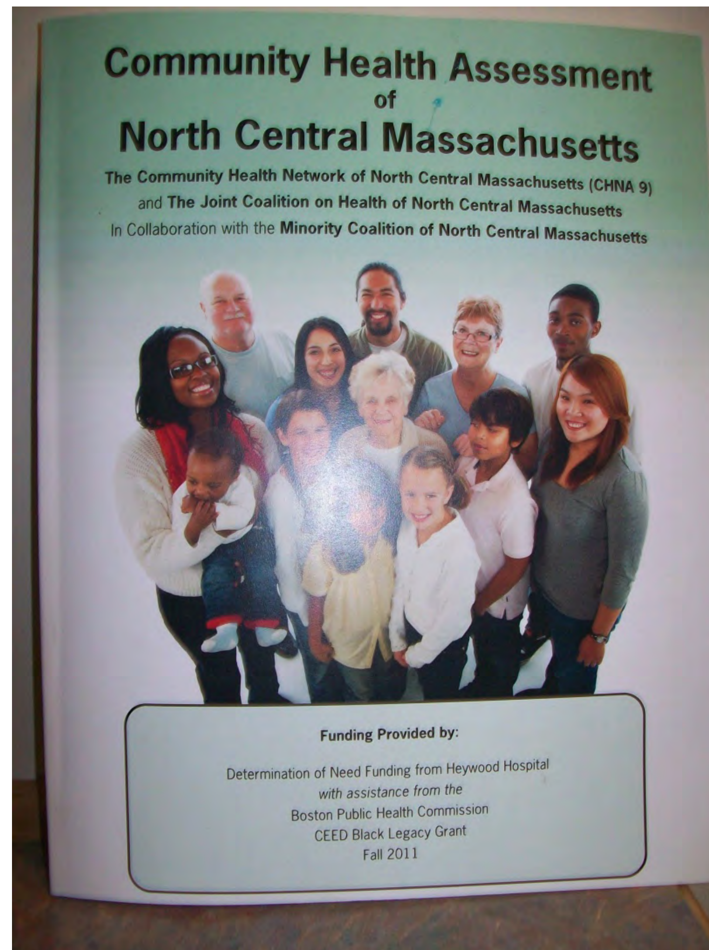
Community Health Network Area {CHNA's}

- *CHNA's are local coalitions of public, non-profit and private sectors working together to build healthier communities in Massachusetts through community based prevention planning and health promotion.*
- *Joining a CHNA can offer the opportunity to work and partner with others, network and share ideas on how to build healthier communities and participate in designing and implementing health improvement projects.*
- *For more information on specific CHNA's:*

  www.mass.gov/eohhs/provider/guidelines resources/services-planning/workforce-development/healthy-communities/chna/configuration-and-contact-persons.html

Example of Community Collaboration

Covering the CHNA 9 Service Area 27 Cities & Towns

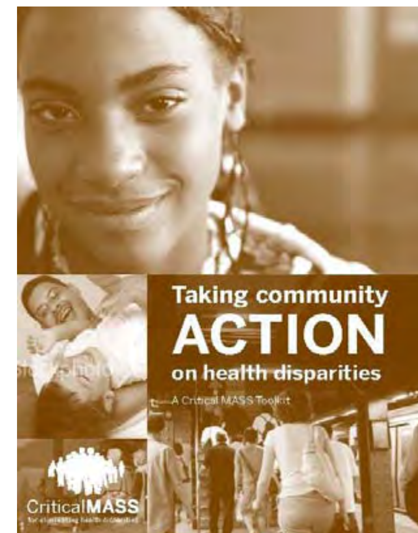


Another Great Resource

Critical MASS for eliminating health disparities seeks to be a catalyst for the mobilization of a sustainable, statewide effort to accelerate the elimination of racial and ethnic health disparities in Massachusetts. We must educate consumers and communities about health disparities. Take advantage of their tool kit.

Critical MASS is a coalition of CCHERS. Inc. Center for Community Health, Education, Research and Service

www.enddisparities.org



Seek out

- Minority Groups, Associations, Coalitions
- Religious Groups, Councils, Meetings
- Hospital Diversity Teams

{For more isolated areas, you may have to go beyond your immediate service area to find these resources, or create them to help service your communities}

- Joined North Central Mass Minority Coalition {NCMMC} {Fitchburg Based} No other groups within our immediate service area
- Co-Lead the NCMMC's Health Disparities Collaborative Committee
- Created the Greater Gardner Religious Council
- Established the Multicultural Task Force
- Steering Committee Member of CHNA 9
- GAIT {Gardner Area Interagency Team} Leader
- Suicide Prevention Task Force

Seek Joint Funding

Apply for grant funding

- To work collaboratively with community partners
- To contract with community programs to provide services
- To allocate funding to community based organizations can show true commitment and add momentum to grassroots solutions

Build and/or Join Coalitions
Share Resources and Collaborate!

With coalitions your impact can be multiplied when you join others in identifying and creating solutions:

- Work on steering committees, boards and coalitions
- Sponsor or participate in health fairs, cultural festivals and celebrations
- Share information through radio stations and newspapers
- Offer education and training opportunities
- Share space as a resource for community meetings
- Invite cultural brokers to committees and membership as they can offer feedback on improving services, determining topics for education, participate in the grievance process, identify potential employees and present cultural information to staff meetings and trainings.
- Examine workforce development recruitment and retainment

Involve Community Stakeholders

When you engage and involve key people in your a boards and committees, you may identify the most efficient and tailored solutions

Engage Client Participation At All Levels

By engaging client participation in all levels involves transferring ownership of health issues directly to the clients. You can work with the community to research health issues, raise awareness, engage and empower clients to take action on improving their health.

- **Involve the Community in Health Research**
  ~Health Needs Assessments are a good example
- **Participate in Cultural Competence Planning**
  ~Add consumers to boards and committees
  ~Workforce development training; recruitment and retainment of diverse populations
- **Improve Awareness and Access to Services**
  ~Providing Service is not enough, need to make sure this meets their specific needs, identify gaps etc. Transportation vouchers, extended hours, specific language line, advertise in newspapers, flyers, websites etc.
- **Participation in the Health Care Process**
  ~Offer information in a language and literacy level that the client can understand.
- **Client Satisfaction Assessments**
  ~Client centered care is based on understanding client needs. Client feedback received in surveys 1-1 interactions or in focus groups is essential in improving services and programs. Keep track of client complaints, interpreter services records and demographic data

Share Cultural Competence Knowledge

Exchanging cultural competence knowledge benefits the whole community:

- Sharing Knowledge and Experience~ The goal of partnering is to create a network where you can exchange ideas and information.
- Sharing Progress with Community and Informing the Public of Available Information~ Social Marketing Plan: emails, newspapers, websites, at meetings, brochures etc.

Example of Community Collaboration YWCA's "Stand Against Racism" Event

The Gardner News

...r Locally Owned Community Newspaper for Gardner, Ashburnham, Hubbardston, Phillipston, Templeton, Westminster, Winchendon

101 GARDNER, MASSACHUSETTS • PUBLISHING SINCE 1869, DAILY SINCE 1897 16 PAGES WEEKEND, APRIL 28-29, 2012

Heywood, minority coalition hold event to 'make a difference'

From FORUM, Page 1

"People, in the way they approach individuals based on color, race, creed, really can deter health care," she said. "We've got to be reaching out to the community."

Mr. Ford also spoke of the fact that minorities remain under represented in government, the business world and other positions of power and influence.

"It's not just a social nice thing to invite people of color on a board," he added. "It's important to have them there so they represent what's going on in a large part of this country."

Those on hand also said that while a great deal of progress has been made — with the election of the nation's first African-American president in Barack Obama cited as a major sign of how the country has shifted — the idea that the U.S. has become a "post-racial society" is misguided, and disparities still remain economically, educationally and in terms of opportunity for people of color.

"I told my daughter, you're young, you're black and you're a woman," said Leona Shaw, operating director of the Montachusett Opportunity Council "You have to be 110 percent. I'm not going to sugar coat it. I've been there. You have to be above and beyond your peers to be taken seriously."

kobrien@thegardnernews.com

News staff photo by KERRY O'BRIEN

Participants discuss diversity and issues of race at Heywood Hospital on Friday.

Heywood Hospital hosts forum to 'Stand Up Against Racism'

BY KERRY O'BRIEN
NEWS STAFF WRITER

GARDNER — Hoping to spark an ongoing discussion about diversity and issues of race, Heywood Hospital and the North Central Massachusetts Minority Coalition held a "Let's Break Bread and Make a Difference" gathering on Friday as part of the YWCA's annual Stand Up Against Racism event.

"We're still very segregated in this country, and we don't realize it," said Adrian Ford, chief administrator and CEO of Three Pyramids Inc. and North Central Massachusetts Minority Coalition.

"We're having a candid conversations because we realize we have to be comfortable having those conversations in order to make a difference," said Barbara Nealon, Heywood's director of social services and multicultural services. "It's important that we have these conversations."

Heywood has taken part in the event for three years. Attendees discussed why it is especially important for the hospital to be a diverse community that welcomes people from across the cultural spectrum.

> *'We've got to be reaching out to the community.'*
>
> **— Barbara Nealon**

"To know that there are people in the institution that can relate to you, to have someone that can relate and understand, it says a lot to me," said Krista Ford-Rhodes, Conservation Program coordinator at the Montachusett Opportunity Council.

According to Ms. Nealon, making people feel comfortable and understood while providing them with the best care possible is not about being color blind, but rather recognizing the things that make people different.

Turn to FORUM, Page 4

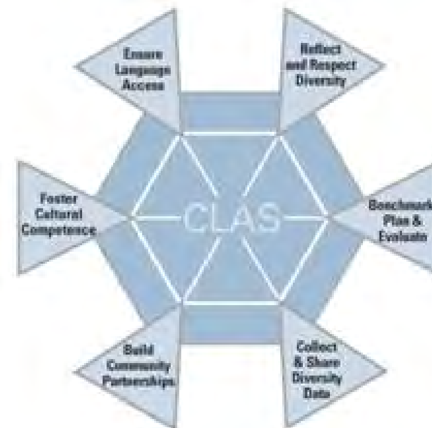
Conclusion

Working with the community is essential. As you partner with others, you can stay connected and build joint capacities. You will be better prepared to understand treat racially, ethnically and linguistically diverse clients as you:

- **Partner** with community organizations
- **Involve** community stakeholders
- **Engage** client participation
- **Share** cultural competence knowledge

CLAS Standards Covered

- Standard 12: Develop partnerships and collaborate with community partners to ensure client participation at all levels.
- Standard 14: Make information about CLAS initiatives and successes available to the public



Sources

Making CLAS Happen Six Areas For Action

www.mass.gov/eohhs/gov/departments/dph/programs/health-equity.html

Massachusetts Department of Public Health December 2008

Community Health Network Areas {CHNA}

www.mass.gov/dpt/ohc

Massachusetts Office of Healthy Communities

Critical Mass for Eliminating Health Disparities

www.enddisparities.org

CCHRS Center for Community Health Education, Research and Service

Tool kit: www.enddisparities.org/criticalmasstoolkit.html

Office of Health Equity

www.mass.gov/dph/healthequity

Massachusetts Department of Public Health's Office of Health Equity

Email me at nea.b@heywood.org

Evaluation

- Appears in your internet browser after webinar ends (please stay logged in!)
- Also available via email if you logged in from your RHTAC invitation
- Required for MA professionals receiving CME or CE for nurses and social workers.
- Strongly encouraged for everyone – we learn from the evaluations!

THANK YOU!

Thank you!

Email us:

refugeehealthta@jsi.com