REFUGEEHEALTH TECHNICAL ASSISTANCE CENTER

Making CLAS Happen
June 20, 2012
12:00 pm EDT

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Making CLAS Happen Webinar. During the presentation all participants will be in a listen-only mode. If you would 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, Wednesday, June 20, 2012. I would now like to turn the conference over to Jennifer Cochran. Please go ahead.

Jennifer Cochran: Great. Thank you very much, and hello to everyone. I want to welcome you to our presentation today on Making CLAS Happen. I'm actually going to talk quickly because we lost a couple of minutes there.

As the operator said, my name is Jennifer Cochran and I'm Project Director for RHTAC, the Refugee Health Technical Assistance Center, a project that's administered by the Refugee and Immigrant Health Program at the Massachusetts Department of Public Health with support from the Office of Refugee Resettlement of the U.S. Department of Health and Human Services.

As was said already, we are Web broadcasting, so please listen to the Webinar over your computer speakers or headphones, and if you need a call-in number you can chat with the chair person. So our, the structure for today's Webinar is summarized on this slide. We're really pleased to have five great presenters, each of whom will be introduced by my Co-Moderator, Chioma Nnaji in a minute.

Altogether they'll be speaking for about 60 minutes. We'll then have a question and answer session segment after the main talks. You may type your questions via the Chat function on the lower left of your screen, really at any time during the presentations. We're going to try to get to as many of your questions as possible, but if we don't get to them all, we'll be posting responses in a summary document online after the Webinar.

So please visit our web site, www.refugeehealthta.org, where we're going to be posting the recording, the transcript and the slides from today's presentation. That'll be together with the Q&A document I just mentioned, and additional resources related to today's presentation.

Please keep in mind that the recording, transcript and slides will be posted probably within the next week or so, while the other documents may take a bit longer to post. So I encourage you to check back regularly and also check out some of the earlier Webinars that are there.

Our email address is also here, refugeehealthta@jsi.com, so you can feel free to email us after the Webinar if you have questions. And a reminder, too, that there will be an evaluation form that will pop up as you leave the Webinar, and we really appreciate your taking time to complete that at the close.

We have a lot of co-sponsors for today's Webinar, and we're really pleased to be joined by just a tremendous group here to bring you this Webinar. In addition to RHTAC, which is supported by the Office of Refugee Resettlement, we have the Multi-Cultural AIDS Coalition, which is supported by the New England AIDS Education and Training Center Minority AIDS Initiative.

And this is funded by the Department of Health and Human Services, Health Resources and Services Administration, and sponsored regionally by Commonwealth Medicine at the UMass Medical School. We're also having as a co-sponsor the Mass Department of Public Health, Office of Health Equity, which is also supported by HHS, Office of Minority Health.

Our objectives for today are summarized here - wait for the slide to catch up with us at...They are, there are four primary objectives that we have. One is to summarize the six areas of action in the Making CLAS Happen manual, which you'll be hearing a lot more about as we go through today's Webinar.

We're going to be exploring the impact of biases, stereotypes, prejudices, xenophobia and racism on policies, practices and norms within a clinical setting. Third, we're going to identify key reasons for implementing Culturally and Linguistically Appropriate Services from service, financial and legal perspective, and fourth, we hope to identify successful strategies for implementing the CLAS standards in clinical settings.

So with that, I'm going to turn the mic over to Chioma to introduce today's speakers and continue forward. So Chioma.

Chioma Nnaji: Thank you Jennifer. Again, my name is Chioma Nnaji, I'm a Program Director at the Multi-Cultural AIDS Coalition. And I just want to give a overview of who our exceptional presenters are today. We have Ms. Georgia Simpson-May, who will be giving a overview of the Making CLAS Happen initiative out of the Department of Public Health Office of Health Equity.

And then we also have Dr. Eric Hardt, who will give us a presentation about why it is important for providers, clinical and social service providers to think about CLAS and implement CLAS. And we will have three case studies from - one from Dr. Mothusi Chilume, another one from Ms. Sue Schlotterbeck.

And then we'll have another one from Ms. Barbara Nealon. And so I want to move on to talk a little bit about the continuing education units that will be available. We have continuing education credits specifically available for Massachusetts providers. Within the other states you can check and see if you can apply Massachusetts approved continuing education credits.

So we have credits for medical providers, and we also have CEUs for nurses and social workers. I also need to say that all of our faculty and our planning committee have nothing to disclose. Moving on into our evaluation, as many of you know, evaluation is very, very important, so we ask that you complete the evaluation after the Webinar.

You will receive a link to the evaluation immediately after the Webinar ends. We definitely require that if you are requesting for CMEs or CEs for nurses and social workers, that you have to complete the Webinar, and we strongly encourage that everyone completes the evaluation for the Webinar, because it will help give feedback the next time that we do it.

So now I want to move on and introduce our first presenter. Ms. Georgia Simpson-May is the Director of the Office of Health Equity for the Massachusetts Department of Public Health. In this capacity, she oversees efforts for MDPH to address health disparities across all bureaus, and other executive Office of Health and Human Services initiatives.

She has 18 years experience in health and human service management and development, including serving as the Deputy Director of the Multi-Cultural AIDS Coalition. Ms. Simpson-May received her undergraduate degree in Biology from Brandeis, a Master's in Management of Human Services from Heller Graduate School for Social Policy Research at Brandeis, and a Graduate Certificate in Epidemiology and Biostatistics from Drexel University School of Public Health.

Ms. Simpson-May, please go ahead. Thank you.

Georgia Simpson-May: Thank you Chioma and good afternoon everyone. This presentation will lay the context for the rest of today's discussions. I will provide background on how we got here, define cultural and linguistic competence, talk about why we even have CLAS standards, present the standards and share our guidance manual for Making CLAS Happen. Presenters to follow will provide concrete examples of how to apply the standards in various settings and situations.

How we got here - in 1985 Health and Human Services Secretary Margaret Heckler released a ground-breaking report on black and minority health. The report was in response to a national paradox, where we were seeing a steady improvement in overall health but substantial and persistent inequities in the health of U.S. minorities, namely blacks, Hispanics, Asian-Pacific Islanders, and Native Americans when compared to that of whites.

Unequal Treatment is another unprecedented report on disparities with an in-depth examination of our healthcare delivery practices. The report states that in 1999, Congress requested the IOM Study to assess the extent of disparities in the types and quality of health services received by U.S. racial and ethnic minorities and non-minorities.

They found significant variations in the rates of medical procedures by race, even when insurance status, income, age and severity of conditions are comparable. Unnatural Causes is an award-winning documentary that explores the root causes of health inequities in our country, and asks the question, why.

It is the culmination of years of research and work in the area of social determinance of health, and demonstrates the health-wealth connection. It shows how medical intervention is one piece of a very complex system of inter-related factors that influence our health and healthcare outcomes.

It shows that one of the most important numbers that determines our health is our address, that where we live, work, play and pray significantly influences wellness, that health in all policies, be it education, transportation or housing policy is an approach that will get us to health equity, and that stress, racism and discriminatory practices are drivers of disparate health outcomes.

Now let's give meaning to cultural and linguistic competence. It 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. Competence implies having the capacity to function effectively within the context of the cultural beliefs, behaviors and needs presented by people and their communities.

So why were CLAS Standards even created? The CLAS Standards, issued by the U.S. Office of Minority Health in 2001 states, and I quote, "That the increasing diversity of the nation brings with it a host of opportunities and challenges that are experienced with increasing frequency and immediacy in healthcare facilities.

"Personal efforts can go a long way to bridge the gap between the staff of healthcare organizations and patients who bring cultural differences to the health encounter, but personal efforts are usually not enough to overcome the common organizational barriers that affect how diverse populations navigate their healthcare and how care is delivered."

So in a nutshell, the standards contribute to the elimination of health disparities, make services more responsive, and are inclusive of all cultures. Why integrate the standards? The Massachusetts Department of Public Health Commissioner John Auerbach has said that CLAS should be part of our DNA. Essentially, it should be the way we do business.

In addition to contributing to reductions in health disparities and meeting the federal mandates, organizations and providers applying the standards may realize increased market share, and encounters with communities that reside within their vicinity, but who do not come in because they don't believe that they will be served well. Organizations can integrate the standards into marketing strategies, performance management and continuous quality improvement processes.

The Standards - there are 14 standards that fall into three categories. Mandates are current federal requirements for all recipients of federal funds. Guidelines are activities recommended for adoption as mandates by federal, state and national accrediting agencies, and recommendations are suggested for voluntary adoption. Out of the 14 standards, only one is a recommendation.

The Standards also fall into three themes, Culturally Competent Care, Language Access Services and Organizational Support for Cultural Competence. Know that although these standards are directed to healthcare organizations, individual providers are also encouraged to use them.

Culturally Competent Practices speaks to knowing the community you serve. One important mention here is that becoming culturally competent is not an end point. It is not something you arrive at. Moving toward becoming more culturally appropriate is a lifelong journey.

It is about adopting a set of core values and practices that will help us all through this journey, which includes our own cultural humility, being reflective and understanding ourselves first, and being open, receptive and non-judgmental about others.

The Language Access Standards are mandated, and speaks to non-discriminatory practices based on preferred or spoken language. These required standards are essential in assuring meaningful and accurate communication between parties. Miscommunication can easily lead to improper diagnoses, poor treatment planning on the part of the provider, and adherence issues on the part of the patient.

Language discordance could be a potential cost driver for an agency for the reasons mentioned. In Massachusetts to assure the use of competent, qualified and trained interpreters, we recommend that medical interpreters become certified by a national certification board.

Organizational Supports are guidelines designed to make CLAS part of how you do business. As standards become part of policy, they become part of practice. All are important, but the two I'd like to highlight are Numbers 10 and 11, Race Ethnicity and Language Data Collection, and Demographic Cultural and Epidemiologic Profiles.

If we don't collect the information, we cannot identify disparities. And if we cannot uncover disparities, we are unable to do anything about them. Data collection is essential. With grant funding awarded to the Mass Department of Public Health, Office of Health Equity from the U.S. Office of Minority Health in 2005, we set out across the state to hear and learn from community-based health and human service organizations about their experiences with the Federal CLAS Standards.

We asked one simple question, what would help you successfully integrate the CLAS Standards into your practices? Making CLAS Happen's Six Areas for Action is a result of those conversations. The intent was to make the CLAS Standards approachable, so consensus was to take the 14 standards, give them meaning, digest them into fewer elements and translate them into actionable items.

We created action areas covering diversity, evaluation, data collection, partnerships, cultural competence and language access, those are the six triangles. The Making CLAS Happen guide organizes the standards into action areas, and embedded within each action area are several standards.

The guide also matches content to needs, clarifies complex concepts, justifies the need for CLAS, empowers users with resources and highlights promising practices. Each area can be addressed individually and in an order determined by the agency. The Making CLAS Happen guide also contains a number of tools, checklists and lessons for others to use in their attempts to make CLAS happen.

It also presents the state and federal laws that are the foundation for culturally competent services, and presents ways to implement CLAS on a budget. One organization that used the guide called it manna from Heaven, kind of like the land of milk and honey, overflowing with abundance. Programs told us that they agree with the intent and the purpose of the CLAS Standards, but didn't know how to effectively implement them. They said that Making CLAS Happen was the missing link.

So the CLAS Standards, moving forward - as we broaden our understanding of culture and what we all contribute to the mosaic of our nation, we have the opportunity to revisit and enhance the CLAS Standards.

In 2010, the U.S. Office of Minority Health embarked upon an effort to elicit feedback on the standards as it sought to promulgate an enhanced version to be more reflective of the mosaic, and to capture the essence of truly moving towards becoming more culturally sensitive, appropriate, and inclusive as well as more rigorous and deliberate in capturing population-based information.

Within the revised categories shared in April 2012, we see that the goal has changed from decreased health disparities to advancing health equity. If we look at culture, it has been expanded to explicitly name religious and spiritual, biological and sociological characteristics.

And the definition of health is no longer implied, but is explicitly defined to include physical, mental, social and spiritual well-being. Ultimately, the CLAS Standards will continue to guide us towards improving our ability to provide quality care and services to all people. Thank you for your time.

Chioma Nnaji: Thank you, Georgia. I would like to remind everybody, as mentioned before, questions will be answered at the end of the presentations, so please note your question using the Chat box, and then we will definitely get to it at the end of all the presentations. So our next presenter is Dr. Eric Hardt.

He is an Associate Professor of Medicine at the Boston University School of Medicine. He is Board Certified in Internal Medicine, Medical Oncology, Geriatrics and Palliative Care Medicine. He remains active, clinically, in inpatient and outpatient care, and follows a diverse group of elder patients in their homes and clinics.

He is an active educator of medical students, health staff, fellows and medical staff on clinical issues in geriatrics, home care, cross cultural medicine and language barriers. He has authored book chapters, training videos and articles in all these areas. Dr. Hardt is also a founding member of the IMIA in the NCIHC, and for over 25 years he has served as a medical consultant to Interpreter Services at BMC.

He was most recently elected as a Founding Member of the National Board of Certification of Medical Interpreters. Dr. Eric Hardt, please go ahead, thank you.

Eric Hardt: Thank you so much. Significantly, I'm a white man from Connecticut who speaks only English. I've been working principally in minority communities for 38 years, and I have just a few minutes to share some more reflective and personal ideas with you, some things that have helped me and continue to help me in my ongoing quest for my own cultural competency. As Georgia mentioned, this is something that, certainly not over for me and never ends for most people.

Yes, we need to take responsibility for disparities as providers. It's sometimes hard for us to swallow. We think that we don't let bad people into nursing school and medical and whatnot. We feel that we're personally just, good people, egalitarian, whatnot.

And yet we look at some of our healthcare outcomes and we find disparities based on race, ethnicity, socioeconomic status, language and whatnot. So how do we understand this disconnect? We think that we're doing our very best, but when others analyze our decisions we seem to be doing things differentially, and having different kinds of outcomes.

If you're interested in this, at the bottom of the slide, just Google Diana Burgess or Michelle van Ryn, both cognitive psychologists who in great detail in a number of articles will give you some insight as to how this happens to, working from our minds into our behavior, how for example, automatic subconscious thoughts and feelings can take over when we're busy, tired, anxious or under pressure.

I know for me, that's all of the time. So it's very good, and I think reassuring to understand how, despite our best efforts, unless we continue to try to get more personally aware, we can lapse into behaviors that result in disparities. Next slide.

Here's just a slide that gives us some concepts about ways in which disparities based on race, ethnicity and language can lead to differential healthcare outcomes. The top three, I would say, biological factors, socioeconomic status, economic factors, are operative in the exam room when we're talking to one patient and one provider, but more or less we need to address these as citizens and as voters and advocates.

The bottom three, I would say are things that we might address best as members of our healthcare professions, access, quality, health risk behaviors. Most of the rest of my time I'm going to talk about the more personal side, the two in the middle.

When one provider is in the room with one patient, how do we deal with things that if not thought about, can resolve in disparities? Particularly, how do we deal with cultural factors, how do we deal with issues of potential discrimination and bias?

Another way to conceptualize this, on the next slide, and George already mentioned the Institute of Medicine's report, one of the good things about the data that's out there in public is that minorities now know all about disparity. This is no longer America's dark secret from the late 80s and early 90s. This is in the newspapers, on TV and radio.

So we need to talk about this frankly and openly because our patients know all about it. They know that there's a difference in quality, even when there's equal access to healthcare and equal insurance and socioeconomic status between minority patients and non-minority patients.

Now the trick is, yes there are differences. At the top of the black box, we see differences that are okay, clinical appropriateness and need based on a patient-to-patient basis, the preferences of patients and families for their healthcare. Those are things that we need to preserve and not obliterate. They are differences that are not really disparities.

In the other two boxes we see the kinds of differences that we define as disparities, things when the - ways in which the healthcare system and regulatory climate operate against minority patients. And then things within our systems and within ourselves, bias, prejudice, stereotyping, discrimination that produces unwanted differences, not like the differences at the top of the box that are okay.

For many years I was intrigued by Milton Bennett's work on cultural competency. I think it's a giveaway that it's a sign of my aging, but I'll go through it with you anyway. And he thought of cultural competency as a developmental process that has several stages. And by the way, these stages can progress to different levels for different situations.

You may be all the way up to Level 6 in the area of sexual preference, and you may be still at the Level 3 in issues of discrimination and differences, disparities based on race. So think of that as we go through them. Stage 1 is denial. That's the sort of, gee, we don't have any Jewish patients in our hospital so we don't really need to provide Kosher food and a Rabbi and whatnot, so people who basically isolate the problem and don't see them at all.

The next stage, which sees differences but is afraid of them and threatened by them, sees them as "a problem." So this is the, you better watch out for the such-and-such a population, because this is how they do things. This is how they understand. And be careful, or they'll wind up doing this. This is - again, this has open eyes, but there's nothing particularly good. This is a stage where you don't want to wind up permanently.

The third stage is one where a lot of people like myself think that they're okay when they have reached it. This is the classic, black, white, gay, straight, it doesn't matter to me. I treat everybody the same. And the bottom line is, people are not the same. The people who minimize typically look for universal qualities in which other patients resemble themselves.

And this is better than the other two stages, but certainly not an end stage. Much better is the stage in which we recognize that there are differences in the health needs of a gay man and a straight man, a black person and a white person, an immigrant refugee or a native born citizen, and that these differences can be valued and respected.

Now we deal with practical matters of learning how to communicate across these differences, learning how take the other's point of view, stand in their shoes, and appreciate really the full meaning of the differences. And then the bottom is really what we hope to get to, which is the point where we no longer see populations who are different as a problem, but we see them as a thing that is very cool, something that we enjoy doing that enriches our own existence and lives both professional and personally. And that's where we hope to get.

In the old days, people used to pick up a handbook of cross-cultural medicine and look up the Italians or the Jews or the Somalians and get three tidbits about them. These days we tend to say, look at yourself before you even think of other people's cultures. Look at your own roots, positive and negative. Be up front about your own biases, stereotypes, experience with discrimination.

Look at - if you think that you're just a normal person, like a white guy from Connecticut, look in the nooks and crannies of your own culture until you start to see that some of these things are quite arbitrary and can be seen from other points of view as a little unusual. And then just simply commit to contact with and study of other cultures

If you're dealing with people who are coming from other countries, other religions, other races, sexual preferences or whatnot, we need to study about it, at least to get some of the content involved so that we can talk about it.

The IOM classifies the root causes of disparities into three systems, those that operate on the systems level, those that operate within healthcare providers like ourselves, including things like stereotyping and poor communication resulting in clinical uncertainty, and things are within the patient, mistrust, noncompliance and delays, things that we sometimes think of as not fixable and not our responsibility, but I would say that they are.

Another good person to Google is Camara Jones, up here. If you Google Video her you'll get her 20-minute discussion of these three varieties of racism. In the interest of time I'll just mention them very quickly. We're, I think, familiar with personally mediated racism, frequently unintentional, often acts of omission rather than commission.

People tend to not notice it. These are little things like the store manager who follows the minority patient around shopping and not the white patient. Or folks who are driving through the black community and all of a sudden find their door locks clicking down when this doesn't happen in the white community.

Internalized racism includes features that are located within the patient, and really sort of manifests an erosion of an individual sense of values. It may present as a kind of expectation or acceptance of a lower standard of care. This may come out in the form of so-called noncompliance or a lack of trust in, not only in people who are different from them.

This may not be just a matter of a black person not trusting a white doctor, it may include a black person not trusting a black doctor. And then finally, perhaps most importantly and hardest to eradicate are issues of institutional racism. These are things that are so ingrained in our system that they are legal, that they are, seem to be no one's fault. They appear to be unchangeable until we grapple with them actively.

Next slide, very quickly, remember particularly in areas of race, if we do nothing, the system works, operates to create a power differential and disparities in favor of whites. We are prohibited from talking about it, all levels of staff. There's a lot of emotional reactions built into these things that inhibit the dialog. And many people who have seen and see instances of racism and whatnot are in total denial.

I'm going to go through one particular example of disparities, next slide, and - let's see here, oh I skipped a slide here. Okay, here is a large study, that's why I picked it, over 100,000 trips to emergency rooms, and there are many other studies like it that show that white patients are more likely to get opioids for pain than non-white patients for all level of pain.

This is a large study, and found that minority patients less likely to get opiates for broken bones, kidney stones and even children. What are the possible causes of this? We'll take a few minutes to poll. Please skip - please check what you consider to be the most likely, best possible explanation for this type of disparity in treatment for pain. Take a few seconds for you to pick a choice.

Be bold. This is anonymous. Pick something. And our moderator will tell us when we can advance. Okay, and we'll say that the vast majority of you said that doctors are reluctant to prescribe opiates. Some say they can't recognize pain in black patients. Black patients are less likely to ask for pain meds.

The next slide - oops, yes, there's no evidence that black patients feel less pain. I think the notion that black patients may feel less enabled to ask for pain medicines when they don't get it, a manifestation of internalized racism. There is evidence that doctors do not have more trouble recognizing pain in black patients, so that is a misconception.

And far and away the most likely cause, I think, is either, we could either call it paternalism or personal racism, that doctors sometimes are reluctant to send a patient home to the black community with a supply of opiates, for one reason or another. This gets translated into institutionalized racism.

This was a large study of many, many, many of the pharmacies in New York City, both chains and mom and pop shops, and the bottom line was, if you asked the question, what kind of pharmacies have inadequate supplies of opiates, according to World Health Organization criteria, or have no opiates at all, the vast majority is, there's a huge difference, organizationally, of whether you can get the right kind of pain meds in your local pharmacy if you're white or black.

And you can see the data up there on the slide. Now some good news is, here's a quick example of something that we can do - and I'll shorten it up in the interest of time, small study on cancer patients with a few minority patients. They did find that there was a disparity in terms of pain, with minority patients having worse pain control than white patients.

Their intervention was a 20-minute individualized coaching session for each patient to help them understand, get more knowledge about pain self-management, address misconceptions, and to rehearse a scripted dialogue that they would give to their doctors when issues of pain came up.

And the bottom line was that in the control group there was no change in pain control. The disparity still remained. In the experimental group, with even a 20-minute intervention, the disparities were totally eliminated. So this is exciting, suggesting it's something that a provider can do in 20 minutes or less might have a impact on a major, major commonly seen disparity.

A few minutes, a couple minutes on disparities and issues related to language, and here is my personal interest. There's scads of data now showing that we have disparities specifically related to language in multiple areas, as you see on the slide. Now, there is a sort of a double whammy, if you will. When there is a language barrier in the room - cross-cultural issues I would say are always present in every encounter, even if there's a shared language.

When there is no shared language, A, the cultural differences may be more substantial on the average, and B they may be much more difficult to address, unless you address the language barrier first. Personally, I would say, you have no shot at understanding cultural issues, and issues of bias and discrimination when you're not doing a good job dealing with the language difference.

The people that train professionals now certify - we can answer questions about this later, medical interpreters that we like to use. There's an argument in the literature about what their role should be. Interpreters that work for diplomats and businessmen and in the courts serve specifically as conduits.

They make no commentary, they don't explain things. They're kind of a voice box that we speak through, where if you are a culturally competent provider that might be all you need. In medical interpretation we tend to think that the role should be expanded because of the power differential between the patient and provider, bigger than the power differential between diplomats or businessmen.

And we think that in some cases we train our medical interpreters to do some explanation, some brokering of relationships, in addition to just passing the message. Of course in both cases, the first obligation is to faithfully transmit the message. By the way, the Office of Civil Rights considers the inability to speak English as a marker for national origin.

It's a violation of our Civil Rights Act to discriminate based on national origin. And really it was under Bill Clinton when the OCR made it very clear that a lower standard of care for patients who don't speak English is, constitutes a violation of the Civil Rights Act.

They specifically said that if you, for your patients who have limited English proficiency, have services that are limited in scope, lower in quality, delayed, if you limit participation, if you give care that's not as effective, if you tell a patient that they have to bring or pay for their own interpreter, you're in violation of federal law.

The last couple of slides are really meant for your subsequent review. They give you some tips about working across a language barrier. I would say that we always try to use an interpreter. There's a debate in the literature about if and when it's okay to use somebody who's truly bilingual that the patient themselves have brought. We can leave that for questions and answers.

Confidentiality is particularly important. I simplify my language. I avoid my complicated flowery figures of speech and get rid of jargon. I plan my statements. I plan for a little bit of extra time when I'm working with an interpreter. I personally like to ask single open-ended questions and then listen to the patients tell a story, and be patient as your interpreter sort of gets the whole story and then relays it to you in chunks.

I ask the interpreter to comment on what they thought about the patient themselves, and I learn a little bit of a language in the patients that I take care of regularly because they think it's a sign of respect that you learn a little Spanish or French or whatnot, even though your language might not be good enough to really get what you need to know to practice good medicine.

This is my last slide, suggesting A, avoid stereotyping, B, remember, our point of view is not the only valid one, C, as Georgia mentioned, it's the law to deal with language differences seriously, and please take personal responsibility for this. I am done. Thanks for the extra couple of minutes.

Chioma Nnaji: Thank you very much Dr. Hardt. The next three presentations that you will hear are actually presentations that will give you a case study. So that will help you understand how you could implement CLAS within your own either healthcare setting, or if you are within a refugee resettlement agency.

So our next presenter is Dr. Mothusi Chilume. He currently works at Whittier Street Health Center as a family physician, and also sees the growing panel of HIV patients at the clinic. He was born and raised in Botswana. He graduated from Luther College in Iowa with a B.A. in Psychobiology, after which he completed his medical training at St. George University School of Medicine in Grenada.

After completing his medical training, he worked in Botswana as a medical officer for three years before coming to the U.S. to complete his residency in family medicine. As part of his residency training, he also did an area of concentration in HIV medicine, and obtained certification as an HIV specialist from the American Academy of HIV Medicine. Dr. Chilume, please go ahead.

Mothusi Chilume: Thank you very much, Chioma. So, my presentation, I'm going to go through my slides quickly. This presentation will hopefully help you bring some of the concepts that have been discussed in the previous two presentations together for you. So we can get started with a case study.

So you, working as a provider in a community health center in Roxbury. I'm biased, of course, because I work in Roxbury, that's why I picked it. But the community health center that you work for 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.

So you happen to be the only provider working at the clinic on a Saturday in your busy urgent care center at the clinic. And in walks in a patient, R.J., who is a 38-year-old male who tells you that he's an immigrant from Ethiopia. R.J. tells you that he can understand and speak some English, but that he is more comfortable speaking in his native language, which is Amharic.

So we're just going to poll the next question and just see what you guys think about what issues you have to deal with at this point and how you would proceed. So let's just take a few seconds and answer however you think would be most appropriate.

Okay, wow. So yes that's, this is the response that I was expecting. Obviously, if you have available interpreting services at your clinic, which really, a clinic that is aware of the population that it serves should be providing for their patients, you should really be able to offer R.J. that service.

And for those of you who know that is the CLAS Standard 6, which does say you should be able to provide your patients at the clinic with options about interpretation services. Or if they happen to prefer that they use a family member to interpret, that is also an option.

So you do offer, you go ahead and you offer R.J. to use the (formal) interpreting system and he tells you that he prefers for his friend, who just your luck, happens to be a certified interpreter at a different clinic. So this works out well for you, you are able to do - to carry on with the visit.

So R.J.'s complaint for the day is that he's having bilateral ear pain. He has been having that for a few months. He thinks that the pain is getting worse, especially in the past couple of weeks. Initially he tells you that he's otherwise healthy, he really has no other complaints besides the ear pain. On exam R.J. seems to be otherwise well.

You do his ear exam and you see that he's got a lot of wax in both his ears, and that really seems to be the major problem for him that day. So as you're returning to conclude the visit with R.J. after offering him some eardrops, R.J. discloses to you that he is in fact HIV positive.

He tells you that he wants to switch his care from the last clinic were he was currently being seen to a smaller clinic such as yours, because you've impressed him so much by offering him interpreting services. So R.J. tells you that he's worried that his HIV positive status will be found out by someone form the large Ethiopian community that go to his current clinic.

He tells you that he was diagnosed in 2006, soon after arriving from his native country. He reports that because he was in denial for all these years, he has actually never been on treatment and has really struggled with this new diagnosis that he was told he has.

He also admits to you that he has not yet disclosed to any of his family, and in fact the friend that he's with for that visit is the only person who knows his HIV status. So, R.J. tells you that he is worried that if his diagnosis were to be discovered by members of his community it would really destroy his status as a respected elder.

So once again I'm going to ask that we just do a poll here and just get your opinion about if you think the fact that R.J. seems to have this perception of a lot of stigma in his community, this is going to affect the kind of care that you provide for him. So let's just take a few seconds here and see what people are thinking.

Okay, again this is the response that I was expecting. Obviously, the fact that he has gone for all these years without getting care or starting medications really proves to you how strong a stigma is in terms of providing care for your patient, especially dealing with sensitive diagnosis like HIV for a lot of patients who are coming from developing worlds where there's still a lot of stigma.

There's still a lot of stigma in the U.S. as well, but definitely coming from other countries the stigma might be even more. And if you don't address this with your patients you can really miss a lot. You can miss an opportunity to discuss with them and see where they are in terms of accepting that diagnosis and moving on to the next step, which could possibly be getting them started with medications.

So - and this is relevant for those of you who know the U.S. recently changed the law about diagnosing - getting people tested for HIV before emigrating to the U.S. So, you know, a lot of patients will be getting tested while they're here now and so this will be a new thing that we'll all have to deal with if we work in healthcare settings or other settings as well. So this is essentially the case I had for everyone, just a couple of concepts for people to think about.

Hopefully this will help you put some of those concepts about the CLAS system that we discussed in the first two presentations. If there are any questions please feel free to ask them at the end of the Webinar. Thank you very much.

Chioma Nnaji: Thank you very much Dr. Chilume. And so now we'll get ready for our next presenter. Our next presenter is Ms. Sue Schlotterbeck. She is the Director of Cultural Language Services at Edward M. Kennedy Community Health Center. She has worked for the health center for over 25 years.

She organizes the health center's organizational wide leadership in the development and implementation of services to address the diversity of patients, with the goal of reducing healthcare disparities and improving patient health.

She is also responsible for the Refugee Preventive Health and Refugee Health Assessment programs. And she chairs the Health Equity Cultural Competence Committee and Refugee Health Team at Kennedy Community Health Center.

She also has previous experience working with Ethiopian refugees in the Sudan and Cambodian refugees in Thailand. And she will focus on health literacy and how that's been implemented within her - at Kennedy Community Health Center. Go ahead.

Sue Schlotterbeck: Thank you Chioma. So the Edward M. Kennedy Community Health Center, we're located in Western Massachusetts and we provide about 139,000 visits a year to about 24,000 patients. We strive try to hire staff that's reflective of the patients in the communities we serve.

So currently our staff speak about 37 languages and come from 40 countries and about 77% of our staff are bilingual. And our patients speak about 93 languages. So we're very diverse in both in terms of the patients we serve and our staff.

We started a Health Equity Cultural Conference Committee about ten years ago and we've done a lot of work over the past ten years. And about two years ago we started a subcommittee to address health literacy. And I just put it up here five bullets of things that I think are important for successful committees.

Having provider champion, and for us that would be champions from all of our different departments, so dental, behavioral health, medical are some of the departments at the health center that we have on our team. Having a diverse team and having a work plan that gets updated every year, and also piloting our ideas, we use the PDSA cycle in order to pilot things on a small level before we roll them out center wide.

And then communicating, both among the team members and center wide so people know what's happening and what the results are as we move forward. This slide just shows you a little bit about what health literacy is, the official definition from the institute of medicine.

It's the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. So it's not just about reading and writing, and it's also not just about the patient in front of you, but it's also about how we communicate as health providers with our patients.

Who's at risk for low health literacy? The literature says about 90 million Americans. About 9 out of 10 adults may lack the skills needed to manage their health and prevent illness. And many of us, I'd say including myself, when we're sick or not feeling well and we go to the doctors office it's often harder to hear and understand what's being said to us because we're feeling a high level of stress.

So this is what we did. We assessed our practice, we established priorities, we then worked to increase staff awareness through newsletter articles and discussions. We improved our environment, both spoken and written communication. And we integrated health literacy into our policies and procedures and then we measured our success.

It is a national priority, and I listed a number of reasons that it's important to focus on health literacy in terms of national priorities. I thought I'd focus on the first two, the CLAS Standards and the Patient-Centered Medical Home. In terms of the CLAS standards there are two standards that relate to health literacy, Standard 1 and Standard 7.

Standard 1 really speaks of offering care that clients can really understand. And standard 7 is really about making available easily understood materials and signage, so both of them closely related to health literacy. The Patient-Centered Medical Home is an innovative program for improving primary care.

And agencies can work toward meeting the National Committee for Quality Assurance, NCQA Patient Center Medical Home standards to receive recognition as a Patient-Centered Medical Home. And I just wanted to point out that two of these standards really are related to health literacy and CLAS.

Standard 1, actually Element S, which speaks specifically about the CLAS standards and Element G7 also talks about the communication skills and then there is another standard in there, Standard 3, which talks about assessing patient families' understanding of medication, again, lots of good reasons to focus on health literacy.

So the assessment that we used - the Agency for Healthcare Research and Quality has a tool kit, a health literacy tool kit. And we actually used their assessment tool. There are 49 questions that focus on the four areas listed on the slide.

And we took the 49 questions and we actually typed them into SurveyMonkey and then sent them out as a link to our staff. That way we could get input from many of our different departments and staff at all different levels of the organization.

When we got the results back we felt that we needed a little more information, and the provider champion on our team came up with two questions, and these were the two questions he thought were important to ask the providers. So the first question is, what issues come up time after time in helping your patients understand and follow through on their treatment plan?

And the second one, what causes you the most aggravation every day in your interaction with patients that relate to spoken communication and written communication? So we then we got more data from that. And then the final thing we did in terms of assessment was we used Rima Rudd's health environment activity packet, which is called First Impressions in a Walking Interview.

And this is really a tool where you can make a phone call, visit the Web page, walk to the entrance and then do a walking interview to really look at your environment and how, what the health literacy demands are from the patient's perspective.

So we had the tool kit, which included more than the assessment, which I just talked about, and we divided it among out team members. Each team member took two of the tools and read them and looked at all the links, and we decided where we were going to start.

And these list of tools at the bottom of the slides are the ones that we started on. I'm going to speak specifically about Tool 5, the Teach-back Method, because that's the one we spend the most time and energy incorporating into our practice.

So we now have a poll here with a question. Teach-back includes, and you can check which one you feel is appropriate. Tell me what I just told you? Did you understand what I told you? Can you please explain it - oh actually, I'm sorry the - we're going to go ahead and skip over this slide because the questions aren't quite as we set them up to be so I'm just going to skip to the next slide, excuse me.

So - sorry one second. Okay. So, teach-back, here is an example of teach-back. Instructions can be confusing. I want to be sure I was clear in how I explained this medicine. Can you tell me what it's for and how you will take it? So, it's not a yes or no question. It's not something that should feel like a test to the patient.

And it's really a chance for the patient to confirm that they understood what was said, and also a chance for the provider to be able to see whether the patient understood what was being explained and to re-teach if necessary. So the idea is to ask the patient to repeat back in their own words what they need to know or do in a non-shaming way.

So we rolled this out. We - I'm sorry, I'm having some problems here, okay. So we piloted this with some of our patients. We had three or four of the people on our team who agreed to pilot it with five to seven patients. And they recorded their results on an evaluation log.

We then shared the results with the committee and there was very good feedback in terms of using this tool. The people on the team then found buddies to also use teach-back and we incorporated it center wide. We then included it in presentations and discussion at department meetings, newsletter articles.

We discussed it with the Quality Care committee, and we included health literacy both in our policies and also in a lot of our trainings. We have online annual trainings and we also have online orientations that include health literacy and teach-back now. And we also did get feedback from our staff.

And one of the reasons that we really decided to focus on teach-back is that it is a patient safety issue. And under the AHRQ 2001 report, Making Healthcare Safer, it does say asking that patients recall and restate what they've been told is one of the top 11 patient safety practices based on the strength of scientific evidence. So there were lots of good reasons to be working in this area.

So our evaluation showed that after we had been working on implementing teach-back for about 8 months, about 61% of our staff reported that they were using teach-back, and about 78% who used teach-back said that it changed the way they communicated with their patients. And we sent this survey out by a SurveyMonkey.

We then, last month we incorporated two questions on teach-back into our annual staff satisfaction survey. And 91% of our staff said they were using teach-back and 88% of staff reported that it had increased their patient's participation in their care.

The other thing that we focused on is written communication. This was less of a priority for us in the beginning. We really felt that spoken communication was more important, but we did start looking at our documents and revising things to able meet the standards developed by HURSA and the CDC.

And these are some of the things we worked on, getting our documents to the sixth grade level or below. Looking at the font of our documents, at the justification of the margins and trying to follow the new standards and guidelines that are available.

One other area that we focused on is changing the way we ask questions. We have a provider who came up with - really trying to incorporate with the patients, instead of asking, do you understand or do you have any questions, trying to ask, what questions do you have? Just a more welcoming way to be able to ask people about having questions.

When we ask, do you understand or do you have any questions, often times the answer is no. And asking, what questions do you have is a more open way to ask patients about that. So here's some resources including the tool kits that I've mentioned. The AHRQ took kit is at the top, and the Rima Rudd tool is at the bottom of this slide and some other great tools.

And on this slide are more great resources around health literacy and some courses that you can take to get CEUs or CMEs in the area of health literacy. So, thank you.

Chioma Nnaji: Thank very much Ms. Schlotterbeck. Our next and final presenter is Ms. Barbara Nealon, who is the Director of Social Service and Multicultural Services at Heywood Hospital. She has been in this position for over 20 years, and specifically works as a patient-family advocate and promoting social justice and community outreach. She has been instrumental with creation of Multicultural Taskforce, which spearheaded the development of a Multicultural Service Department.

The department focuses on diversity, interpretive services and spiritual services. Her work has been published nationally by the American Hospital Association. And in 2009 she was recognized by the Massachusetts Department of Public Health for her work piloting the

Making CLAS Happen manual, and outstanding contribution to the elimination of racial, ethnic, and linguistic health disparities in the common wealth. Ms. Nealon, go ahead.

Barbara Nealon: Thank you Chioma. Today we want to talk about community partnership, and we need to partner with our community organizations really to make a difference. We no longer can work as islands. We need to work integrated within our community organizations. We need to seek joint funding and build and/or join community boards and coalitions.

Examples of this include building relationships with key organizations within your community. We've got to come out of our castles in our healthcare institutions and actually get to know who the city select men are, the mayors, the legislators, the various grassroots organizations, find out exactly what they are able to do for you and what you can do for them.

This includes refugee assistance programs, community health agencies, youth and family organizations - faith-based groups are oftentimes overlooked and they're a great resource, local schools and universities. If you have little or 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. This is the most important thing that if you take anything away from my presentation is this, as long as you have initiative, you can make a difference. There are many resources out there and are available and many of them are free. And here's some examples on how to take action now.

As mentioned in Georgia's presentation, Making CLAS Happen - The Six Areas for Action, is a great resource book. If you haven't had a chance to get on to the Web site for this, please do that. You'll do yourself great justice and your community will benefit immensely. There's also the Community Health Network areas here, CHNAs.

At Heywood we participate in CHNA 9. There - These are local coalitions of public nonprofit and private sectors working together to build healthier communities in Massachusetts. And through this we provide prevention, planning and health promotion. It's a great opportunity. If you haven't thought about joining one, I'd strongly urge you to do that.

Through our CHNA 9, we developed this community health needs assessment that is, I'd say a great resource. And right now, we've been able to offer some mini grants and some good sized grants in our community to effect change and eliminate health disparities.

Another great resource and a team that I work very closely with is Critical Mass for eliminating health disparities. They also have an action toolkit and I strongly urge you to make contact with them to find out what kind of great resources they may be able to offer you.

You need to seek out minority groups, associations and coalitions, religious groups, councils and meetings and hospital diversity teams. And again, if you are in isolated areas, you may have to go beyond your immediate service area to find these resources or you may need to create them to help your communities.

At Heywood Hospital, we were a very homogenous facility and community up to about ten years ago. And we were in denial. I believe that there were many of us from the community who said, you know, "Why should we be doing - offering interpreter services? Why should we be focusing on minority health issues? We don't have that many within our community?"

What we did is we went to the City of Fitchburg who had the North Central Mass Minority Coalition, who didn't do a lot of work out in our neck of the woods. And we became a member of the North Central Mass Minority Coalition. And through that organization, the North Central Mass Minority Coalition now covers our entire CHNA 9 service area which includes 27 cities and towns.

We do some great work, including our health disparities collaborative, which now includes the full hospitals within our catchment area. So we're looking at the REL data. We're working on data collection. We're looking at interpreter services, sharing resources. So again, we have found the benefit of collaborating with others, even others outside of our immediate service area to help out.

We created the Greater Gardner Religious Council. We found our religious leaders out there floundering around with trying to network and make a difference within our community. So, and I needed a volunteer clergy support system at the hospital. So I lead the Greater Gardner Religious Council and we facilitate meetings here and we provide community education. And the churches invite us out and it's a great way to really get out into the trenches.

We, in 1998, we established the Multi-Cultural Task Force. And through those efforts, we had our CEO and executive team, plus our frontline staff and members and our community. We have an EMS Chaplin. We have the minority coalition sitting on that team. We were able to identify needs and we developed the Multi-Cultural Service Department which offers interpreter services.

And just to point out, prior to us offering interpreter services in-house, our largest group of patients that we serviced were American Sign Language patients and that was through use of the Mass Commission for the Deaf and Hard of Hearing only.

When we started our in-house interpreter program, our encounters went from 56 encounters a year to 252, and today we're up over 1500, which in some institutions that may not be great volume, but we were evidence to prove that if you bring it, they will come.

Our - we serve on the steering committee for CHNA 9 for the Gardner Area Interagency Team. This group's been around over 30 years and we are really interdisciplinary. We have the legislature sitting on this team. We effect change at a grassroots level and we have a pulse in our community now.

We, based on this current needs assessment that we also did with CHNA 9, we identified we have a high suicide rate within our team. In March we started to embrace all the other members, including school systems, public health departments, legislators, and we are really making a difference regarding all of this intervention.

We need to look at joint funding, but we need to apply for grant funding to help us work collaboratively with community partners, to contract with community programs to provide services, allocate funding to community-based organizations can show true commitment and add momentum to grassroots solutions.

We want - you need to build and join coalitions, share those resources and collaborate. We can impact multiply (sic) in various areas whereby working on steering committees, boards and coalitions, sponsor or participate, health fairs, cultural festivals and celebrations.

Share information through radio stations, newspapers, offer education and training opportunities, share space as a resource for community meetings, invite cultural brokers to committees and membership as they offer feedback on improving services, determining topics for education and participate in the grievance process.

Identify potential employees and present cultural information to staff meetings and training, examine work force development, recruitment and retainment. You want to involve community stakeholders. When you engage and involve key people in your boards and committees you may identify the most efficient and tailored solutions.

Engage client participation at all levels. You want to involve them in community and health research, so our needs assessment was a very good example. Participate in cultural competence planning. Add customers to boards and committees. Workforce development and training, recruitment retaining for all diverse populations within your service area is key.

Improve awareness and access to services, being able to identify gaps, well, transportation voucher programs extended hours, you may be able to do a lot of great work with that, participation in the healthcare process with language and literacy levels that the client can understand. And client satisfaction assessments are key.

You want to share your cultural competence knowledge. By doing that you will learn, the community learns. You want to share your progress with the community as well. Here's just a quick example that we had. We co-sponsored with the North Central Mass Minority Coalition, the YWCA Stand Against Racism event and it was in the - we invited the newspaper who actually participated in the whole process, which is really great.

So in conclusion, working with 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 your community organizations, involve community stakeholders, engage client participation and share cultural competence notice - knowledge.

In this presentation, we did cover two standards, which is Standard 12 and 14 of the CLAS standards. We have some resources here for you and I'm going to turn the presentation back over to Chioma.

Chioma Nnaji: Thank you very, very much and I would like to thank all of the presenters that we had on today. I'm going to pass it back over to Jennifer and she will talk a little bit about what will be available on the Web after the training - after the Webinar, and then we can get to some of the questions that you all have posted. Jennifer?

Jennifer Cochran: Great, thank you, Chioma. And let me add my things to the presenters. You gave us a lot of material, and let me say that there were a lot of questions that were coming in through the chat box about, can I get the slides? When are they going to be available? So just a reminder to everyone that full slide sets, together with the transcript and the recording will all be on the Refugee Health TA Web site, and that's www.refugeehealthta.org and /webinars.

You'll be able to find them there. I also want to say that we know that there were a lot of resources that were put up as speakers were finishing their talks. They had slides that just have a really rich amount of resources. We are going to be compiling those into a single document.

So that'll be a side-by-side document also posted on the Web site where you'll be able to - you'll have active links there so you'll be able to look at some of the toolkits that were mentioned, some of the other resources and, of course, the Making CLAS Happen toolkit or guide that is on the Mass Department of Public Health Web site.

And we strongly encourage you to take a look at those resources, explore away. The Web site again, is www.refugeehealthta - so that's all one word - refugeehealthta, for technical assistance, dot org. And for those of you who haven't yet visited the Web site, I'm going to point out a couple of things that are available there.

First we have a number of archived recordings for archived Webinars, including one on language access that you may be interested to go back and listen to when you have a - well, I was going to say a moment, but really an hour, to do that. There are other resources that are available there. And then we have something called Community Dialogue that I would invite everyone to join in.

And that is an opportunity for people from the community to share information with each other. We have a number of threads that are going currently in the Community Dialogue. So you're welcome to visit the Web site and stay for a while and see what's there.

We've had a number of questions that have come in through the Chat box, some of which have been answered already by speakers. So I am going to - actually at this point I'm going to pass it back to Chioma and while she's - I know she has a question for a couple of speakers. While she's asking that, I'm going to compile a couple of the shorter questions to see if we can answer those as well, so Chioma.

Chioma Nnaji: Okay. And so this question could be answered - could go towards Georgia and/or Dr. Hardt. And the question is, "What are some of your suggestions for administrators or staff to facilitate those necessary discussions around the impact of racism or xenophobia or sexism and how providers can sort of reach those various levels around cultural awareness - self-awareness?"

Eric Hardt: Ms. Simpson, I defer to you. This is Eric.

Georgia Simpson-May: Interesting, Eric. I was going to defer to you as the content expert.

Eric Hardt: Okay, well, then I'm going to speak, Georgia. In a - one thing, one quick thing I will add is that, find local champions.

Georgia Simpson-May: Yes.

Eric Hardt: You know, find somebody who's operating a relatively high level to plug into your administration as a - as high a level as you can. And, you know, as a white man, I have to say that sometimes you're in a very good position to advocate about racism, about sexism and about language when you don't have the demographics of the population that you're aggregating for.

So you don't necessarily have to look for somebody with English as a second language to advocate for good interpreter services. Sometimes you get the attention of the mainstream by just having an average Joe Blow be your advocate. A doctor is always helpful because they tend to have a fair bit of power. But the Director or Nursing can also be a terrific ally. Georgia?

Georgia Simpson-May: What I - yes. What I would add is, if you go to the Boston Public Health Commission's Web site, they have what's called the Center for Social Justice and Health Equity. They do a lot of work around racism. It's actually Chioma, you might be able to help me with the title, it's Dismantling Racism. And so they have a process for having those very difficult conversations with just that audience that you've identified in your question.

Jennifer Cochran: Great. Chioma, can I ask a - some, a couple questions that have come in here?

Chioma Nnaji: Definitely.

Jennifer Cochran: Great, okay. So, one of the questions is around - and again I think this may be going to Eric as the clinician who's here. Then, so it's directed to Dr. Hardt and, "What effective strategies have you used to get clinical providers who serve HIV positive people of color to attend cultural competency training sessions to help their - them start or continue their journey to cultural competency fluency?"

Eric Hardt: I have two suggestions. Bring good speakers that you've heard speak, and number two and probably more important, avoid special sessions. For many years I was asked to give special cultural competency sessions, and frequently people run away from them because they think they're too touchy-feely.

When you're doing - planning a training session in this area, get it right into the regular keychain, CME and other schedule of the target audience that you're looking at, whether it's grand rounds, nursing conference of the week or whatnot, have it look like a regular old CME session, particularly one with risk management credit.

Jennifer Cochran: Thank you. Anyone else want to add to that, that the...

Georgia Simpson-May: Yes. I would - hi it's Georgia and I - that's a great suggestion. And I would also add that you can reach or extend beyond that particular audience if you also begin to look at the standards as, you know, part of your performance management and quality improvement processes, and really integrate them, embed them in being a better agency overall. That's one approach that we advocate for.

Jennifer Cochran: Great, thank you.

Sue Schlotterbeck: Hi, and this is Sue. I also want to just comment on, you know, really incorporating this into new hire orientation so that all of your staff get this type of training, and then any type of annual training that you require of your staff, including this.

Jennifer Cochran: Great points, all. Now it's, not surprisingly, here's a question that came up around funding opportunities. And so the question is, "Do you know of any funding opportunities that support implementing CLAS within an organization?" Anybody?

Georgia Simpson-May: This is Georgia. I'm not aware of any at this moment.

Jennifer Cochran: Okay.

Georgia Simpson-May: But it's not to say that it's...

Jennifer Cochran: If anyone would know, you would know.

Georgia Simpson-May: Yes. I mean, it's an - it's very important, even at the national level. So what I would say is keep an eye out on, you know, what's going to happen with the Affordable Care Act, and then become familiar with the health disparities, the health equity portion or minority health portion of the Act and some of the elements within there, because they do talk about being culturally and linguistically appropriate within the Act itself.

Jennifer Cochran: Very true, thank you.

Chioma Nnaji: And, can - if I can say something about that, Jennifer, this is Chioma. I just wanted to add, based on Barbara's presentation, she talked about community assessments. In one of the sort of initiatives that is happening, particularly out of NIH funding is around community academic partnerships.

And so these community academic partnerships allow community health centers, smaller community-based organizations, grassroots organizations to partner with academic institutions to begin sort of these planning processes around what's happening within certain communities and what are ways in which we can address what's happening in certain communities.

And they actually provide funding for that planning process. And then they provide funding for you to develop sort of that intervention. And that intervention can be a behavioral level intervention. It could be a community level intervention, but it can also be a system-based intervention, so something that can be impacting the, your policies and procedures within a health center.

So looking at some of those other types of funding that might not directly say something about CLAS, but that will help you engage community and do something with community that can make change.

Georgia Simpson-May: It's Georgia and I would also like to add that within the Making CLAS Happen manual, we do have a section about CLAS on a budget. So we understand that there are resource constraints and we were very mindful of that. And so, even if you take a peek at that, to maybe get you started while you seek out additional funding, you may be able to begin, you know, implementing some areas of the CLAS standards.

Jennifer Cochran: Very good. I'm going to pose one more question that actually follows that quite nicely, and I think that that will probably be about where we get to today. And the reason I state follows it is that someone is asking about needs assessments, and how to get more information on needs assessment models, or how does somebody start a needs assessment, if you were doing it for the first time, if there is any advice or if you know of good resources you can point people towards.

So this might be for Barbara or for Georgia...

Barbara Nealon: We have a CHNA 9, we have, we conduct the needs assessments usually every three years, so we had formulated a template many, many years ago, but this last go-through, our report, when you actually read the amount of detail in there, we cut and pasted out bits and pieces, and again, utilizing our different resources that we had, we cut and pasted different templates from different areas.

So again, MassCHIP gives you a lot of information. And we were able to incorporate a lot of that data. But our focus groups and so forth, trying to get things formatted in a certain way, where the public could actually digest that information, we had to make sure though, that it had to be very user friendly.

So again, your CLAS manual has some templates, Critical Mass has templates, but you can Google almost anything. Department of Public Health, you have our language needs assessment, Georgia, that helps us in many aspects with our needs assessment as well. So I think - again, there's a lot of free things out there that you don't have to purchase, templates or, you can cut and paste and modify templates to meet your needs.

Georgia Simpson-May: Yes, I would also add - thank you for that, Barbara, that if you go to the U.S. Office of Minority Health, their Web site, and probably look up, Think Cultural Health, that was one of the slides I had, they may also have some resources available to folks about the CLAS Standards and integrating them and doing the appropriate needs assessment. But all of the other items that Barbara mentioned are very relevant.

In terms of MassCHIP, that's a database sponsored by the Massachusetts Department of Public Health, and you can find some readily available data, information to begin to build your case. And then I would probably also recommend engaging, as Barbara mentioned, you know, the community and other stakeholders in that process, and ensuring that that's the direction you want to go in, modify the direction if need be.

But you can tailor some of the tools from the CLAS Happen to your own particular local needs.

Jennifer Cochran: Yes, and it's Jennifer. So I just also want to remind people who are outside of Massachusetts - we do have a national audience today, we have spoken a lot about Massachusetts resources, but many of these are directly useful for you, regardless of the state you're in, or where we refer to MassCHIP, which is a publicly available data site, chances are most states have something quite similar to it.

So you can check on your state's Department of Public Health Web site to see if, to what extent or how you might access publicly available health data. I encourage you do that. At this point I will remind folks again, you've seen a couple of these things come up, that please, if you can, avoid logging out of the Webinar until we close it, which we're going to do promptly in one minute.

At that point the evaluation will come up. And a reminder that for those who are requesting continuing education credits, the evaluation is required for all of you. We read every evaluation. We read them and we listen to them, we use them to help formulate for additional Webinars. So I want to thank you for doing that.

I'm going to also, again, thank our many co-sponsors for today's Webinar, and I want to especially thank the Office of Refugee Resettlement, and our partner, John Snow, Inc. in Boston for their support for the Refugee Health TA Center, which provided the technical base and invite - through which we invited many of you to join us. Chioma, a closing message from you as well, please.

Chioma Nnaji: I would just like to second everything that you're saying, and thank the presenters and also thank those who have joined us. If there were any questions that were not answered, we will make sure that we pose them to the presenters and also post them on the Web site.

Jennifer Cochran: Great. Thank you to everyone, and have a great rest of your day. Thank you.

Man: Thank you, have a great day.

Woman: Thank you.

Operator: Ladies and gentlemen, that does conclude the Webinar for today. We thank you for your participation and ask that you please disconnect your line.

END