SCHOOL OF PUBLIC HEALTH
UNIVERSITY AT ALBANY State University of New York

Public Health Live Transcript
December 2014 Program
Bridging Gaps: The Vital Role of Cultural Competence in Healthcare

Moderator: Hello and welcome to Public Health Live, the Third Thursday Breakfast Broadcast. I'm Rachel Breidster, and I'll be your moderator today. Before we get started I would like to ask that you please fill out your online evaluation at the close of the webcast. Continuing education credits are available after you take our short posttest, and your feedback is always helpful in planning future programs. We encourage you to let us know what topics are of interest to you and how we can best serve your needs. As for today's program, we will be taking your questions throughout the hour by phone. Our toll free number is 1-800-452-0662 or you may send written questions by email. Please e-mail us at any time throughout the hour at phlive.ny@gmail.com. Today's program is "Bridging Gaps: The Vital Role of Cultural Competence in Healthcare." On today's program we will address the benefits of culturally and linguistically appropriate health services, methods for providing those services, and why providing culturally competent care is essential to improving overall individual and population based health outcomes. Our guests are Wilma Alvarado-Little, a language access advocate and James O'Barr, the Migrant Health Coordinator for the northeast region at Hudson River HealthCare, Inc. Thank you both very much for being here.
Wilma Alvarado-Little: Thank you.
James O'Barr: Glad to be here.

Moderator: We've got a pretty big topic in front of us today, cultural and linguistic diversity, and appropriateness of healthcare. So James, can you start us off by discussing some of the key concepts that we're referring to when we talk about culture.
James O'Barr: Well, you're right, this is a very big topic. We can probably spend a couple of hours just talking about culture. Culture is actually a very old word, originally, and it is appropriate because I deal with farm workers and we originally talked about plants and how we help plants grow. But in our time, that definition has changed and has become expanded and continues to expand. But it refers to the language, the customs and the learned behaviors that define a particular group of people or it can define an organization, people in an organization and how they behave. These are learned behaviors. They're not handed down from on high. And there are many, many, many cultures. This is where public health has to bridge a gap because, especially in this country where we're a melting pot of cultures, public health is intended to create a healthy environment for everyone, not just one group of people, not just certain persons but everyone. That's the mission of public health.

Moderator: And just to clarify, when we say culture, I think a lot of people kind of limit their focus to racial and ethnic perceptions, but you're referring to other groups as well, aren't you?

James O'Barr: Absolutely. That's why I say it continues to expand. We might have meant that 20, 30, 40 years ago, ethnic diversity, but now we're talking about people for example who have HIV/AIDS. They have their own culture. Deaf people have their own culture, people who use sign language. LGBT folks have their own culture and any organization has its own culture, its own distinct culture.

Moderator: So talk to me about how these individual cultures are related to health.
James O'Barr: Because each culture has its own language and its own meanings, its own understandings, in order to provide healthcare, we have to at least have sensitivity to the fact that what we mean and think as healthcare providers may not be the same thing. We might use words, for example, that people understand differently. Certainly if people speak another language and I think Wilma is going to give an example of that, just how the different meanings can alter what it is we're able to do. Again, cultural competence, I think, is not exactly the right word. It's very difficult to be competent in one's own culture, but [much harder] to be sensitive to and aware of the fact that there are other cultures and they are not less than ours. We are not superior. They are not inferior. But they're different.

Moderator: So coming from that perspective and understanding, we address different cultures and trying to build more sensitivity to how people communicate, certainly we can see that in healthcare, this becomes a really important issue. So can you talk to us, Wilma, about culturally and linguistically appropriate services which are also known as the CLAS standards?
Wilma Alvarado-Little: Sure, the CLAS standards are defined as services that are respectful and responsive to individual cultural health beliefs and practices. We're not limiting it to race, ethnicity and language. As James mentioned, the organization has its culture, but there are also cultures within the organizations, especially in healthcare, drawing from the experience of being hospital based, you can see that maybe the physical therapists have their culture within the organization. The social workers have their culture within the organization. So how do we provide services and resources within the organization so that there is not a disconnect? So this is something that the CLAS standards help to define – areas and services so that they are respectful and also taking into consideration preferred languages as opposed to primary language. One of the questions that I ask when I work with clients or patients is, "in what language do you get sick, in what language do you access your emotions?" These are questions that resonate with the individual and with the communities. These are some of the things that are helpful with the CLAS standards so that these can be employed by all members of the organization regardless of the size and at every point of contact.

Moderator: Can you provide some background on the CLAS standards and how you were involved with that?
Wilma Alvarado-Little: Oh, sure. It was a very, very exciting process. The national CLAS standards were originally developed by the Health and Human Services Office of Minority Health in 2000. So then after ten years you want to know what's going on and so in 2010 the Office of Minority Health launched an initiative to update the standards and that incorporated public comment and ongoing consultation with an advisory committee that was made up of 36 experts that represented various professions and disciplines. In 2013, we were very excited to release the enhanced CLAS standards at the White House. So now there are 15 standards. Each is an action step that

organizations and professions can use in their implementation of culturally and linguistically appropriate services.

Moderator: That is very exciting. Now, what is the purpose of the CLAS standards? Why did these come about?
Wilma Alvarado-Little: They're intended to advance health equity, help eliminate disparities and improve the quality of services. Before, there really wasn't a lot of information as to how to go about this, so HHS Office of Minority Health was able to provide guidance in this way. They established a blueprint for health and healthcare organizations to implement and provide culturally and linguistically appropriate services.

Moderator: Excellent. Now that we've talked about the background of CLAS and where it came from, let's revisit why culturally and linguistically appropriate services are important for individuals in community health.
Wilma Alvarado-Little: One of the reasons, and there is so much to this, like James said, we can talk about this a lot, but there have been rapid changes in the demographic trends in the U.S. in the last decade. In 2011, for the first time the majority of the babies born in the U.S. were members of a racial or ethnic minority group. So now we're talking about the majority-minority. So I think research indicates that by 2050 this will be the situation. The nation is projected to grow increasingly diverse, so being able to get in front of these issues will be so beneficial, not only to individuals but also organizations, so that they have the tools and the resources available to provide the best quality of care to those whom they serve. That's one of the reasons why this is really important.

Moderator: Do you feel that the importance of culturally and linguistically appropriate services has changed healthcare delivery policy?
Wilma Alvarado-Little: Yes. The national healthcare policies and legislation, such as the Affordable Care Act, have also helped to redefine and underscore culturally and linguistically appropriate services. There are some states, such as Washington, California, Connecticut, New Jersey, and Oregon, that have passed legislation regarding educating the healthcare providers on cultural competency. This is a wonderful tool for our up-and-coming providers, so that, again, they have this information before they hit a unit. There's so much learning going on in their own profession, that to have these resources is really helpful. The Joint Commission has also done an amazing amount of work as well. They set up several standards that support appropriate services; they've developed work such as advancing effective communication with a road map for hospitals that guide them through the journey of providing cultural and linguistically appropriate services. This is important because providing cultural competency isn't just, "let me check off this box, poof, we're done." It is a journey and it is evolving and we're always looking at how our demographics change within our communities. These resources help keep us ahead of the issues. The Liaison Committee on Medical Education and the Accreditation Council for Continuing Medical Education folks have done these pieces as well.

Moderator: So lots of work is being done.
Wilma Alvarado-Little: Yes.

Moderator: How do these services translate to different health outcomes?

Wilma Alvarado-Little: One of the outcomes also is involving CLAS. Say for example if there's a patient or a client for example who is unable to be able to communicate information in a way that's appropriate, something as basic as being NPO before a procedure. If that is communicated in a way that an individual doesn't understand – and we're talking maybe health literacy as well – our healthcare system is complicated enough speaking in English to English-speakers, so now let's add a cultural or linguistic layer to it. There is the decrease of medical errors if information is communicated in a way that is culturally and linguistically appropriate. Also, I don't want to limit it to race, ethnicity, and language in terms of being ahead of those medical errors as well. In addition, poor communication and a lack of competence can lead to higher rates of readmission and increase lengths of stays. In these fragile financial times, this is really an important issue to address not only from the patient side but from the provider side as well.

Moderator: Can this impact how a healthcare organization does its work?
Wilma Alvarado-Little: Yes, adopting the framework and implementation offers an organization the opportunity to improve the communication and helps ensure that the conversations are going to be met. We're looking at quality of care. We'll be able to provide better patient adherence and utilization of preventative services, especially now that we have the ACA. Then, we have effective provider communication and that impacts the patient outcomes as well. So we're able to measure patient satisfaction in a way that will provide the data and the information that will be helpful to organizations, to providers, and also the patients themselves. This will provide an opportunity for patients and clients to feel more comfortable in expressing their concerns and knowing that they have the ability to be empowered to express their needs in a way that's appropriate.

Moderator: I think you've made a pretty solid case that we have this increasingly diverse population and a one-size fits all approach is not going to adequately meet the needs of the patient population. How will the CLAS standards help to reduce discrimination and improve overall healthcare quality and access?
Wilma Alvarado-Little: The CLAS standards provide information to be able, as I said earlier, to get ahead of some of the issues. One of the things that will help regarding discrimination [can be summed up in] one of my favorite quotes by Anais Nin that says, "We don't see things as they are, we see things as we are." So the CLAS standards will help us by providing that guidance to see things through the lenses of others. For example, if we look at it from a geographical, cultural perspective, in some countries and some areas, depending on the socioeconomic levels and different factors, issues of keeping an appointment can be problematic. So if we're looking at the needs of somebody who is, for example, in an area where transportation is an issue, are we going to keep that in mind when we have a provider that schedules an appointment? Are there child care issues for an individual who has to balance child care versus keeping an appointment not only for him or herself but also for their child? How do we go ahead and schedule things so that it is in a way that will optimize access to care for different individuals and groups? Sometimes not understanding why somebody is facing a barrier can lead to that discrimination. Hopefully, by utilizing some of the resources, this can open the conversation.

Moderator: Excellent. Thank you so much for sharing all of that information. Now, we recently spoke to Dina who directs the New York Statewide Spanish AIDS, or SIDA, hotline in Amsterdam, New York, about why they have a Spanish language AIDS hotline.
Dina Arroyo [Video]: Hi, my name is Dina Arroyo and I work for Centro Civico and I am the Program Director of the New York Statewide Spanish AIDS Hotline. The SIDA hotline has been here in Centro Civico since 1988. That's close to 26 years and it was founded by the AIDS Institute. It's very unique because it's the only Spanish AIDS hotline in the state of New York. There is a huge need in the state of New York because of the barriers of the language. There's a lot of people that don't speak English, and all the information is mostly in English. So the hotline breaks this barrier and allow the people to know the latest information about HIV/AIDS and different STDs. The SIDA hotline deals with diversity with training because so many people come from so many different countries, and we have to be ready for that. Not every person explains everything the same way. We receive intensive training to be able to deal with that. We have operators from Puerto Rico, Santo Domingo, Costa Rica so we can serve the diversity of the people who call the hotline. They're great and people always call back to give feedback, positive, negative, they just call us back to let us know. They make a connection. The hotline is supposed to be for New York, but since we're working very intensely now with Facebook and Instagram and all that, we're receiving calls from all over the nation. Please, don't hesitate. Call us, because we're really here to help you get the services that you need because there's a lot of people out there that don't know how to get service. They don't know how to get to services. We are a very important tool for the community right now. For what we know and the evaluations that we get, there's a lot of people getting a lot of care, getting support and getting what they need just because they're calling the hotline. I would like to let everybody know if they have any questions related to HIV/AIDS, Hepatitis C or anything related to HIV, they can call us Monday through Friday from 8 am to 5 pm. The hotline number is 1-800-233-7432.

Moderator: So now that we have an opportunity to see the implementation of some of these services in the field, Wilma, can you talk about specific guidelines for implementing the standards?
Wilma Alvarado-Little: Sure. The initial CLAS standards are comprised of the 15 standards. They're intended to be used together, so they are mutually reinforced. As you'll see on one of the slides, there's the principle standard. That serves as a foundation for the other standards. Then the standards are broken up into three themes: governance, leadership, and workforce; communication and language assistance; and then engagement, continuous improvement, and accountability.

Moderator: Thank you so much for framing how the standards are organized. James, let's turn to you for a minute and hear about how the Peekskill Area Health Center has led the way towards ensuring that you're providing culturally and linguistically appropriate services to your patient base?
James O'Barr: It's quite a story, but as we were talking about culture, I was thinking, in a certain sense it comes out of the 1960s which was a big cultural change in this country. We had the Vietnam War of course. We had the Civil Rights Movement; we had the War on Poverty and the establishment of community health centers and federally qualified community health centers in the mid-1960s. In the early 1970s in Peekskill, New York, despite all of that change, and particularly the changes of the Civil Rights Movement and the War on Poverty, the black community in Peekskill still did not

have easily accessible and affordable and culturally competent healthcare. That's to say black culture did not -- was not seen as good as white culture at that time. So some neighbors, specifically led by four black women in Peekskill, got together and started organizing. They had grown tired. They were all mothers. They had grown tired of taking their kids by bus because they didn't have cars to travel with. They took their kids to the county hospital, Westchester County Hospital or the Medical Center. They had to drag their kids 20 miles by buses and then spend time in clinics waiting, spend time waiting for lab work, going and getting prescriptions filled, taking the bus home. It was a long day of dragging their children around. They got really tired of it so they started organizing. They were eventually able to organize not only black neighbors but white neighbors and eventually got a federal grant for a health center. The center opened in 1975 with 12 employees. It was called the Peekskill Area Health Center. Federally qualified health centers, community health centers, are required to have a board. On that board, 51% of the members are required to be users of the health center. That was the case at the Peekskill Area Health Center. Because they had begun from a position of cultural awareness and sensitivity because of the way they were treated, that really was part of the DNA of the Peekskill Area Health Center from the very beginning.

Moderator: I think part of the point you're making is that it's important for an agency to have an awareness or a sensitivity to the diverse cultures and needs of individual populations as part of its mission for the organization. What makes this sustainable for agencies?

James O'Barr: In the case of the Peekskill Area Health Center, during the 1980s we began to see a large number of immigrants coming into Peekskill. There were people coming in from Latin American countries and Central American countries, Colombia, Ecuador, Puerto Rico and the Caribbean. The health center realized that up to that time it was mostly black and white members of the community who were being seen, but as the numbers of people from other cultures, other countries, other linguistic groups began to come in, it was realized that there was more to be done and in 1989 the health center was awarded migrant health funding. At that point, the health center was going beyond Peekskill and was in five counties of the Hudson Valley and was required to serve farm workers who came from Maine, from Jamaica, Honduras, did I say Maine? I meant Mexico. We still had African Americans coming up from the south, another culture entirely, and we had farm workers, Mexican American farm workers from the Rio Grande Valley of Texas. It was at that point that we became migrant health providers; we decided we needed to do something about our corporate culture to ensure that we had cultural sensitivity operating at every level and in everything that we did.

Moderator: What are the ways that you specifically worked to build those culturally and linguistically appropriate services with the communities?

James O'Barr: Coming back to the Migrant Health Program, migrant health goes back to the 1960s, it was another big cultural change because it was the Migrant Health Act that eventually led to the establishment of community health centers. The Migrant Health Law was signed into law in 1962. It was understood that in order to reach farm workers, you had to go to them. You could not wait for them to come to you. So people were at the very beginning doing outreach and it was not understood everywhere in the country because a lot of farm work was being done by black African Americans, but there were still large numbers of Mexicans coming up from Mexico and also Puerto Rico.

From the very beginning, migrant health had a cultural component to it. People spoke Spanish; a lot of the providers spoke Spanish. They were doing outreach, going into the culture and the camps of the workers. So that was there from the very beginning. I think becoming a migrant health provider really required cultural competency. It then carried over into the health center and its larger corporate culture.

Moderator: Great, so it certainly seems like the Hudson River HealthCare structure really changed to meet the needs of the population. Wilma, can you talk about the additional components of the CLAS standards because it seems like the Hudson River HealthCenter was already meeting some of those needs based on the population changes that you saw. What are some of the additional components of CLAS that we need to talk about?

Wilma Alvarado-Little: As we saw with Centro Civico, they were already doing things that were meeting the needs of the community they served. The first theme focused on governance, leadership, and workforce. Implementing class is a responsibility of the entire organization. As we've seen with both of these organizations, it wasn't something that was a top down or a bottom up approach. It was bidirectional. That really helps address the needs of the communities and also identify what those needs of the community are in addition to providing the work force with the resources that they need in order to do the job that they really want to do to serve the communities. So this helps address situations that would be potential areas of disconnect between policy and practice. So the standards teach us that implementing the class standards at every point of contact is really a critical way of meeting the needs of the community. So when we're talking about cultural relevance, cultural awareness, cultural sensitivity and also linguistic sensitivity, these are pieces that the CLAS standards can help with. Standard number two helps underscore a lot of things that these organizations have already gone ahead and addressed. This is one of the things that is so helpful when you're implementing the CLAS standards. You know your community. You've identified some of the challenges, and then the leadership and workforce discusses what to do and how to do it well and how to do something that's going to make sense.

Moderator: Is there work that needs to be done to educate within organizations? How do you get organizations to buy in and decide that it's worth their while to start implementing the CLAS standards?

Wilma Alvarado-Little: Looking back at standard three, it is important to assess whether your workforce reflects the community that you're serving or also the individuals that are going to be living within your community. It is important to look at whether there is an awareness of that. How do we educate and train our workforce, and that's one of the things that the CLAS standards helps to identify, how can you educate and train. If you're going to train, what are you going to train on if you haven't educated folks on what you need to do? These are some of the things that we're looking at. Again, you're looking at the diversity of the professionals. as we talked about earlier. This is something that Centro Civico and James have discussed. That was a big part of the success that they have.

Moderator: Thank you very much, Wilma. Now we'll see some examples of how Centro Civico incorporates cultural competence principles into some of their programs and services.

Fabrizia Rodriguez [Video]: Hello, my name is Fabrizia Rodriguez and I am the Director of the Community Development Initiative Program with Centro Civico. Centro Civico was established in 1988 and our goal and mission predominantly is to help people become self-sufficient, so we try to be the vehicle to mobilize that. We are a Latino organization but we serve all cultures and try to generate unique services. It's very important to understand cultural diversity. Specifically, I would point to Montgomery and Fulton County because in the past decade this community has become so diverse. We have every culture from Indian, Asian, African-American and different types of Latino cultures that have all migrated here from different parts of the state. Additionally, we have different genders, different ages and different socioeconomic groups. Montgomery County in the past decade has become one of the most diverse counties you'll find between Albany and Utica, New York. The CDI program has various components to it. One is mobilization and that is the biggest one. We are a grant funded program by the Department of Health AIDS Institute that focuses primarily on mobilizing the Montgomery and Fulton county communities and on educating them on HIV issues and also keeping them mobilized on doing prevention work and working together. The other component of the CDI program is advocacy. We participate in state and local lobbying where we try to keep everybody informed about what the issues are with legislation with HIV. We'll have city-wide events such as a health fair. We'll do HIV testing day. We coordinate all that, but have everyone else in the community participate to actually be the ones who actively do the work. Then lastly, we do community assessments. Every contract period, which is five years, within that contract period we're required to do at least one community assessment to see what the needs are in the community. The CDI department, to work on community immigration, we collaborate as much as possible and again it goes back to the mobilization where we host and coordinate these events but rely on the community to participate. By doing that, we're integrating each different group. For instance, we work with ARC, with the seniors, the Office of the Aging, which brings in a different population. We're working with the school districts and getting students involved and we work with other nonprofit groups such as Catholic Charities. Each one has unique consumers that come so working together with whatever event we're hosting, it becomes a community integration project. Language is important. We're one of the very few organizations that have bilingual staff. That has become the biggest hurdle with our Latino population. They have issues with housing let's say and they don't know who to talk to and they can come to Centro Civico and talk to Fabrizia and ask HIV/AIDs questions so they'll come here and ask those types of questions. Monday through Friday, 9:00 AM to 12:00 PM we have walk-in hours and anyone can walk in and get assistance, especially with translation. We'll have someone come in and when we sit down -- for instance, I had someone who needed help with the daycare funds. They didn't understand why their daycare funds were taken away. So it's important that I knew how to help her and that, even though my focus is on HIV/AIDS, she had difference issues. It's important for the consumer because they don't have anywhere else to go. I had to be the middle person to call down to the Department of Social Services and clear it up for them. It's a big piece to servicing all the needs of the consumers that we have. Specifically, with diet, if you don't know culturally what the consumer eats on a daily basis, you won't understand why it's so hard for them, for example, to lower their cholesterol let's say. If I had a consumer who was American, Caucasian, I also have to be sensitive to what their needs are and understand that they have a different diet than what I grew up and I have to be mindful of why it's challenging for them. Not even their cultural upbringing but their economic standards if

they're low income, there are things here and there that are very important because you can give as much advice as you want, as many referrals as you want but are these goals realistic or should they take baby steps? What are some things I can talk to them about? Also if there's someone I can connect them with who can relate to them. My biggest advice for other communities who are trying to be culturally or linguistically aware or mindful, especially when doing social work, is to get out there. Whatever population you're working for, look for those educational seminars. The other main thing is to speak to other organizations that are bicultural in that culture that you're trying to get educated on. Building those relationships with other organizations that deal with the population you want to work with daily, they're your best resources. You'll be surprised how much they want to help you help your consumers.

Moderator: Sounds like some of what she's talking about refers back to principle one that you had mentioned or the principle standards. Can you elaborate on that a little bit?

Wilma Alvarado-Little: The principle standard helps frame the essential goal of all of the standards. By providing effective, equitable and understandable and respectful quality of care and services, we create a safe and welcoming environment at every point of contact. That's really going to be appreciated not only by the diversity of individuals but also our providers as well. It also helps meet the communication needs so that individuals understand that the healthcare services they're receiving, they can participate in them and also be empowered to ask questions and ensure that when they speak with the provider they're communicating what they understand. That opens it up for the provider to, for example, do something like a teach-back: "Tell me a little about what you're understanding" type of thing. Then it helps to eliminate the discrimination and the disparities.

Moderator: Excellent. What are some of the other areas that agencies need to look at to effectively implement CLAS standards?

Wilma Alvarado-Little: Some of the other things that they'll look at are in theme two, the communication and language assistance. We talked about theme one which is talking about governance, leadership, and the work force. So when we go into theme two, these themes can either run parallel or they can go ahead and run consecutively, depending again on what the organization's culture is. Are they regarding strategic plans, how are they implementing things? Theme two deals more with communication language assistance. It talks about meeting the patient's communication needs, whether it be sign language, Braille, interpreting which is the oral communication and translation which is the written communication. They have to say that regarding the communication and language assistance piece. With these two terms they're unfortunately used interchangeably. Interpreting is the oral plain and simple and translation is the written. And this impacts the provider's request when they're asking for either an interpreter or a translator because they're asking for two different skill sets. If you are hospital based, sometimes as interpreters we have to have both. What is part of the governance for this, for 5, 6, 7, and 8 of the standards, is that this theme helps organizations comply with Title VI Office for Civil Rights of 1964, the Americans with Disabilities Act of 1990, and then other federal, state, and local mandates that require the provision of language access services. For example, here in New York State, we have governor Cuomo's executive order number 26 which mandates that state agencies provide culturally and linguistically appropriate services so this is one of the ways.

Moderator: Can you share with us an example of how cultural misunderstandings influence health outcomes?
Wilma Alvarado-Little: Yes, unfortunately there's a case of a situation where poor communication led to tragic outcomes. So there is the case of Willie Ramirez in Florida. He was an 18 year old Hispanic male and what happened was he had told his girlfriend that he was feeling "intoxicado" which in this situation meant that he fell nauseous, and then he fainted. When she and his mother got him to the emergency room, somebody who had a sense of the ability of speaking Spanish converted that word to mean that it was more of a drug situation. So he was being worked up for a drug overdose instead of the primary issue which ended up with having very, very serious consequences and he has now been diagnosed as a quadriplegic. This resulted in a $71 million lawsuit for that healthcare organization. It was a malpractice settlement that would have been avoided had there been an appropriate utilization of linguistic services. Also, Dr. Glenn Flores has done a lot of work regarding issues in medical errors in interpreting and outcomes of that. And then the National Health Law Program has a publication as well called "The High Cost of Language Barriers in Medical Malpractice," which documents some of these unfortunate situations that are due to linguistic misunderstandings.

Moderator: So I think standards 5 through 8 really help to address some of that. In the interest of time, let's move on and talk about what theme three is of the CLAS standards and what those areas are for agencies to focus on.
Wilma Alvarado-Little: Absolutely. Theme three involves engagement, continuous improvement and accountability. These focus on how the communities are being engaged and how organizations are continuing to improve their services and also how organizations can continue to evaluate these efforts? So these are some of the things that these themes will focus on the necessary adoptions, implementation, and maintenance of culturally and linguistically appropriate policies. Again, we're not having that disconnect between the policy and the practice and we're providing resources not only for the patients but the providers as well.

Moderator: Do you have an example of how an organization can be accountable in upholding the values?
Wilma Alvarado-Little: Yes, for example there was a study that was published in the Journal of Healthcare Management and what they described was that they had identified that within the Latino community, there were a lot of cases where moms were bringing their children in for ear infections. So first, they identified this as a concern, which was a fabulous example of a relationship with the leadership and workforce. What they were able to do was provide moms with a tool kit that would help check for temperatures and ear infections that basically cost $3 as opposed to spending $300 for an ER visit.

Moderator: Excellent. That sounds like a really good way to address the problem and be preventative. What are the specific CLAS standards that address the third CLAS theme area?
Wilma Alvarado-Little: One of the things that addresses the last theme area is talking about how do you go ahead and continue to improve and engage your community. One of the things that the CLAS standards did with this piece is that it goes ahead and has information on how to be able to conduct these ongoing assessments. When you look at the blueprint, it has the resources there. If you're doing this, how are you doing it, is it

working. Evaluation is always going to be part of this. It's not always at the end. You can have an ongoing evaluation piece and then identify how this is translating into accountability for the organization and whether there is something else that needs to be done for the community to have that understanding and buy-in.

Moderator: It sounds like from what you're saying it's really important to have the staff buy-in, it's important to get staff trained. James, can you talk specifically about how the Hudson River HealthCare ensured that your staff was both culturally and linguistically trained in appropriate care provision?
James O'Barr: Probably the most important thing we did, as the populations we served became increasingly diverse, was to go to them and bring new board members in, new staff in, and members of the communities we were serving were brought in as advisory and support committees. For example, in a couple of our health centers where we have a very heavy Latino population, Comité Latino is working both to do health promotion in their communities and fundraising for the health center to be involved with the health center. So I'd say, again, that's probably the most important thing we did. It's also important to say that we're not just talking about ethnic, racial and linguistic diversity. We have programs that serve the homeless, people with HIV/AIDS, members of the LGBT communities. Who else? We have many more. It's diversity with a capital D. We had a slide up showing members of our Planetree orientation which all staff receive. They spend two days of training, learning about the history, the mission, the organizational values, guiding principles of our organization. Of course, amongst those guiding principles is cultural competence at an organizational level.

Moderator: Absolutely. Why is it important to expand your sites within the community?
James O'Barr: To demand our sites? You mean create new health centers?

Moderator: Where you're providing services.
James O'Barr: Probably in part because that's our mission: to reach out and serve. That's our mission: to serve the underserved and those who do not have access to healthcare. It didn't stop at Peekskill. By 1994, we had five sites, and the first two sites that were not in Peekskill were farm worker sites. We have continued to expand. By now we're up to 30 health centers in the Hudson Valley and Long Island. But because the need is there and because that is our mission to serve those needs and because we're good at it, as I have said before, from the very beginning we were at least culturally sensitive and aware, and that has grown with time.

Moderator: Which is fantastic. Can you describe specific activities that your center has implemented to respond to the different linguistic and cultural needs of your client base?
James O'Barr: We have ongoing training, continual training both for staff and providers specifically. We created a Cultural Competence Committee in 1994 to continually explore ways in which our organization improves its staff cultural competence and organizational cultural competence. It's an ongoing thing. We have members of our staff who serve on this committee. We have ad hoc committees which are constantly being created. For example, when Ebola became an issue, we looked at the possibility that we might be dealing with Ebola – from somebody from West Africa or somebody who had been infected. Also, recently we had been working with the LGBT communities to make sure that those folks are comfortable when they come into the health center. The other thing we've been doing is training patients. We have workshops for patients

in working with providers, communicating with providers so that they are feeling more confident and have more agency in dealing with their providers.

Moderator: Which is excellent. Now, where has all of this led you as an agency today? I know you have statistics to share about the demographics of your population, the demographics of your board. Talk to us a little about that.
James O'Barr: I'd be glad to. As I said at the very beginning, our board is required to have 51% of its members be users of one of our health centers. Currently we have close to 100,000 patients, 94,000 patients. So we have 20 board members. We try to keep it as close as possible to the breakdown of African Americans, Hispanics, Latinos and other racial ethnic or other cultures. For example, LGBT people would be represented, homeless people, maybe, those impacted by HIV/AIDS. That's a continual process. We're constantly looking at the figures we get back from the cultural diversity of the patient population. They tell us who the folks are that are coming in and we reassess, do we need more people from a different community on our board, or do we need to create a support group in that community?

Moderator: So it sounds like from what you said, your organization really grew out of a grassroots cultural sensitivity situation and you really maintained that even as your organization has grown to be able to serve a much broader population. That's really terrific. In doing this also, it sounds like you've really taken the CLAS standards and incorporated those. I'd like to make sure everyone watching today knows how to find out more information about the resources we talked about. If you look on your screen and also within your slide handouts available on our website, we have the hotline number as well as Hudson River Healthcare's number and more information about what we've discussed today. Now that we know what the CLAS standards are and heard a little about an agency that's worked so hard to provide this competent staff, Wilma, where can we go to find more information about how to use these standards?
Wilma Alvarado-Little: There's a blueprint for advancing and sustaining the class policy and practice referred to as the blueprint and that's the new guidance document for the class standards. That explains the enhancements, the concepts found throughout the standard, and you can find those at www.thinkculturalhealth.hhs.gov.

Moderator: Excellent. Is there anyone you would like to acknowledge in today's program? We're going to take a few questions from the audience but I know there were folks you wanted to acknowledge in your presentation.
Wilma Alvarado-Little: Thank you very much. I wanted to acknowledge Dr. Nadine Gracia, she's the Deputy Assistant Secretary for Minority Health and the Director of the Office of Minority Health U.S. Department of Health and Human Services. And also Ms. Christine Montgomery, she's the Management and Project Officer for Think Cultural Health, Office of Minority Health. And Mr. Godfrey Jacobs, he's the Senior Program Manager for Health Determinants & Disparities Practice SRA International. They have done a wonderful job of guiding us through the revision of the CLAS standards.

Moderator: Excellent, thank you both so much. We have a couple of questions from the audience. The first is, "In cases where patients are reporting the use of herbals in the treatment of a chronic medical condition, particularly among patients of diverse backgrounds, how would you recommend a medical provider effectively navigate

through their own beliefs regarding nontraditional treatments if they conflict with that of the patients?"
James O'Barr: Well you have this very commonly in the farm worker population and other communities that we serve as well but particularly with our farm workers. One of the things we do is we get the providers, the nurses and the physicians and nurse practitioners, physicians assistants, whoever is working with them, to educate themselves about herbal remedies, the use of curanderas, which still happens. It's partly an education. If those remedies are working and people are getting healthier, there's nothing wrong with them as long as they're not toxic.
Wilma Alvarado-Little: Or have some kind of interaction.
James O'Barr: Right. So we try to honor that and not make it look like they're getting inferior medicine or doing something wrong but to show an understanding.
Wilma Alvarado-Little: Also, too, taking it back a step before that, creating that environment where that patient will disclose that they are also utilizing this form. To other communities and other populations this may be treatments, whereas we call it "alternative medicine" here in the states. It is important to be creating that environment where patients can disclose and then have the provider be aware of it so that he or she can do the best in the interest of his or her patient. Creating that space would be really helpful first. We can say, "yes, doctor, I'm going to take what you tell me and then go home and do" what cultures have been doing for a long time. So being able to have the opportunity to have that relationship and to have the discussion is really helpful.

Moderator: Let's see if we can squeeze in one more question. "As racial and ethnic minorities become the majority, why do public health advocacy groups still refer to these groups as minorities?" This is a big question and we only have a couple of minutes so let's see what your thoughts are.
Wilma Alvarado-Little: Earlier in the presentation I mentioned this is what the data and the research is showing. As James had said to me earlier, you said it so beautifully, this is a habit.
James O'Barr: It's a habit, a term of art, minority-majority. This is no longer functional. And the language has to change as we change.
Wilma Alvarado-Little: Then we'll see how it influences policy and how it will go into practice.

Moderator: Let's hope that it does, that as things change we develop our policies to respond to the changing needs of our population .Thank you both very much for starting the conversation on what's a very big topic. It was great to hear from you both today.
Wilma Alvarado-Little & James O'Barr: Thank you for having us.

Moderator: Thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME, and CHES credits, learners must visit www.phlive.org and complete an evaluation and post-test for today's offering. Additional information on upcoming webcasts and relevant public health topics can be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. This webcast will be available on our website within two weeks of today's show. Please join us for our next

webcast on January 15th, “Prediabetes: How Healthcare Providers can Take Action.” I’m Rachel Breidster, thank you for joining us on Public Health Live.