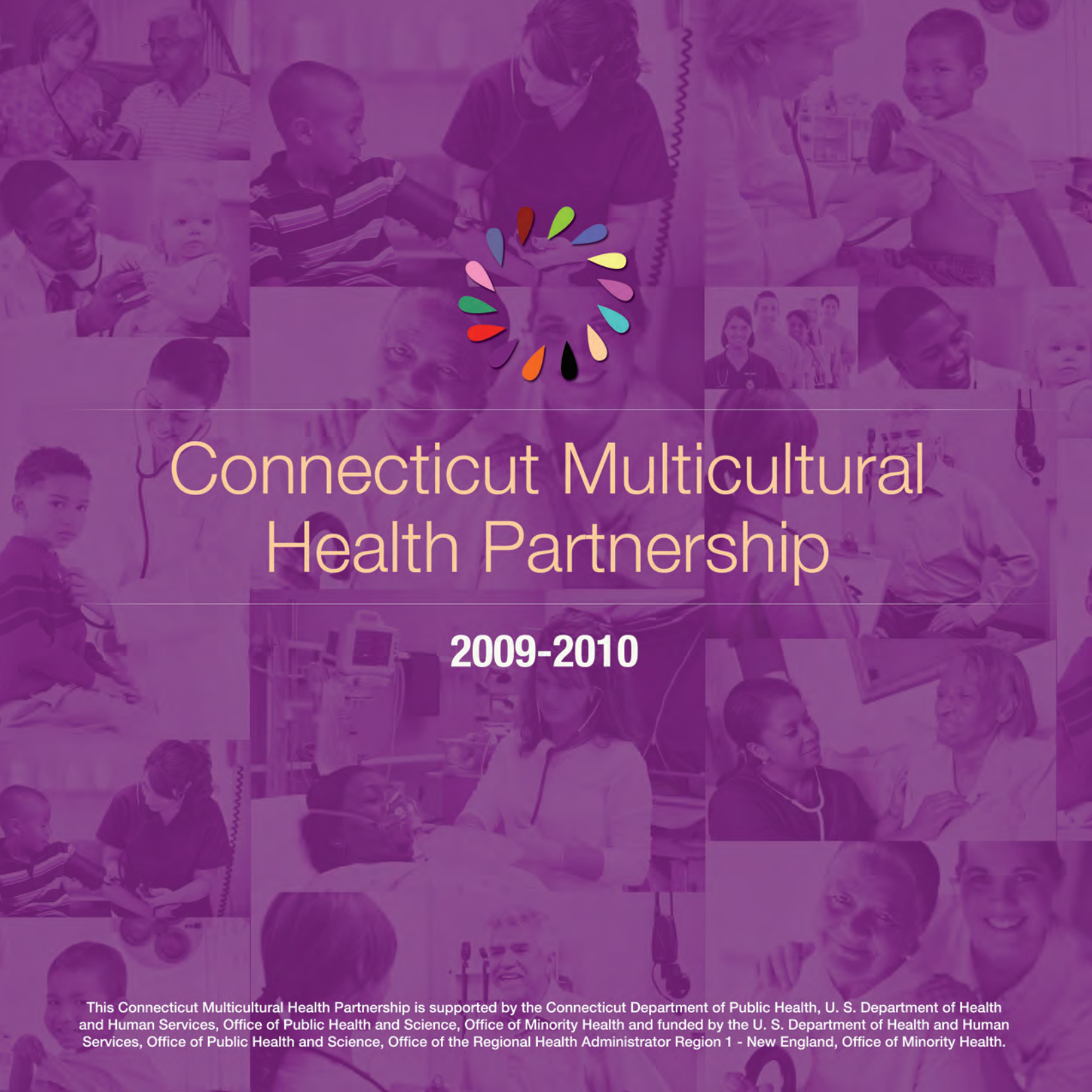

Connecticut Multicultural Health Partnership

2009-2010

This Connecticut Multicultural Health Partnership is supported by the Connecticut Department of Public Health, U. S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health and funded by the U. S. Department of Health and Human Services, Office of Public Health and Science, Office of the Regional Health Administrator Region 1 - New England, Office of Minority Health.

Mission of the Partnership

To develop and implement a state plan to identify and address health disparities and multicultural health issues through the effective and systematic collaboration of a diverse, multidisciplinary group (the Partnership). A major focus of the plan will be the implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) in Connecticut.

Members of the Partnership

Executive Committee

The central steering body and major workers make up the Executive Committee consisting of the Officers and the Committee Chairs. There are 6 committees as follows: Awareness & Outreach, Communication & Media, Consumer Initiatives, Data, Surveillance & Evaluation, Language Services and Professional Development. Each committee is charged with making recommendations built on the foundation of the CLAS Standards for statewide implementation based on each committee's goals and subject area.

General Members

The General Membership consists of all people who agree to the vision and mission and want to support the work of the Connecticut Multicultural Health (CMHP) Partnership. Members are able to have varying involvement at different times throughout their membership. The CMHP respects the variability in members' availability regarding involvement, and welcome everyone in whatever capacity they can engage. All members will be invited to conferences and meeting of the CMHP.

Officers

Nancy Berger, MPH
Chair

Catherine Russell, EdD
Vice Chair of Planning

Marilyn Alverio
Vice Chair of Communications

Lorrie Greenhouse Gardella, JD, ACSW
Vice Chair of Development

Meg Hooper, MPA
Secretary

Committee Chairs

Awareness & Outreach
Karen D'Angleo
Stacy Brown

Comunication & Media
Marilyn Alverio

Consumer Initiatives
Emily Jensen
Paloma Dee

Data Surveillance & Evaluation
Jill Coghlan

Language Services
Meredith Ferraro
Michael Pascucilla

Professional Development
Catherine Russell

Staff

Angela Jimenez
CMHP Administrator
DPH, Office of Multicultural Health

Emily Jensen
CMHP Project Manager
Eastern AHEC, Inc.

Faces of Disparity Awareness Campaign

Presentation of the **Communication & Media Committee**

The ***Faces of Disparity*** Awareness Campaign, which was created by the Communication and Media Committee, consists of two complementary media productions: The ***Faces of Disparity*** Exhibit, and the ***Faces of Disparity*** Video. The exhibit and video, which may be shown independently or together, raise awareness of health disparities in Connecticut and introduce the CLAS Standards (National Standards on Culturally and Linguistically Appropriate Services) as resources for change. Faces of Disparity is suitable for general audiences, policy makers, professionals, educators, and students.

The ***Faces of Disparity*** Exhibit is a portable display of nine free-standing panels that portray health disparities by means of personal stories. Connecticut residents from various racial, ethnic, cultural, and economic backgrounds describe how health disparities have affected their access to effective care. Each story is followed by relevant public health data and by a CLAS Standard that, if implemented, would improve health care and health outcomes for others. The ***Faces of Disparity*** exhibit is travelling throughout the state, and has already been viewed by an estimated 800 residents at such venues as the State Legislative Office Building; the University of Connecticut Health Center; Saint Joseph College; Trinity Episcopal Church. Panels are available to all CMHP members for use in educational programs and for display at their locations.

The ***Faces of Disparity*** Video is a 15-minute documentary that integrates personal stories of health care consumers (as portrayed in the exhibit) with the perspectives of leading experts in health care and public health. The video defines health disparities, identifies contributing factors, and presents CLAS Standards as resources for change. ***Faces of Disparity*** DVDs have been distributed to CMHP members.

The video also may be viewed on the CMHP website: ***www.ctmhp.org.***

> "The doctor knew nothing about my culture. He will never understand the damage that he caused."
>
> *Shaheen from Stamford*

> "My father does not speak English. When he was diagnosed with prostate cancer, he did not understand the doctor or the treatment that was recommended..."
>
> *Mario from New Britain*

> "Health is not just seeing the doctor in the office; it's not just having surgery. It reflects the whole body and wellness and a state of body and mind. And if someone is living in poverty or they are living in a situation where they don't have access to food or an education or a job, they are not going to be as healthy as a counterpart who has those things."
>
> *M. Natalie Achong, M.D.*
> *Board Certified OB/GYN; Clinical Instructor*
> *Yale University School of Medicine*

Recruit, Engage and Inspire to Lead (REIL) Project

Presentation of the **Cultural Competency Committee** (now part of the Consumer Initiatives Committee)

The Connecticut Multicultural Health Partnership seeks to ameliorate health disparities and securing input from the customers and service recipients is a vital component. This was done by conducting three focus groups, two of which were conducted at the Urban League of Greater Hartford with 52 participants currently enrolled in the League's GED preparation/training classes and a third group comprised nine professional women.

Race matters in the pursuit of eliminating health disparities but racial concordance of the service provider-service recipient was not the primary factor in seeking or receiving quality health care according to the majority of focus group participants. Racial concordance was a preference for one-third of the participants but the resounding response clearly described the cultural competent provider as being knowledgeable of cultural implications and the community being serviced. The quality of the encounter was the significant factor in evaluating the quality of care received.

Recommendations for CMHP Members

1. Patient choice in provider assignment may improve engagement and retention of patients with most focus group participants stating they never had the opportunity to choose their physician but they would like to have that opportunity.
2. Concordance in race, ethnicity and/or sex may be important to the patient and thus improve health outcomes.
3. Do not assume a provider of the same race, ethnicity or linguistic heritage as the patient is culturally competent. Patients have had bad experiences with their physicians within their racial/ethnic group as well as with those representing other groups.
4. Promote the training and experience of your professional and support staff. Patients want to know what their healthcare organizations are doing to improve the quality of care they receive.
5. Develop and promote safe venues for patients and staff to raise issues of discrimination or unfair treatment practices or biases. It is believed that raising such issues can cause a staff person to be fired or a patient to not be seen.

One participant seemed to sum up the majority of opinions: **"…Race- Does not make a difference as long as they (physicians) are knowledgeable about the complaint, diagnosis, and cultural differences in treatment."**

For more information on this report visit the CMHP website: **www.ctmhp.org**.

Language Needs and Services of Local Health Districts and Community Health Centers

Presented by the **Language Services Committee**

The Language Services Committee is working to ensure that language is not a barrier to the receipt of appropriate health care and health education through the promotion of linguistic competency to health professionals and organizations. The Committee chose to conduct surveys of both Local Health Departments (LHDs) and Community Health Centers (CHCs) because an evaluation of available language access services in these community resources for health care has not been documented.

Local Health Departments

Types of Language Services Offered

Translations are the most common form of language service, with three-quarters of the LHDs providing educational materials, and 70% having signs and posters or forms written in a language other than English. The most common method of providing interpretation was through bilingual staff (30%), followed by volunteer interpreters (22%).

Survey Highlights

- The 33 respondents provide public health services to over 2 million Connecticut residents.
- Nearly one-third of the LHDs reported that they encountered people with LEP every week and, at the other end of the spectrum, one-third had encounters less than once a month.
- Spanish was the most common language encountered, with Chinese being second.
- Slightly less than half of the LHDs conducted an assessment of the size of LEP population in their community.
- The cost of providing language services was the highest ranking barrier to address the needs of LEP community. Other challenges included limited availability of interpreters and limited availability of translated materials for some languages.

Types of Language Services Offered by LHDs (n=32)

	Offer	Planning	Do Not Offer
Translated educational materials	76%	9%	15%
Translated signs & posters	70%	6%	24%
Translated forms	52%	12%	36%
Bilingual staff	30%	3%	67%
Volunteer interpreters	22%	19%	59%
Media outlets	18%	3%	79%
Telephone language lines	18%	3%	81%
Communication Boards	6%	6%	88%
Paid interpreters	9%	6%	85%
Web-based information	6%	12%	82%

Community Health Departments

Types of Language Services Offered

Face-to-face independent or contractual interpreters (both professional and volunteer) were rarely used for Spanish or other languages. Telephonic interpretation was used by all CHCs for Spanish speaking patients and by 89% for patients who speak languages other than English or Spanish. Signage in Spanish was used by two-thirds of the CHCs and signage in other languages by one-third. Twenty-two percent have Spanish language health education programs, but none of the Centers offered classes in other languages. Social networks or bulletin boards are utilized to communicate with patients in Spanish but not to communicate in other languages.

Survey Highlights

- Spanish is by far the most common language encountered. Hindi, Portuguese, Tagalog and Urdu are the other languages that are encountered.
- The CHCs try to meet language needs by utilizing bilingual clinical and non-clinical staff and family members. All the CHC used telephonic interpretation as well, while none of the centers had access to video-conferencing.
- Translation services were the most likely language service to be provided and this was done so by untrained internal staff.
- A smaller number of community health centers required completing a course in medical interpretation and passing a competency exam on medical interpretation skills.
- Community health centers are likely to have policies regarding language services and train staff on assessing patient language abilities and tracking linguistic demographics.

Types of Language Services Offered by CHCs (n=9)

	Spanish	Other Languages
In-person interpretation		
Bilingual clinical staff	100%	67%
Bilingual non-clinical staff	100%	44%
Staff interpreters	78%	22%
Family members	89%	100%
Independent interpreter	0%	0%
Commercial service	11%	0%
Volunteers	0%	0%
Technological interpretation		
Telephone interpretation	100%	89%
Video-Conferencing	0%	0%
Other Services		
Signage	67%	33%
Health education information	22%	0%

For more information and the complete report visit the CMHP website: **www.ctmhp.org**.

Training Recommendations for Connecticut

Presented by the **Professional Development Committee**

The purpose of the Professional Development Committee is to contribute to the overall mission of the Connecticut Multicultural Health Partnership by enhancing the cross-cultural skills of public health and health care professionals through training recommendations, dissemination of training materials and educational forums. A survey analysis, focus groups and key informant interviews were conducted and the following training recommendations were made:

1. Disseminate and/or implement a basic training in the CLAS Standards across the state and in multiple health and social service environments.
2. Provide a high level, organizational training, to leadership and senior management on the best practices and exemplary models that promote cultural and linguistic competency throughout an organization.
3. Provide training to assist agencies with developing standardized protocol to effectively respond to consumers when they do not speak English or speak very little English.
4. Provide training for organizations to incorporate consumer survey data into short and long term planning processes and quality improvement initiatives.
5. Provide training among similar organizations to establish data collection categories and for purposes in collecting data so that information is useful to share across agencies and/or to compare program outcomes by initiative.
6. Facilitate discussion groups with administration and management on the concepts of “reasonable” and “meaningful” language access services as intended by the Office of Civil Rights.
7. Provide training to human resource personnel on the recruitment, retention and promotion of language and cultural groups that represent the communities they serve, as a concept/practice beyond Affirmative Action requirements.
8. Provide training in developing organizational and educational materials that are easily understood by consumer populations, and that institute an approval procedure with consumer group input before dissemination. Include materials that are in English as well as other languages.
9. Provide training to organizations in developing and writing grievance procedures that take cross-cultural conflict resolution issues into consideration and that are appropriate to varying levels of literacy.
10. Facilitate the exchange of low literacy educational materials and educational materials translated in multiple languages for easy access of staff members to download and distribute to the populations they serve.
11. Facilitate the exchange of commonly used forms across agencies in multiple languages so the same form does not need to be translated separately by each health care organization.
12. Widely disseminate training programs in cultural competency that are available to health care and social service professionals that are readily available for self-study and free of charge.

A Report on Cultural Competency Training for Healthcare Providers in Connecticut can be accessed from our website: **www.ctmhp.org**.

Unnatural Causes: Is Inequality Making Us Sick? Episode: Place Matters

Presented by the **Awareness & Outreach Committee**

The Connecticut Multicultural Health Partnership's Awareness & Outreach Committee, in partnership with the Hispanic Health Council, Community Based Education at UConn School of Medicine, the Center for Eliminating Health Disparities among Latinos, and the Leukemia and Lymphoma Society, has hosted a series of events throughout Connecticut featuring the "Place Matters" segment of the film *Unnatural Causes: Is Inequality Making Us Sick?* This segment highlights how the environment in which we live affects our health, examines how poor social conditions may lead to chronic stress and cause chronic illness, and features one low-income neighborhood that has worked to create a healthier community. Through this film, participants are exposed to the concept of health inequities and the social determinants of health. After each viewing, participants discussed how social factors affect the health of our local communities, and brainstormed ways to improve these social conditions.

The Awareness & Outreach events have included the following:

- On January 21st, a grand rounds for health care providers featuring "Place Matters" was held at Bridgeport Hospital. Following the viewing, three panelists connected the issues in the film to the Bridgeport community and emphasized the impact that the environment has on one's health. To our knowledge, this was the first *Unnatural Causes* grand rounds in Connecticut.
- On February 14th, members of Trinity Episcopal Church gathered after Sunday services to watch the film segment and learn more about health equity. This kicked-off a four week initiative to help improve the health of the Trinity community. This event was held in collaboration with the CMHP Consumer Initiatives Committee.
- On April 8th, community members, UConn faculty, and medical, public health, and undergraduate students, watched the film episode and heard from several respondents who provided a local context for health equity work currently happening in CT. Afterwards, participants broke into smaller groups for dinner and discussion about how to best address these health inequities.
- On May 27th, staff from community-based organizations in New Britain screened the film and discussed its implications for their city. Additional community events are planned for June.

As of May, 2010, over 235 participants have taken part in these events. Feedback has been overwhelmingly positive and participants have requested more of these awareness-building events as well as a strong call to action to eliminate health inequities.

Additional event sponsors include the Bridgeport Department of Health and Social Services, Bridgeport Hospital, Trinity Episcopal Church, Universal Health Care Foundation of Connecticut, Connecticut AHEC, UConn Public Health Student Organization, the Institute for Community Research, HRA of New Britain Head Start/School Readiness, the New Britain YWCA, and Community Health Center, Inc.

Host an *Unnatural Causes* Community Discussion with your Group.

Experienced facilitators will guide the discussion to bring awareness of health and healthcare inequalities, explore ideas and advocate a **Call to Action**. For more information visit our website:

www.ctmhp.org

Increasing Access and Improving Quality

Presented by the **Consumer Initiatives Committee**

The Consumer Initiatives Committee focused on three venues to increase access to health care and to improve the quality of health care. In doing so, the Committee conducted literature reviews and site visits of the Community Health Worker Model, Complimentary and Alternative Medicine and Health Information Management System.

Community Health Workers

Community Health Workers (CHWs) have an important role in eliminating health disparities in heart disease and stroke. Adequate translation of research into clinical practice remains a major challenge. However, addressing this issue has national implications toward sustainable funding; appropriate reimbursement to support enhanced efforts that integrate community health workers as part of the healthcare team. This will lead to effective utilization of their skills; improved community health worker training, supervision and career development; as well as policy changes and cost-benefit evaluations.[1]

Recommendations to CMHP Members

1. Provide CHWs with essential training and professional development on-the-job.
2. Ensure those who supervise CHWs have a true understanding of the nature of the job, the responsibilities involved, and the stressors that are frequently encountered (i.e. eligibility requirements, fee-for-service, transportation, etc).
3. Track CHW effectiveness to support sustainable funding levels.
4. Create career pathways and development opportunities for CHW to grow within an organization.
5. Write a letter of commendation for a CHW who is particularly skilled
6. Support standardized credentialing or certification of CHWs.

Complimentary & Alternative Medicine

Complementary medicine is different from alternative medicine. Complementary medicine is used together with conventional medicine; alternative medicine is used in place of conventional medicine. The use of complementary and alternative medicine, including acupuncture, chiropractic, biofeedback, herbal medicine, folk medicine, and others have increased in the US.

Alternative medicine is defined as the *treatment of illness using remedies such as homeopathy or naturopathy that are not considered part of mainstream medicine (Webster Medical Dictionary)*. It is also defined as the healing arts not taught in traditional Western medical schools that promote options to conventional medicine that is taught in these schools. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a Western physician.

[1]PMID: 16389138 [PubMed - indexed for MEDLINE] Am J Prev Med. 2007 May;32(5):435-47

Recommendations to CMHP Members

1. Provide Complimentary and Alternative Medicine (CAM) presentations and workshops during in-service other continuing educational programming offered to staff.
2. Ensure clinical staff has an understanding of the traditional health beliefs and practices among ethnic populations the agency or organization serves (i.e. comprising 10% or more of the population in the agency's catchment area).
3. Encourage patients to tell their physicians and other health care providers of any traditional medicines or native healers being utilized.
4. Pilot the offering of traditional medicines and/or hire native healers as part of the health care team.

Health Information Management Systems Society's (HIMSS)

"The Electronic Health Record (EHR) is a longitudinal electronic record of a patient's health information generated by one or more encounters in any care delivery system. Included in this database are demographics, progress notes, problem areas, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the work flow. The EHR has the ability to generate a complete record of the a clinical patient encounter, as well as supporting other care related activities directly or indirectly via interface-including evidence based decision support, quality management and outcomes."

Recommendations for CMHP Members

1. Become an expert in the EHR that your health care clinic or organization utilizes and mentor colleagues and staff.
2. Request aggregate data on the racial/ethnic populations in your health care organization and review data regarding health status, health outcomes, and treatment services offered and treatment service provided to assess equity in the health care services that are provided.
3. Request aggregate data of the health insurance companies your organization contract with to assess equity in the care provided to your employees.

Reducing Health Disparities through Consumer Initiatives can be found on our website: **www.ctmhp.org**.

Join the Connecticut Multicultural Health Partnership

- Share your leadership and expertise
- Collaborate on multicultural health issues to maximize utilization of resources, promote coordination and reduce duplication of effort
- Provide guidance and support to the Committees
- Participate in forums to deliberate on health equity issues
- Actively engage in and commit to the development and implementation of the state plan to address Multicultural Health issues with a focus on CLAS standards
- Contribute to the Partnership's networking and information sharing
- Ensure that participation in the Partnership is beneficial to members and their respective organizations

Connecticut Multicultural Health Partnership

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