Connecticut Department of Public Health

Recruit, Engage, Inspire to Lead

CONNECTICUT
Multicultural Health
Partnership

U. S. Department of Health and Human Services
Office of Public Health and Science
Office of Minority Health

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

Connecticut Multicultural Health Partnership

“Recruit, Engage, Inspire to Lead” Project

The purpose of the “Recruit, Engage, Inspire to Lead” project was to recruit and engage partners at all levels/sectors to participate in a leadership capacity in the new CT Multicultural Health Partnership. This Outreach Consultant queried Co-chairs of the Multicultural Health Partnership to ascertain interest in this project, which would also help with increasing membership to their committee, and assist committee work to address the CLAS standards and related health disparities.

This Outreach Consultant worked with Co-Chairs to help plan for regional meetings and prepare invitational lists to recruit a broad range of participants and organizations to attend regional meetings. Organizational mailing lists were utilized as well as private email list serves, a newsletter, recommendations and referrals from Partnership members. We worked to involve diverse groups of people that have not currently participated in Partnership meetings. At least 25% of regional meeting participants comprised members of an ethnic minority. A question was included in our evaluation form to receive contact information for individuals and organizations that individuals felt should be recruited for future meetings. Ten new contacts were received. I also worked with Co-Chairs to develop agendas, invitation letters and presentations for meetings. Co-chairs were asked to talk about their work and invite participants to join their committees. Listings of potential participants were compiled and given to Angela Jimenez, Research Associate who emailed them on Office of Multicultural Health letter head. Evaluation forms were also given to Angela Jimenez to tally for Partnership membership. We researched venues in each region and solicited caterers to arrange light meals for participants.

Regional Meetings were scheduled in northern CT, central CT and southern CT and held within a broad range of venues including a Mosque, Dimes Savings Bank, the Department of Transportation, and the Urban League of Greater Hartford. Breakfast, lunch and dinner meetings were arranged.

REGIONAL MEETINGS:

Regional meeting reports are included. Attendees reported out on activities within their respective agencies and organizations that support the elimination of health disparities.

The Faith-Based Initiatives regional meeting was held on Tuesday, May 12, 2009 from 5-7 at the Muhammad Islamic Center, 870 Dixwell Avenue, Hamden, CT 06514.

Attendance: 19

New Partners:

- Susan Davis, APRN, Community Health Network of CT Inc., 11 Fairfield Boulevard, Wallingford CT – also volunteered for Office.
- Leslie Radcliffe, Pitts Chapel UFWB Church, 64 Brewster Street, New Haven, CT 06511
- Betty C. Murray, Community Engagement Specialist, CT Associating of Directors of Health, 241 Main Street,
- Four individuals expressed interest in the following committees: Advocacy, Awareness and Outreach, Policy & Program Development.
- A list of 112 potential partners was invited.

The Access Regional Meeting was held Thursday, May 28, 2009 from 12-3 p.m. at Dimes Savings Bank, 290 Salem Turnpike, Norwich, CT 06360.
Attendance: 12

New Partners:

- Brad Plebani, Deputy Director, Center for Medicare Advocacy, Inc. PO Box 350, Willimantic, CT 06226
- Kathryn Ratcliff, Department of Sociology, UCONN, Storrs, CT
- Rebecca Willis, Community Health Center Association of CT, 375 Willare Avenue, Newington CT 06111 – offered to host meeting and advertised regional meeting in newsletter – over 400 recipients.
- 5 individuals expressed interest in the following committees: Workforce Development, Awareness and Outreach and Access.

The Workforce Development Regional Meeting was held Thursday, June 25, 2009, from 9-12 p.m. at the Department of Transportation, Berlin Turnpike, Newington, CT.
Attendance: 18

New Partners:

- Jill Coghlan, Data Librarian, CT State Data Center, UCONN, Storrs, CT – agreed to chair Data & Surveillance Committee
- Peter Kennedy, Chair, Dept of Health Sciences, 200 Bloomfield, West Hartford, CT 06117
- Andre Caban, Membership Services Coordinator, CT Aids Resource Coalition, CARC, 20-28 Sergeant Street, Hartford, CT 06105
- Alicia Woodsby, Public Policy Director, National Alliance on Mental Illness, 241 Main Street, Hartford, CT
- Mary Winar, Project Coordinator, CT Office of Rural Health, 4 Park Place, Winsted, CT

- Tricia Harrity, Northwestern CT AHEC, 530 Middlebury Rd. Middlebury, CT
- Eight individuals expressed interest in the following committees: Data & Surveillance, Policy & Program, Workforce Development, Access, Advocacy, Cultural Competency, Policy & Program Development, Advocacy.

Total: 12 new Partners recruited. 17 committee members recruited.

Meeting Materials/Handouts – sample folder included:

- Agenda
- CT Multicultural Health Partnership Structure
- Partnership Vision, Mission, Goals, Function, Key Strategies
- Committee Sign up sheet
- CLAS Standards
- Potential Key Partners Decision Making Grid
- Partnership Evaluation
- You've Got the Power brochure
- Healthy and Right for You brochure

In July 2009, there was consensus to change the format of the discussion agenda format of the regional meeting to cultural competency focus groups. The average grass root consumer was missing from the regional meetings. To truly inform our work on addressing health disparities, we need the consumer perspective on communication gaps, relationship barriers and cultural collisions that produce disparities.

This Outreach Consultant worked with the Co-Chair of the Cultural Competency Committee to develop the focus group questions which are included along with the summary and outcomes.

2 Cultural Competency Focus Groups were held in the state capital in Hartford, CT at the Urban League of Greater Hartford, 140 Woodland Avenue.

- Tuesday October 6, 2009
  Attendance: 35 participants, GED preparation/training class, primarily 30 years and younger, African American & Latino males and females.

- Wednesday, October 7. 2000
  Attendance: 17 participants, GED preparation/training class, primarily 30 years and older, African American & Latino males and females.
  The majority of individuals from these groups were not knowledgeable of the CT Multicultural Partnership or the terms, health disparity and cultural competency. There remains a tremendous need for awareness and education among grass root and disenfranchised populations.

- Friday and Saturday, November 27, 28. – 9 African American and African Caribbean females were polled from Hartford's suburban areas for a comparative analysis of a third focus group.

Since a goal of this project is to strengthen leadership at all levels/sectors to promote an effective action agenda, comparing responses with minority leaders was suggested. Many strategies to build trust and relationships with providers were delineated. Indicators to reduce and eliminate health disparities and inequities were noted. The observation that suburban individuals were able to choose their provider had strong implications.

Evaluation:

Catherine Russell, Partnership Vice-Chair helped to design the Evaluation forms which are included. It surveyed services, target populations and recommended strategies to improve community participation. It queried understanding, receptivity and effectiveness of the regional meetings. It also included a committee sign up check list, partnership membership interest, contact information for self or others recommended for recruitment and a place for additional comments. The return number for evaluation forms was disappointing but the information gathered was very helpful and beneficial.

Outcomes:

The "Recruit, Engage, Inspire to Lead" project coordinated regional and local heath related activities that prioritized issues, incorporated strategies to improve community participation and collaboration and increased readiness and ability to initiate coordinated community action and grant submissions. Participants reported productive networking relationships and business agreements. Attendees shared their allied health work and ideas and became knowledgeable of health disparity initiatives throughout the state.

Dr. Abdul-Majid Karim Hasan, Faith-Based Initiatives Regional Meeting

“Recruit, Engage, Inspire to Lead”

Muhammad Islamic Center

870 Dixwell Avenue, Hamden, CT 06514

May 12, 2009

5-7 p.m.

Resident Imam, introduced himself to participants and welcomed everyone to the mosque. He gave a brief overview of the main principles of Islam, the religious faith of Muslims and talked about how proud he was of the work of his daughter, Tanya Abdul-Karim Williams, who co-chairs the Faith-Based Initiatives Committee in the Multicultural Health Partnership. He gave a brief invocation and then asked Rev. Captain Forester Lanchester, Director of the Bridgeport Salvation Army and Co-chair of the Faith-Based Initiative Committee, to give an opening prayer.

Rev. Captain Lanchester then talked about the sequential collaborative work anticipated from this meeting and the committee goal from the CLAS Standards, to develop a plan to promote community involvement for the implementation of standards and resident voice in the health care system, to raise awareness of health issues and health promotion initiatives. He talked about Tanya Abdul-Karim Williams’ work with the Health Awareness Advisory Council and the Faith-Based Initiative Committee’s desire to conduct regional health fairs to raise awareness, and get individuals more involved in self care and health advocacy. He asked everyone to complete the Committee’s Community Health Needs Assessment. The Committee will use this data to guide their efforts and to share information with allied health organizations and hospital advisory boards. He informed that there were community boards in every hospital. He would like to begin organizing individuals by planning a health day meeting every month.

Michele Stewart-Copes, Community Outreach Coordinator, gave an overview of the Multicultural Health Partnership’s vision, mission, purpose, goals and committees. She asked participants to complete the evaluation form and to join a committee of their interest. Catherine Russell, Co-Chair of the Education & Training Committee, reviewed the work of her committee and gave an overview of CLAS, the national standards for Culturally and Linguistically Appropriate Services in health care.

Participants were asked to introduce themselves and to highlight their work to support the elimination of health disparities and ideas and initiatives to promote community involvement in implementing CLAS standards in the health care

system. Felicia Epps talked about her coordination role in the DPH Office of Multicultural Health and recorded discussion points on a flip chart.

- Catherine Russell discussed a strategy of training individuals to serve on community boards.

- The Salvation Army in Bridgeport is teaching people how to shop in a more healthy way. They also formed cooking teams to teach families to cook healthier. They are educating people about the health care system and questions to ask regarding exams, to eliminate fear. Rev. Lanchester reported that 30% of African Americans lacked health insurance. Many cannot read or write. He would like to invite Providers to attend Faith Conferences to better understand best practices and culture in health care.

- Susan Davis, Community Health Network of CT is conducting a Neighbors helping Neighbors Initiative. They access dial up linguistic translators in hospitals. She would like to link with churches. She offered her services on community health education including insurance information and health games for children.

- Pastors should become more involved in the community and participate in van ministries to outreach to grass root populations.

- Betty Murray with the CT Association of Directors of Health has a Kellogg grant to work with faith based centers to study correlations with health outcomes and health disparities. They are documenting the direct correlation between spiritual and physical health.

- The Executive Director of the Christian Community Coalition is conducting monthly forums to assess and discuss how to meet physical and spiritual needs. They are educating Pastors. He talked about the upcoming Gospel Fest in New Haven and Fatherhood weekend. They are educating men about the importance of prostate exams and taking care of the whole man. There is a collaboration to address health, housing, violence, etc. He would like to link with other ministers to collaborate on future grant funded initiatives.
- Abdul Rachman Muhammad explained the work with “My People Clinical Services” identifying mental health disparities concerning people of color and addressing social determinants which impact stress levels.

Tanya Abdul-karim Williams, discussed the goals of the Health Awareness Advisory Council and a desired “Call to Action” to spiritual leaders for cultural competency. She also discussed anticipated benefits from the Community Needs Assessment Tool.

CT. Statewide Multicultural Health Partnership Initiative

Workforce Development Committee Regional Forum

Theme: “Recruit, Engage, Inspire to Lead”

Place: CT. Department of Transportation

June 25, 2009

9:00 – 12:00 p.m.

Minutes

Marie Spivey, Workforce Development Committee Co-Chair, welcomed all participants to the Forum meeting and reviewed the purpose of this forum, as well as the mission, vision and goals of the Statewide Multicultural Health Partnership. Each of the 20 participants introduced themselves and highlighted the work that they were providing or supporting to eliminate health disparities in their organizations or communities to build a diverse workforce.

Michele Stewart-Copes, Committee Co-Chair, recorded the Connecticut healthcare workforce pipeline work discussed and reviewed the “Recruit, Engage, Inspire to Lead” project’s initiative for diverse partnership recruitment and explained the work of the partnership’s 11 committees. Seven individuals from the group volunteered to join the Partnership and respective committees.

Ms. Spivey reviewed the Workforce Development Work Plan goals, objectives and expected outcomes that were disseminated in a handout folder to the participants. She also described the national CLAS Standards document in the folder and explained that the Workforce Development Committee was charged with supporting CLAS Standard 2, to support diverse and under represented individuals to advance in health care careers, and to recruit, retain and promote at all levels. She engaged participants in a conversation about their educational and training programs that referenced these objectives.

Ann Levie explained her committee assignment to compile a listing of organizations that were working to recruit and build a diverse workforce. Her web search listed many national organizations. The listings were given to a graduate student to identify what work/programs/initiatives were being provided in Connecticut.

Pipeline Discussion:

- CT. Northwest Community College, Winsted, CT:

  - 2nd year of a grant to recruit high school students for health professional careers
  - – guiding CNA's for success in college, English as a second language, continuing education to strengthen academic skills.

- University of Hartford, Chair of the Health Sciences Department:
  - health professions recruitment efforts underway
  - limited curricula available in cultural competency

- AHEC – 4 regional offices
  - youth health service corps.
  - college youth corps,
  - Allied Health Professional Network blog/ newsletter,
  - underrepresented population in service learning projects
  - Waterbury Youth Corps targeting 9th grade, trying to get to 7th grade
  - Building science and math for college preparation and success for college entry,
  - service learning-based program with March of Dimes – low birth weight babies.

- CT Association for United Spanish Action (CAUSA):
  - formalized collaboration to improve the skills of front line workers
  - workforce development grant, 110 employed and retained,
  - 1st Spanish diabetes conference,
  - developed retention tracking system.

- CT AIDS Resource Coalition:
  - disparities in health tracking
  - AIDS With You & For You – partner with ST. Francis Hospital
  - OMH grant – multilevel approach, client awareness of medical interpreting – Provider Education
  - National Be Safe Model – Latino population, 20 providers, consistent training, cultural sensitive environment for patients.
  - Medical Interpreter field – reaching out to CNA's and others
  - success with empowering patients as advocates with confidence, LEP patients followed.
  - Comprehensive Medical Home.
  - High skill level for Medical Interpreters (some resistance from bi-lingual staff, surprised at difficulty) –huge obstacle
  - on site retention, offsite issues, on site performance.
  - Puerto Rican Spanish dialect – different words/ different expressions,
  - on site workforce support is too often overlooked – must build into infrastructure

- CT Association for Community Health Centers

- Program Coordinator Workforce Development – 13 qualified health centers

- CT Health Foundation grant – Central AHEC
  - Internationally trained health care providers,
    - developing support structure to license diverse professionals
    - “Welcome Back program to East Coast”
    - Financial support to go through process and help with English.

- High School Initiatives
  - Sports Science Academy: Health Sciences, Health Careers Explorations, Shadowing
  - Goal – Public Health Magnet School –
  - Partnership: CREC, ST. Francis Hospital, University of Hartford.

- Capital Workforce Partners:
  - State of CT. 3-yr. Grant acquired: targeting under prepared adult learners interested in higher-level health careers.
  - Certified nursing assistants participated as a cohort in each of 4 60-week sessions to improve their academic and personal support skills.
  - Twenty-three of the first 25 individuals completed the first session; and similar numbers achieved completion in the following 3 classes.
  - Four agency collaboration – 1199 Training and Education Fund, Capital Workforce Partners, Capital Community College, & Capitol Region Education Council,
  - Intensive Case Management: – daily calls to support, counsel, mentor students, 23 completed program and received certificates, celebration and studied what worked and didn’t, students became mentors for next class of 3 cohorts, 80% went into credit bearing college courses, motivated in classroom as moved to classes as cohort,
  - Outcomes: LPN course completion, surgical technicians, human service tracks, pre-nursing
  - USDOL High Growth grant and Robertwood Johnson Foundation Grant: Work-based Learning Partnership with 10 long-term care facilities and VNA Healthcare.
  - Goal- further educate 646 CNA’s over a 3-yr period at the worksites
  - Implemented tools to change the organizational culture.
  - Learned in ways that they have not learned before
  - Partnership with the educational institutions enabled CWP to acquire ½ college credit for each of 6 specialty courses completed,
  - Each student has a clinical staff mentor who oversees relationships and practiced care with patients

- Consider this program to be a model for collaborative infrastructure
  - Hope to replicate in other areas of the state.

V. Workforce Shortage Issues:

- Multiple numbers of eligible candidates are on the waiting list for nursing programs
- Faculty for the programs are “aging-out”.
- Other allied health positions need recruitment efforts, e.g. dental hygienists, certified diabetes educators, CDE’s
- Threats to budget – need more lobbying at grass roots level
- Need increased number of days professional development for faculty
  - new teaching strategies needed for under-prepared adult learners
  - need for data, (status of health disparities in state, population groups, what’s working, what is not)

VI. **Next Steps –** Development of a Holistic Approach to eliminating disparities.

- Community/Workforce/Academic/Employer Partnership
- Need to increase cooperation, coordination and collaboration between groups
- Look at Migrant Worker Model of putting a face on medical contacts
- Need a gatekeeper or Case Manager to do follow up work for students or individuals going through the pipeline

VIII. Community Health Center Association

- Future grant opportunities
- Students and residents need better exposure to community Health Centers

IX. Investigate private healthcare agencies to learn what are they doing to promote staff within? The Partnership is being helped by the Conference of Churches organization currently inventorying a number of organizations and agencies.

The Connecticut Multicultural Health Partnership

CMHP Regional Meeting Evaluation

1. **Is your organization engaged in serving or interested in representing diverse populations?** ____YES ____NO If so, please check all that apply

Services: ___Advocacy/Outreach ___Basic Needs ___Communication/Media

___ Crises Services ___Domestic Violence/Sexual Assault ___Education

___Legal/Immigration ___Medical/Dental ___Mental Health/Substance Abuse

___Spiritual/Faith ___Workforce/Employment ___Other (please explain): ____________

Populations: ___African Origin ___Latino ___Native American ___Asian

___Economically disadvantaged ___Religious minority ___Limited English Speakers

___Blind/Deaf ___Disabled ___Mentally ill ___Chronic Unemployed ___Undocumented

___Un/under Insured ___Other (please explain): ______________________________

2. **How did you hear about the Partnership?**
   ____Personal E-mail invitation by the Partnership
   ____E-mail invitation forwarded to you
   ____Word of mouth
   ____Advertisement (e.g. press release, radio announcement)
   ____Other:
   please describe____

3. **Following the presentation, do you have a clear understanding of the Partnership, including its mission, goals & committee functions?**
   ____YES ____NO ____Not Sure

4. **Did you have an opportunity during the regional meeting to report on the activities that your organization does towards the elimination of health disparities?**
   ____YES ____NO ____Did not want to report

5. **What strategies would you recommend to improve community participation and increase readiness and ability to initiate coordinated community action?**

____Meetings in community rooms of congregate housing

____Hold meetings at schools or churches

____Conduct door-to-door petitions

____Coordinate town hall rallies or a capitol rally

____Train community members as representatives/advocates for advisory/governing board participation

____Provide guidance and support to individuals through organizational/legal grievance procedures

____Others

6. **What initiatives, priority issues, or next steps would you recommend to the Partnership?**

____

___Access ___Advocacy ___Awareness/Outreach ____Communication/Media

___Cultural Competency ___Data & Surveillance ___Ed/Training ___Faith-Based

___Language Proficiency ___Policy & Program Dev ___Workforce Dev

____

7. **Which one of the Partnership's committees interest you?**

8. **Would you like to become a member of the Partnership?**
   ____YES ____NO ___Not Sure

Name & Title: ____

Organization: ____

Address: ____

Email: ______________________ **Telephone:** __________________

9. Your comments and thoughts are welcomed!

____

____

Please provide contact information for individuals and organizations that should be recruited to the Partnership

____

Culturally Competence Health & Social Service Providers: Health Care Consumer Focus Groups

Most people who are involved in issues related to health disparities/health equity and cultural competence tend to be health care/social service providers, agency or organizationally affiliated activists/advocates, and/or policy makers. The voice of the average customer or health care recipient tends to be absent or minimal. This is unfortunate because not only is the average customer a major stakeholder, she/he has information that will contribute to a more holistic approach to solving health disparities/inequities challenges. The Multicultural Health Partnership seeks to create a plan for the state that ensures the amelioration of health disparities, and as such, securing input from the average customer/service recipient to inform the plan is considered a vital component. One way to address this obvious deficit was to create opportunities to solicit and collect feedback or input from a range of customer populations.

This document is a summary of three such 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 (Groups I and II) and a third group, comprised of nine professional women of African descent, queried over the Thanksgiving holiday (Group III).

The purpose of these focus groups was:

- To solicit the customer's definition of key constructs – health disparity and cultural competence
- To generate a list of characteristics which customers expect/seek in their health care and social service providers
- To determine the extent or degree to which ethnicity (race)/culture play in provider choices
- To ascertain, from customers, those provider characteristics that hinder/impede service delivery

All participants had sought and received services from health care/social service providers, including physicians, nurse practitioners, dentists, opticians, and podiatrists, nurses, psychologists, allergist, social worker, psychiatrist, and counselors. These providers were Chinese, Caucasian, African American, Southeast Asian, Jewish, African, Afro-Caribbean, and Latino (Hispanic).

Most of Group I and II participants indicated that they did **not** have the option of choosing their provider, though they would like to do so. The professional group of women (Group III) indicated that they had always chosen their provider and intends to continue to do so in the future. This difference is probably reflected between receiving health care by a clinic with public insurance compared to selecting private practitioners with private insurance.

Queried about the criteria they would use to choose their provider, the following characteristics, listed in order of statement, was provided:

Group I (tended to be 30 years or older)

- Sex-some women expressed a preference for women
- Experience (length of practice – no interns/residents
- Cost
- Location
- Someone who would take their insurance
- Hours of operations (weekend hours in particular)
- Race
- Doctors who listen to you, rather than tell you what they want
- Clean office – friendly staff
- Someone you can have a relationship with
- Privacy

Group II (tended to be 30 years old or younger)

- Personality – down to earth
- Respectful, smart, know what they are doing, also funny
- Location of practice/service
- Experience – length of work – how well they know their job

Group III (23 years and older**)**

- Recommendations from family and friends
- Insurance eligibility, location, quality of webpage, internet reports
- Parent's choices (pediatrician)
- Ratings based on research, feedback from customers, and publications

Professional, cultural and personal qualities that respondents look for in medical/social service provider were:

Group I

- Their appearance
- Way they carry themselves – knowledge, dress
- Personality – how they speak to people
- Experienced
- Age – older preferred
- Men were perceived as being more comfortable to talk with and sometimes more competent and more patient than female providers.
- Female providers were perceived as more compassionate, listen better/ and listen longer than men, and women understand women's needs
- Caucasian providers take patients/clients more seriously than African American social service providers
- Providers should be chosen not assigned

Group II

- Politeness
- Respectful
- Speak/understand patient's/person's language
- Do not like providers who:
  - Have an attitude
  - Do not want to respond to your questions
  - Do not appear to care about your issue or problem

Group III

- Professionalism including time for questions and to learn my history
- People person, personable, does not rush, someone who sits and talks before the exam
- Nice and attentive
- Culture is irrelevant
- Culture is relevant – given a choice would choose a provider of sme race
- Generally competent and knowledge
- Good *bedside manners*
- Discusses diagnosis and treatment options as opposed to dictating them
- Accessible – conscious of his/her limitation
- Does not rush through exams or explanations
- Provides time for questions to ensure understanding

Questioned about the role of ethnicity (race) or culture of the provider as a consideration in provider choice, respondents indicated:

Group I

- Race/culture does not matter
- Race does matter
- Foreign doctors- African, Indian – provide better services than Americans
- Sometimes doctors are prejudiced

Group II

- Race/culture does not matter

Group III

- Race does not matter (7)
- Race matters (2)[1]

Each of the groups defined cultural competence.

Group I

- Cultural competence – different/diverse practitioners; no racism- all are treated equally no matter what type of insurance.

Group II

- Cultural competence – understand the culture of others, not judging culture [of others], being sensitive.

Group III

- Someone who is willing and able to understand and affirm cultural differences and sensitive to preferences; when all cultures are represented equally in all aspects of life – medically, educational, and political; understanding culture at all levels and relating to all communities, such as Africans and the Caribbean communities;

[1] It makes a difference if the presenting condition is related to ethnicity, such as a skin condition; the commonality of the shared cultural experience facilitates greater trust.

- Showing honest respect for the person and the care they are prescribing is critical; and

- Possessing a set of skills, knowledge and behaviors that enable the provider to treat clients of varying ethnic and racial backgrounds. Different groups of people are going to respond to medical culture and even express symptoms in different ways. A culturally competent doctor must be equipped with the skills and knowledge necessary to decipher what a patient is expressing via their behavior and statements even if or when it differs from that of the dominant culture.

Asked to define health disparities/health inequities, the following was offered:

Group I

- Health disparities/health inequities – no insurance, limited insurance coverage, requiring co-pays, lack coverage for medication, lack coverage for dental care and surgery.

Group II

- Health disparities/health inequities - not enough health care, "not good enough" health care.

Finally, focus group participants were asked about the characteristics of culturally competent individual practitioners and organizations. They responded:

Culturally competent organizations -

- Organizations that hire people who represent the community (*show people who look like you*)
- Organizations with racially diverse staff
- Organizations that are impartial providing services (*non-judgmental)*
- Organizations that are willing to work with others
- Ability to utilize cross cultural skills when providing services to culturally different populations
- Have services available in languages other than English

Culturally competent individual practitioners –

- Non-judgmental
- Organized and follow-up with services and communication

- Organized, not rushed
- Patient, pleasant, professional, aware of the need to comfort patients (help to make patient feel comfortable)
- Willing and able to affirm cultural differences
- Ensure patients/clients are comfortable in their environments
- Trained in recognizing and addressing the concerns of minority (and sometimes majority) populations around them
- Understand the medical experience and attitudes toward health and illness of different ethnic groups
- Understand how culture influences how patients/clients express their symptoms
- Does not try to force patients/clients into pre-set molds
- Provides services in which certain procedures are only performed with the patient's/client's permission
- Prefaced and followed-up explanation that is delivered calmly, clearly, and thoroughly in a language that the patient understands
- Able to communicate in different languages or linguistic styles and takes the time to learn differences in order to be culturally sensitive

The session ended with focus group participants being asked to share any other comments about culturally competent practitioners (social and medical). Their comments are listed below:

- Disparities are due to discrimination
- If you complain about discrimination in a medical setting, you will get fired
- Black schools do not provide a good education – white schools do a better job
- The [system] needs to pay attention to the health care needs of the elderly
- It is hard to get African Americans together as a group

Further Analysis of Preferred Physician's Race

Participants were asked to respond to two confidential questions related to the preferred choice of the ethnicity of their physician.

Of the thirty-two participants who responded, nearly half (47%) expressed no ethnic/racial preference for their physician. They indicated that competence and knowledge were the primary consideration in selecting a doctor.

Thirty-eight percent of respondents indicated a preference for African American physicians. All of the respondents who prefer an African American physician were of African descent and/or Latino.
The following reasons were given

- *Understand more about certain health conditions faced by Blacks*
- *Understand African American better*
- *Easier to connect with*
- *Feel more comfortable*
- *Like to see my people advance*

The remaining 20% of the respondent preferred Caucasian or Indian physicians. The primary reasons were due to Caucasians being *trustworthy* and *know more*; and Indians are *deep into health care*.

In summary, participants seem to prefer providers who are culturally sensitive and interested (have had bad experiences from providers within the culture); race and culture does not make a doctor more competent – although being familiar with the community served is an asset.

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"*

Recommendations for CMHP Members:

1. While race matters in the pursuit of eliminating health disparities, racial concordance is not the primary factor in seeking or receiving quality health care. Though race may be a preference, participants clarified that cultural competence (knowledge of cultural implications) and quality of the health care encounter are significant factors in evaluating the quality of care received.

    a. Patient choice in provider assignment may improve engagement and retention of patient/client efforts and follow-through.

    b. Concordance in race, ethnicity and/or sex may be important to the patient and thus improve health outcomes.

        i. Do not assume a provider of the same race, ethnic or linguistic heritage as the patient is culturally competent.

c. The training of all staff in cultural competence and responding to health literacy needs and language needs are vital in providing quality care as perceived by patients.

d. Promote the training and experience of your professional and support staff.

e. Develop and promote **safe** venues for patients and staff to raise issues of discrimination or unfair treatment practices or biases.

Cultural Competence – Focus Group Questions

1. Tell us about the types of health care providers – social and medical – from whom you have received services? (Possible responses: dentists, doctors, social workers, psychiatrists, psychologists, naturopaths, etc.).

2. Generally, what was the ethnicity/culture (race) of the provider?

3. Did you have the option to choose your provider? Yes or No – I f no, would you like to choose your own providers in the future?

4. For those of you who chose your health/social service providers or would like the option of choosing your health/social service providers, what criteria did you use or will you use to select a specific provider?

5. What particular professional, cultural, and personal qualities do you or would you look for in a medical or social service provider?

6. When you think about your experiences receiving services or your observations or involvement with relatives or friends who received services from a health or social service provider, what kinds of behaviors, written or oral communication by them did you like (not like) and why?

7. Is the ethnicity or culture (race) of the provider an important consideration in your choice of health/social service providers? Why? Why not?

8. In the best of all worlds, would you rather receive services from someone who is of the same ethnicity/culture (race) as yourself? If no, why not? If yes, why?

9. The Federal government is putting resources into programs to increase the cultural competence of health and social service providers or practitioners. Cultural competence has been defined in various ways by a range of professionals. However, we want to know how members of various communities define cultural competence based on their own experiences as service recipients and/or their observations of service provision. Therefore, our question to you is - what does cultural competence mean to you?

10. Based on your experiences, what are the qualities of a culturally competent health and social service practitioners? What are the qualities of culturally competent health and social service organizations?

Are there any issues or concerns that have not been addressed?