Session Objectives

By the end of this session participants will be able to:

- Describe cancer/health disparities
- List at least one proven strategy for promoting cancer equity
- Describe the Culturally Effective Organizations Framework and the component elements for improving their own organization’s capacity to provide high quality care and services for all
What Creates Health?

Health Behaviors 30%

- Education
- Employment
- Income
- Family & Social Support
- Community Safety
- Environmental Quality
- Built Environment

Public Health

Social Determinants of Health

Health Care Services

Total Population Health: A Framework for NH

advancing Equity for all

Prevention Protection Promotion
HEALTH EQUITY MEANS THAT EVERY PERSON HAS AN OPPORTUNITY TO ACHIEVE OPTIMAL HEALTH REGARDLESS OF:

- The color of their skin
- Level of education
- Gender identity
- Sexual orientation
- Religion
- The job they have
- The neighborhood they live in
- Whether or not they have a disability

WHAT DOES IT TAKE TO SERVE ALL PEOPLE WELL?

With the highest quality care, programs and services?

NH is Healthy!

Does this resonate with our experience?

http://www.countyhealthrankings.org/app/new-hampshire/2018/overview

Disparities

“Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions”

(NIH, 1999)

Inequities

“Differences in health that are unnecessary, avoidable, unfair and unjust”

(Whitehead, 1992)

“systematic, socially produced (and therefore modifiable) and unfair”

(Whitehead & Dahlgren, 2006)
CANCER HEALTH DISPARITIES

Cancer Health Disparities

- Adverse differences between certain population groups in cancer measures, such as:
  - incidence (new cases)
  - prevalence (all existing cases)
  - morbidity (cancer-related health complications)
  - mortality (deaths)
  - survivorship and quality of life after cancer treatment,
  - burden of cancer or related health conditions,
  - screening rates, and
  - stage at diagnosis
Cancer Health Disparities

- These population groups may be characterized by:
  - race,
  - ethnicity,
  - physical/cognitive ability,
  - gender identity,
  - sexual orientation,
  - geographic location,
  - income,
  - education,
  - language,
  - whether immigrant/foreign born, and
  - other characteristics.

- People who are poor, lack health insurance, and are medically underserved (have limited or no access to effective health care) often bear a greater burden of disease.

Overall Cancer Incidence and Death Rates

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>All Sites</th>
<th>Incidence</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>490.1</td>
<td>192.7</td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>504.1</td>
<td>238.8</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>334.9</td>
<td>155.5</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>356.0</td>
<td>129.1</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>257.6</td>
<td>100.4</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>477.5</td>
<td>190.7</td>
<td></td>
</tr>
</tbody>
</table>

Statistics are for 2000–2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer (1) and deaths (2) per year per 100,000 men and women. Accessed on 4/3/18 from https://www.cancer.gov/about-ncc/organization/crchd/cancer-health-disparities-fact-sheet#q1
## Female Breast Cancer Incidence and Death Rates

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Incidence</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>127.8</td>
<td>25.5</td>
</tr>
<tr>
<td>African American/Black</td>
<td>118.3</td>
<td>33.8</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>89.0</td>
<td>12.6</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>89.3</td>
<td>16.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>69.8</td>
<td>16.1</td>
</tr>
<tr>
<td>White</td>
<td>132.5</td>
<td>25.0</td>
</tr>
</tbody>
</table>

## Cervical Cancer Incidence and Death Rates

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Incidence</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>8.7</td>
<td>2.5</td>
</tr>
<tr>
<td>African American/Black</td>
<td>11.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>13.8</td>
<td>3.3</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>6.6</td>
<td>4.0</td>
</tr>
<tr>
<td>White</td>
<td>8.5</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Prostate Cancer Incidence and Death Rates

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Prostate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incidence</td>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>168.0</td>
<td>20.9</td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>285.5</td>
<td>62.3</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>56.5</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>140.8</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>48.2</td>
<td>25.5</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>161.4</td>
<td>25.6</td>
<td></td>
</tr>
</tbody>
</table>

Colorectal and Lung Cancer Incidence and Death Rates

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Colorectal</th>
<th>Lung and Bronchus</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incidence</td>
<td>Death</td>
<td>Incidence</td>
<td>Death</td>
</tr>
<tr>
<td>All</td>
<td>51.6</td>
<td>19.4</td>
<td>64.5</td>
<td>54.7</td>
</tr>
<tr>
<td>African American/Black</td>
<td>62.1</td>
<td>26.7</td>
<td>76.6</td>
<td>62.0</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>41.6</td>
<td>12.3</td>
<td>39.4</td>
<td>26.9</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>39.3</td>
<td>13.6</td>
<td>33.3</td>
<td>23.6</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>40.8</td>
<td>17.0</td>
<td>44.0</td>
<td>39.9</td>
</tr>
<tr>
<td>White</td>
<td>51.2</td>
<td>18.9</td>
<td>65.7</td>
<td>56.0</td>
</tr>
</tbody>
</table>
Met Mammography by Income
NH 2016 BRFSS – preliminary findings

NH Cancer Registry

ON THE CODING AND REPORTING OF RACE AND ETHNICITY IN NEW HAMPSHIRE FOR PURPOSES OF CANCER REPORTING

Background: The objective was to investigate how data on race and ethnicity are collected by hospitals reporting to the New Hampshire State Cancer Registry (NHSCR).

Method: NHSCR surveyed hospitals asking how information on race and ethnicity were collected. A review of relevant legal mandates and national guidelines was undertaken.

Results: Many hospitals lack policies on collection, computer systems fail to support national guidelines, and staff rely on visual inspection.

Conclusions: Hospital staffs are not now culturally equipped to collect race and ethnicity in a meaningful way. The numerator in cancer incidence rates is most likely not accurate and for some smaller populations very biased. A new framework is needed that takes into account the needs of the democracy. (Ethem Dis. 2003;15:324-331)

Key Words: Ethnicity, Race, Registry

INTRODUCTION

In the annual calculations of population incidence rates on cancer, two numbers are required. The denominator, the base population, comes from the US Census Bureau and the 2000 Census. The numerator for a specific geographic region, usually a state, is drawn from reports submitted to a central cancer registry mostly by hospitals. When these reports are broken down by race or ethnicity, the denominator, using 2000 Census data, was collected by utilizing a process of self-identification under guidance of the Office of Management and Budget (OMB) Statistical Directive 15. The numerator is most often collected under a 2000 Census.

MANDATES

Most central cancer registries are not in a position to require medical providers to collect information on race and ethnicity. Rather, the legislative language requires identified providers to report a selected set of information to the central registry. The means or methods for collecting the information are left to the discretion of the medical provider. Therefore, a starting question becomes, "What is the legal and institutional mandate to collect information on race and ethnicity?"
WISDOM - https://wisdom.dhhs.nh.gov

Select a Specific Cancer Dashboard or a Community Profile
Colorectal Cancer Community Profile
Contrast Two Regions

NH Health WISDOM

Determinants of Health (2011-2015)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Greater Manchester (public health region)</th>
<th>North Country (public health region)</th>
<th>NH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Vulnerability Index (SVI): summary of 16 indicators</td>
<td>2.9</td>
<td>4.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Adult education, age 25 or more without a high school diploma or equivalent (%)</td>
<td>0.0</td>
<td>12.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Children, population age less than 18 (%)</td>
<td>21.1</td>
<td>18.3</td>
<td>20.5</td>
</tr>
<tr>
<td>Elderly, population age 65 and over (%)</td>
<td>13.1</td>
<td>28.8</td>
<td>15.3</td>
</tr>
<tr>
<td>Health insurance, age less than 65 without insurance (%)</td>
<td>11.2</td>
<td>15.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Minority, Hispanic or non-white race (%)</td>
<td>14.1</td>
<td>5.1</td>
<td>8.6</td>
</tr>
<tr>
<td>Poverty, population living below Federal poverty level (%)</td>
<td>10.5</td>
<td>13.9</td>
<td>6.0</td>
</tr>
<tr>
<td>Per capita income (in 2015 inflation-adjusted $)</td>
<td>$33,768</td>
<td>$25,020</td>
<td>$34,361</td>
</tr>
</tbody>
</table>

Accessed on 4/3/18 from https://wisdom.dhhs.nh.gov/wisdom/#CommunityProf_08AD1EBB90DA94AF887552A840FBA44E_Anon

CRC Community Profile: Contrast Two Regions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC Screening</td>
<td>79.9% (45,861 adults)</td>
<td>76.6% (18,549 adults)</td>
<td>79.1% (378,195 adults)</td>
</tr>
</tbody>
</table>

CRC Screening per USPSTF Guidelines

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC Screening per USPSTF Guidelines</td>
<td>75.9% (36,417 adults)</td>
<td>75.0% (15,132 adults)</td>
<td>74.9% (208,201 adults)</td>
</tr>
</tbody>
</table>

CRC Incidence

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC Incidence</td>
<td>34.7 Per 100K people (2011 - 2015)</td>
<td>37.7 Per 100K people (2011 - 2015)</td>
<td>38.8 Per 100K people (2011 - 2015)</td>
</tr>
<tr>
<td></td>
<td>354 cases</td>
<td>155 cases</td>
<td>3,091 cases</td>
</tr>
</tbody>
</table>

CRC Mortality

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>115 cases</td>
<td>87 cases</td>
<td>1,032 cases</td>
</tr>
</tbody>
</table>

*Significantly higher than rest of state
Colorectal Cancer Mortality

Perceived Barriers to Colonoscopy
Perceived Barriers to Colonoscopy

- 26% are for reasons relating to the social determinants of health or access to healthcare
Breakdown of “Other” Perceived Barriers to Colonoscopy

What is the most important reason you have NEVER had one of these exams or NOT had one of these exams in the last 10 years?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>44%</td>
</tr>
<tr>
<td>Too painful, unpleasant, or embarrassing</td>
<td>3%</td>
</tr>
<tr>
<td>Preparation for test</td>
<td>2%</td>
</tr>
<tr>
<td>No insurance coverage</td>
<td>2%</td>
</tr>
<tr>
<td>Never considered or thought about it</td>
<td>2%</td>
</tr>
<tr>
<td>Haven’t had any problems</td>
<td>2%</td>
</tr>
<tr>
<td>Had another type of colorectal exam</td>
<td>1%</td>
</tr>
<tr>
<td>Don’t have doctor</td>
<td>7%</td>
</tr>
<tr>
<td>Didn’t need or didn’t know was needed</td>
<td>7%</td>
</tr>
<tr>
<td>Been putting off</td>
<td>3%</td>
</tr>
<tr>
<td>No family history/Not at risk</td>
<td>2%</td>
</tr>
<tr>
<td>Medical Reason</td>
<td>2%</td>
</tr>
<tr>
<td>Fear</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t want to</td>
<td>14%</td>
</tr>
<tr>
<td>Cost</td>
<td>8%</td>
</tr>
</tbody>
</table>

~19% are for reasons relating to the social determinants of health or access to healthcare

STRATEGIES FOR PROMOTING CANCER EQUITY
Make Use of Available Resources:
**CDC: Reducing Health Disparities in Cancer**

**Increase Screening**
- Outreach & Education
- Research

**Modify Risk Behaviors**
- Community Interventions
- Increase Participation in Clinical Trials

CDC and other public health agencies, health care providers, and communities of all racial and ethnic groups must become partners in a national effort to—

- Improve early detection of cancer through routine mammography, Pap tests, and colorectal cancer screening
- Implement evidence-based community interventions to increase screening and modify risk behaviors
- Develop research projects that will encourage minority groups to participate in clinical trials of the cancer prevention measures that significantly reduce disparities in cancer outcomes
- Undertake research that will inform effective interventions to reduce cancer disparities and improve health. There is a growing need for interventions that are accessible and available to people regardless of socioeconomic status or lifestyle behaviors that address the social environment
- Use a variety of media and channels to reach cancer information to diverse populations in a variety of settings

Access to quality cancer care and clinical trials needs to be expanded to ensure that minority groups are provided the same care and access to state-of-the-art technology that patients in major cancer centers receive.

First of all, increased coordination of care and lack of physician referrals are common barriers to cancer screening and other preventive services. Health care providers play a critical role in recommending and increasing use of preventive services. Research shows that physician recommendation is a major predictor of adequacy of screening.

https://www.cdc.gov/cancer/healthdisparities/basic_info/disparities.htm

---

Make Use of Available Resources:
**CDC - Cancer Disparities in Rural America**

Cancer is more treatable when detected early. However, rural Americans have lower rates of cancer detection and treatment. In addition, rural residents also have increased rates of tobacco use, colorectal cancer, and cervical cancer. Therefore, we are taking a look at the disparities in cancer rates across rural areas.

WHAT THE SCIENCE SAYS
 CDC/CANCER Disparities in Rural America

PRESSENRLEASE

CANCER CONTROL PROGRAMS
 More Information from CDC

CANCER PREVENTION RESOURCES
 More Information from CDC

https://www.cdc.gov/ruralhealth/cancer.html
Be Attentive to What’s Known Matters: NQF Disparities Sensitive Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Title</th>
<th>Measure Description</th>
<th>Quality Gap Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>460</td>
<td>Risk-adjusted morbidity and mortality for esophagectomy for cancer</td>
<td>Percentage of patients aged 18 years and older undergoing elective esophagectomy for esophageal cancer who developed any of the following postoperative conditions: bleeding requiring reoperation, anastomosis leak requiring medical or surgical treatment, reintubation, ventilation 48 hours, pneumonia, or discharge mortality</td>
<td>17.6%</td>
</tr>
<tr>
<td>390</td>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiation therapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)</td>
<td>60.00%</td>
</tr>
<tr>
<td>389</td>
<td>Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving intermittent prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer</td>
<td>60.00%</td>
</tr>
<tr>
<td>386</td>
<td>Oncology: Cancer Stage Documented</td>
<td>Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period</td>
<td>60.00%</td>
</tr>
<tr>
<td>1634</td>
<td>Hospice and Palliative Care – Pain Screening</td>
<td>Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.</td>
<td>15.00%</td>
</tr>
<tr>
<td>1637</td>
<td>Hospice and Palliative Care – Pain Assessment</td>
<td>This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.</td>
<td>15.00%</td>
</tr>
<tr>
<td>1641</td>
<td>Hospice and Palliative Care – Treatment Preferences</td>
<td>Percentage of patients with chart documentation of preferences for life sustaining treatments.</td>
<td>31.90%</td>
</tr>
<tr>
<td>215</td>
<td>Proportion not admitted to hospice</td>
<td>Percentage of patients who died from cancer not admitted to hospice</td>
<td>1.17 odds ratio</td>
</tr>
<tr>
<td>0032</td>
<td>Cervical Cancer Screening</td>
<td>Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.</td>
<td>8 – 16%</td>
</tr>
</tbody>
</table>


Be Creative & Partner

- CCC Equity Task Force
- Innovative approach to “finding” some of the people missed by existing data sources
- Used employment as a key SDOH
- Created tools to help small businesses promote cancer screenings and increase accessibility to cancer screenings

Conduct Targeted Outreach

When it comes to Breast & Cervical Cancer:

Be your own advocate... it could save your life.

- THE REALITY...
- THE GOOD NEWS...

Cervical cancer is the most common cancer in women worldwide.

1 in 8 women

FREE screenings available!

PUBLIC HEALTH AND COMMUNITY DEVELOPMENT

Screenings offered near you.

To schedule your free screening, call: 603.271.4886

www.getscreenednh.com

Make Screening Accessible

Let No Woman Be Overlooked - Free Breast and Cervical Cancer Screening

APPOINTMENTS: 1-800-852-3345 OR 603-271-4331

Our Locations | Our Services

HOME ABOUT SERVICES SCREENING SITES ADDITIONAL RESOURCES UPDATES

Our Services

The “Let No Woman Be Overlooked” program provides free breast and cervical cancer screenings for:

- Women ages 40 to 74
- Pregnant women
- Self-referred women with no insurance

Our Mission

We join programs to help break the cycle of breast and cervical cancer mortality.
Use Community Health Workers

The Role of CHWs in Combatting Colorectal Cancer

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Year</th>
<th>Target Population</th>
<th>Intervention Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for Colorectal Cancer Screening Rates</td>
<td>2013</td>
<td>MIA</td>
<td>Patient navigation and screening promotion</td>
</tr>
<tr>
<td>Determination of colorectal cancer screening by Filipino Americans: community health workers as a feasibility study</td>
<td>2012</td>
<td>Filipino Americans</td>
<td>Patient education and screening promotion by community health workers</td>
</tr>
<tr>
<td>Effectiveness of community health workers in providing outreach and education for colorectal cancer screening in Appalachian Kentucky</td>
<td>2012</td>
<td>An underserved geographic region</td>
<td>CHW-led patient education</td>
</tr>
<tr>
<td>A pilot study of lay health worker outreach and colorectal cancer screening among Chinese American women</td>
<td>2010</td>
<td>Chinese American women</td>
<td>Lay health worker group education sessions</td>
</tr>
<tr>
<td>Use of a patient navigator in increasing colorectal cancer screening in an urban multiethnic health center</td>
<td>2005</td>
<td>Urban residents</td>
<td>Patient navigation and screening promotion</td>
</tr>
<tr>
<td>A multiethnic comparison of colorectal cancer screening among community health center patients - results of a mailed study</td>
<td>2009</td>
<td>Urban minorities</td>
<td>Patient navigation and screening promotion</td>
</tr>
<tr>
<td>Influences of the health worker outreach in evaluating colorectal cancer screening disparities in Vietnamese Americans</td>
<td>2004</td>
<td>Vietnamese Americans</td>
<td>Lay health worker group education sessions</td>
</tr>
<tr>
<td>The impact of a patient navigator on uptake on colorectal cancer screening in a large primary care network</td>
<td>2004</td>
<td>Vulnerable populations</td>
<td>Patient navigation and screening promotion</td>
</tr>
<tr>
<td>Patient navigation improves cancer diagnosis in a vulnerable, individually randomized trial of adults in an underserved population</td>
<td>2012</td>
<td>Low income minorities</td>
<td>Patient navigation to reduce delays</td>
</tr>
</tbody>
</table>

http://www.michigan.gov/documents/mdhhs/CHWsCaFactSheet_501771_7.pdf

Learn about and use the FRAMEWORK TO PROVIDE HIGH QUALITY CARE AND SERVICES FOR ALL
Become a more culturally effective organization

Culturally Effective Healthcare Organizations: A Framework for Success, April 2015
http://iasp.brandeis.edu/pdfs/2015CE.pdf

Cultural Competence

Gender | Ability
Beliefs | Thoughts
Geography | Ethnicity
Language | Sexual Orientation

Improved quality of care, safety, and patient satisfaction
Reduced health disparities
Increased revenue
Organizational Cultural Competency... 

...goes beyond collective cultural competence

Individual => cultural competence
Organizational => cultural effectiveness

Organizational Cultural Effectiveness...

Culturally Effective Organizational Practices

- Improvement for diverse patients
- Utilization patterns
- Patient and family satisfaction
- Treatment adherence
- Levels of patient trust
National Organizations that have Created Standards & Best Practices

A Crosswalk
What do they all have in common?
7 Elements

Framework for a Culturally Effective Organization

- Policies and Procedures
- Leadership
- Data Collection and Analysis
- Community Engagement
- Language and Communication Access
- Staff Cultural Competence
- Workforce Diversity and Inclusion

- Improved quality of care, safety, and patient satisfaction
- Reduced health disparities
- Increased revenue

Language & Communication Access
Staff Cultural Competence

CLAS Standards 5-8, and 4 & 13
Language & Communication Access
Staff Cultural Competence

WHAT DO THESE ELEMENTS LOOK LIKE IN YOUR ORGANIZATIONS?

Language & Communication Access
Federal Civil Rights Laws Compliance
Staff Cultural Competence
Many opportunities

New Hampshire Health & Equity Partnership
Diversity & Cultural Competence Trainers

Training
Knowledge useful abilities backbone of required for a training today

Webinar
LUNCH & LEARN

Data Collection & Analysis

CLAS Standards 10, 11, & 12
It's important to disaggregate your data to identify disparities:

- by age
- by income
- by education
- by insurance status
- by race/ethnicity

WISDOM - https://wisdom.dhhs.nh.gov
Colorectal Cancer Incidence by geography

Colorectal Cancer Incidence by Sex
How about disaggregating by other variables?
Why collect data…?  
Data Matters!!

“We cannot manage what we cannot measure.”  
- David Kindig, MD, MPH, University of Wisconsin School of Medicine

“It is not the data, it is what you do with it.”  
- Maryland Hospital Indicator Project

Example  
Promoting Breastfeeding in Massachusetts
Percent of Mothers Breastfeeding
Massachusetts

State

Target

Percent of Mothers Breastfeeding
by Race/Ethnicity, Massachusetts

Asian

Hispanic

State

White, Non-Hispanic

Black, Non-Hispanic

0% 20% 40% 60% 80% 100%

77%

71%

70%

70%

68%

Breastfeeding Among Mothers by Ethnicity, MA

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Asian Indian</th>
<th>Japanese</th>
<th>Pakistani</th>
<th>Nigerian</th>
<th>Salvadoran</th>
<th>Colombian</th>
<th>Barbadian</th>
<th>Korean</th>
<th>Jamaican</th>
<th>Dominican</th>
<th>Mexican</th>
<th>Haitian</th>
<th>Filipino</th>
<th>Thai</th>
<th>Cuban</th>
<th>MA TOTAL</th>
<th>Chinese</th>
<th>Puerto Rican</th>
<th>Afr-Amer</th>
<th>Vietnamese</th>
<th>Laotian</th>
<th>Cambodian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>91%</td>
<td>81%</td>
<td>71%</td>
<td>71%</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
<td>71%</td>
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<td>71%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**ETHNICITY QUESTION:**
* Do you consider yourself Hispanic/Latino?  
  - Yes
  - No

**RACE QUESTION:**
* Which category(ies) best describes your race?  
  - American Indian/Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian/Other Pacific Islander
  - White

**OMB Standards**
Remember...

Individuals must self-identify

Always ask ethnicity first

Gender Identity & Sexual Orientation

1. What sex were you assigned at birth, on your original birth certificate?
   - Female
   - Male

2. What is your current gender identity? (Check all that apply)
   - Female
   - Male
   - Trans female / Trans woman
   - Trans male / Trans man
   - Genderqueer / Gender non-conforming
   - Different identity (please state): _____

3. Do you think of yourself as:
   - Bisexual
   - Lesbian or Gay
   - Straight
   - Something else
   - Don’t know
Engagement, Continuous Improvement & Accountability

Hospitals learn about the very different ways in which patients and families may experience health and healthcare services.

Individuals from populations most likely to experience health disparities provide insight into barriers to receiving care so that hospitals may address them.

PFACs and providers use the knowledge gained to co-develop culturally appropriate strategies that increase patient engagement.

Patient and Family Advisory Councils: Advancing Culturally Effective Patient-Centered Care

* Hospitals learn about the very different ways in which patients and families may experience health and healthcare services.
* Individuals from populations most likely to experience health disparities provide insight into barriers to receiving care so that hospitals may address them.
* PFACs and providers use the knowledge gained to co-develop culturally appropriate strategies that increase patient engagement.

https://iasp.brandeis.edu/pdfs/2016/PFAC.pdf
Community Engagement

Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

<table>
<thead>
<tr>
<th>Outreach</th>
<th>Consult</th>
<th>Involve</th>
<th>Collaborate</th>
<th>Shared Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some Community Engagement</td>
<td>More Community Engagement</td>
<td>Better Community Engagement</td>
<td>Community Involvement</td>
<td>Strong Bilateral Relationship</td>
</tr>
<tr>
<td>Communication flows from one to the other to others</td>
<td>Communication flows to the community and then back, answer seeking</td>
<td>Gets information or feedback from the community</td>
<td>Communication flow in bilateral</td>
<td>Final decision making is at community level</td>
</tr>
<tr>
<td>Provides community with information</td>
<td>Entities consult</td>
<td>Entities share information</td>
<td>Entities cooperate with each other</td>
<td>Entities have formed strong partnership structures</td>
</tr>
<tr>
<td>Outcomes: Optimal</td>
<td>Outcomes: Develops connections</td>
<td>Outcomes: Visibility of partnerships established with increased cooperation</td>
<td>Outcomes: Partnership building, trust building</td>
<td>Outcomes: Broader health outcomes affecting broader community</td>
</tr>
</tbody>
</table>

Reference: Modified by the authors from the International Association for Public Participation.

Workforce Diversity & Inclusion

CLAS Standards 3
How can you improve

- Outreach to underrepresented communities
  - Cultural events in your area
- Post job opportunities in places where diverse community members look
  - Equitynh listserv
  - Ethnic papers / forums
- Include CLC in staff evaluations
- Value lived experience
- Talk about culture and diversity
  - diversity council?

Join the NH HE&P Listserv and post job opportunities there

www.equitynh.org
Leadership:
Show the way! Walk the talk!

- Elements of a culturally effective organization need to be understood and supported by leadership / governance / supervisors.
- Progress within each element should be reported to advisory / governance groups on a regular basis.
Policies and Procedures:
The only thing that is constant is change!

* Providing culturally sensitive services requires that knowledge of diversity be applied to policy and practice.

* Our community changes, so our policies must also change in order to be effective.

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Start with an Assessment

* **Individual:**
  * Begin by assessing one’s own cultural awareness, knowledge and skills
    * Clinicians benefit by heightening awareness, influencing attitudes toward practice, and motivating the development of knowledge and skills

* **Organizational:**
  * Assess attitudes, practices, policies and structures of administrators and service providers
    * Determine the needs, preferences and satisfaction of family members/consumers
Many Options, some are free

### Start with an Assessment

<table>
<thead>
<tr>
<th>Individual</th>
<th>Organizational</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLC Health Practitioner Assessment</strong></td>
<td><strong>CLC Assessment Tool: Based on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)</strong></td>
</tr>
<tr>
<td><strong>Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services</strong></td>
<td><strong>IHI Achieving Health Equity: A Guide for Health Care Organizations</strong></td>
</tr>
<tr>
<td><strong>Self-Assessment Checklist for Personnel Providing Services and Supports to LGBTQ Youth and Their Families</strong></td>
<td><strong>Cultural and Linguistic Competence Policy Assessment (CLCPA)</strong></td>
</tr>
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Robin Froman, Consultant and Interim Director, Center for Nursing Scholarship, University of Connecticut School of Nursing, Telephone: (860) 486-3716 or (707) 433-1402, Email: RFD@vbbn.com

Dennis P. Andrulis, PhD, MPH, Director, Center for Health Equality, Drexel University School of Public Health, 1505 Race Street/Bellef Building/11th floor, Philadelphia, PA 19102, Telephone: (212) 762-1402, Email: dpa28@drexel.edu
Make an Action Plan

* After you and your staff complete an individual assessment, choose a couple things that you can improve within your daily interactions.

* After the organization has completed an organizational assessment, a team should determine a couple areas that are in need of improvement and create an action plan to address those areas.

Remember...

✓ Cultural competence is essential for high quality for all.

✓ Organizational cultural effectiveness has 7 elements.

✓ We all have a key role to play in improving the environments and organizations in which we work.
Work on Implementing the Elements to Become a Culturally Effective Organization

1) Start with an assessment
2) Check out the online toolkit and webinar
3) Join the CEOrgs Work Group

Thank you!

Trinidad Tellez, MD
Office of Health Equity
trinidad.tellez@dhhs.state.nh.us