

Final Report
Health Care Cultural Competency
Steering Committee

Springfield, Missouri

June 17, 2010

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Executive Summary

In 2009, the University of Missouri Extension began a new initiative to help reduce health disparities in Missouri's urban areas: St. Louis, Kansas City and Springfield. The St. Louis team focused on strategies related to building healthy communities, the Kansas City team investigated ways to improve health care access and the Springfield team (Health Care Cultural Competency Steering Committee) explored strategies to enhance the quality and quantity of health care employees in the workforce. Specifically, the Springfield team developed a set of recommendations that focused on the cultural competency and diversity of personnel employed by local health care providers. The eight recommendations approved by the Health Care Cultural Competency Steering Committee under a patient-centered care framework are as follows:

1. Within willing health care organizations located in Greene County, assist in determining health care leaders' perceptions of the importance of cultural competency and diversity.
2. Using information from the health care leaders' assessment above, assist by creating and presenting a strong business case for the benefits of allocating resources to projects that promote diversity in the workplace, cultural competency in practice and/or general patient-centered care.
3. Assist in determining what cultural competency education and training currently exists in health care organizations located in Greene County.
4. Within health care organizations located in Greene County, assist in determining minority and Caucasian consumer perceptions related to diversity and cultural competency in health care services.
5. Within health care organizations located in Greene County, assist in determining minority and Caucasian employee perceptions related to diversity and cultural competency at their work environment and in the community.
6. Develop and promote an ongoing, research-based public education and awareness marketing campaign related to diversity and cultural competency for health care providers, employees and the general community.
7. Report to community leaders, agencies, organizations and the media to assist in formulation, development and implementation of policies, practices and programs that promote, improve and implement cultural competency in health care organizations.

8. Adapt and develop patient-centered care training programs and/or workshops for health care employees in Greene County including sessions that speak to core competencies related to cultural competency to address needs uncovered by initial assessments.

It is recommended that consideration be given to the establishment of an autonomous ad hoc Patient-Centered Care Task Force, consisting of 12 members. The Task Force would be established in the fall of 2010 to oversee and be responsible for the implementation of the recommendations state above. The Task Force would include an ongoing systemic process with appropriate feedback loops, to create awareness, improve public education and strengthen the assessment process. The Patient-Centered Care Task Force would develop appropriate timelines to keep each project on schedule to ensure that recommendations one through seven are completed by the fall of 2012 and recommendation eight is well underway at that time.

Background

Project Overview

Early in 2009, leaders within the University of Missouri Extension decided to embark on an important new initiative to help reduce health disparities in Missouri's urban areas. Because health status can be influenced by many variables including, but not limited to, health literacy, income, education, environmental factors, race and ethnicity, cultural influences, and access to quality medical care, it was determined that three separate, yet coordinated, Urban Impact Teams would be created. The thought was that this would enable the teams to gather information that could be shared to improve the health status of residents in each of Missouri's three urban areas.

Urban Impact Teams were then established in St. Louis, Kansas City and Springfield. Though the work of all three urban efforts is coordinated by a nine-member Statewide Coordinating Team from the University of Missouri Extension, each local initiative has its own distinct leadership and focus, and is designed to address specific issues related to health disparities. The three individual efforts are described below:

Reducing Health Disparities Through a Focus on Healthy Communities: The St. Louis team is exploring strategies related to building healthy communities. This team is focusing on place-based indicators where people live, work, learn and play that can promote good health. Place-based indicators such as access to fresh foods, safe recreational facilities, clean air, safe neighborhoods and others can positively impact the health of citizens in communities.

Reducing Health Disparities Through a Focus on Health Care Access: The Kansas City team is investigating ways to improve health care access. The primary focus of this team is on the development of educational strategies to promote preventive health, health care coaching and managed self care for both acute and chronic disease conditions. Self determination and resilience as it relates to access or need for health care can be a proactive addition to the local health care system.

Reducing Health Disparities Through a Focus on Workforce Development: The Springfield team is exploring strategies to enhance the quality and quantity of health care employees in the workforce. Specifically, this team is focusing on the cultural competency and diversity of personnel employed by local health care providers. Cultural competency skills and the recruitment and retention of minority health care professionals and staff can improve the quality of patient care, enhance employee satisfaction and better position health systems and clinics to meet the emerging challenges including workforce shortages.

Springfield Team



Near the end of 2009 and beginning of 2010, a Health Care Cultural Competency Steering Committee (Springfield Urban Impact Team) was assembled. The 22-member Steering Committee included strong representation from health care organizations, educational institutions, local governmental entities and the nonprofit sector (see Appendix A – Health Care Cultural Competency Steering Committee Members).

During the first Steering Committee meeting in January 2010, cultural competency was defined as an ability to understand, communicate with, and effectively interact with people of different cultures (Mercedes Martin & Billy Vaughn, 2007). Additionally, it was explained that the purpose of the Steering Committee was to research and finalize recommended strategies to enhance cultural competency and diversity in local health care organizations by the end of May 2010 (phase one). Phase two, with a timeframe determined by the local Springfield team, would then consist of resource development and implementation of the specific recommendations. During the Steering Committee meeting, the following Cultural Competency Model was also shared as a point of reference to help determine the primary focus of the team's effort.

Cultural Competency Model

(Developed by Tim Siebert)

	Recruitment & Retention	Education & Training
Health Care Providers	Recruitment & Retention of Minority Health Care Providers	Education & Training of All Health Care Providers
Colleges & Universities	Recruitment & Retention of Minority Students Majoring in Allied Health Fields	Education & Training of All Students Majoring in Allied Health Fields

At the meeting, it was discussed and decided that the scope of work should be limited to three of the four boxes in the Cultural Competency Model outlined above: (1) Recruitment & Retention of Minority Health Care Providers, (2) Recruitment & Retention of Minority Students Majoring in Allied Health Fields and (3) Education and Training of All Health Care Providers. It was determined that college and university allied health programs were already educating and training students in cultural competency; therefore, there was no need to focus on this area.

Steering Committee members further decided that efforts should be divided into two subcommittees: (1) Recruitment & Retention Subcommittee (see Appendix B – Recruitment & Retention Subcommittee Members) and (2) Education & Training Subcommittee (see Appendix C – Education & Training Subcommittee Members). Each Steering Committee member then signed up to serve on one of the two subcommittees with other representatives recruited from the community. Additionally, it was determined that all subcommittee recommendations would need to receive final approval from the Steering Committee.

Approximately two weeks following the first organizational meeting of the Steering Committee, the Springfield team officially kicked off its effort with a four-hour Cultural Competency Workshop led by Dr. Karen Edison, Director of the University of Missouri Center for Health Policy. Others from the University of Missouri also assisted Dr. Edison. Following the workshop, the Steering Committee agreed to engage Dr. Edison and her team as facilitators for the Springfield initiative.

Between January 1 and May 31, 2010, the Steering Committee met four times, both subcommittees met two times, and the Steering Committee co-chairs and subcommittee co-chairs met two times. Additional meetings also took place with the subcommittee co-chairs. Email was also used to communicate and gather input from appropriate parties throughout the entire process. All Steering Committee and subcommittee meetings took place at the Springfield Area Chamber of Commerce.

During the course of our proceedings, the Recruitment & Retention Subcommittee decided to conduct two preliminary assessments: (1) a survey of large local health care providers to determine what programs and/or practices they utilize to recruit and retain minority employees and (2) a survey of large local educational institutions to determine existing programs and/or practices they employ to recruit and retain minority students and employees in allied health programs. The Education & Training Subcommittee also conducted a quick nonscientific survey of large local health care providers to determine what programs and/or practices they have implemented to address cultural competency. The purpose of the three surveys above was not to obtain detailed information, but merely to get a general feel for the programs and/or practices currently in existence locally. Overall, it was found that programs and/or practices in all three categories appeared to be limited.

Additionally, during our deliberations, personnel at the University of Missouri Center for Health Policy conducted research on the Springfield team's behalf, including a summary of promising national practices in cultural competency and diversity (see Appendix D – Promising National Practices in Cultural Competency and Diversity) and promising practices in cultural competency and diversity in Missouri (see Appendix E – Promising Practices in Cultural Competency and Diversity in Missouri).

The Case for Cultural Competency and Diversity

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt, et. al., 2008).

Cultural competency is important because it "is one of the main ingredients in closing the disparities gap in health care. It is the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes" (The Office of Minority Health website, U. S. Department of Health & Human Services).

The case for addressing cultural competency and diversity in health care is based on rapidly changing demographics, labor-force needs and critical clinical issues of equity.

Changing Demographics

According to U. S. Census statistics, the nation will be more racially and ethnically diverse by mid-century with minorities expected to become the majority in 2042. By 2023, minorities will make up more than half of all children. In 2050, minorities are expected to represent 54 percent of the population in the United States. At that time, it is projected that one in three United States residents will be Hispanic while the Black and Asian population is estimated to represent 15 percent and 9.2 percent respectively.

The trend with increasing numbers of minorities has been long-term. For example, in 1967 whites represented 83 percent of the nation's population compared to 67 percent in 2006. This has also been the trend in Missouri with 12 percent minorities in 1990 compared to 17 percent in 2005.

Likewise, in Greene County, from 2000 to 2008, Hispanic growth increased 61 percent, Black American growth increased 28 percent and Asian growth increased 30 percent. In 2008, there were 3 percent Blacks, 3 percent Hispanics and 1 percent Asians in Greene County compared to 12 percent Blacks, 3 percent Hispanics and 2 percent Asians in Missouri.

Labor-Force Considerations

According to the U.S. Census, from 2000-2008, the U.S., the Midwestern States, and Missouri all followed the same demographic trends of losses of non-Hispanics in the age groups 0-19 and 20-44 while showing gains of Hispanics in those same age groups. At the same time there were large increases in the older age cohorts (45-64; 65+). Almost all that growth was in the non-Hispanic population. Hence, there has been a net reduction of the younger segments of the population with this reduction being partially compensated with the growth of younger immigrant population, most of whom are Latino/Hispanic.

The demographic changes are as follows for the Midwestern States (U.S. Census Bureau of 12-state region) between 2000 and 2008: for the age group 0-19, non-Hispanics decreased by 1 million, while Hispanics in that age range grew over 433,000; and for the age group 20-44, non-Hispanics decreased by 1.4 million while Hispanics grew over 382,000.

Missouri followed the same pattern of the Midwestern States between 2000 and 2008: for the 0-19 age group the non-Hispanics loss was 43,000 but the Hispanic gain was 31,000; and for the 20-44 age group the non-Hispanic loss was 53,000 but the Hispanic gain was 25,000. And additionally, Missouri followed the pattern of the Midwestern States with large increases of the older segments of the population (45-64; 65+).

The only significant growth seen in Missouri's working age population is in the Hispanic portion of the younger age cohorts (0 to 19 and 20 to 44). What this means is that because the non-Hispanic population is aging and because the non-Hispanic younger age cohorts are not growing, Missouri will be seeing in the very near future a potentially massive labor shortage. To fill this gap, employers will need to attract and recruit employees from the cohorts that are increasing, such as the Hispanic population.

There are three implications for health care as baby boomer employees in health care retire. First, as highlighted in the demographic changes above, consumer diversity is on the rise. Health systems and clinics that increase the diversity of their organization will be better equipped to identify and meet the increasing cultural demands of the younger generations. Second, there are not as many people in the working age population to fill those positions. Last, as the population ages the demand for health care services will increase. This increased demand will further exacerbate employment shortages in the health care sector. Since Latinos are the growing segment of the younger age cohorts, it is expected that businesses will be looking to this segment to meet these increased labor demands.

Critical Clinical Issues

The case for equity in Missouri is clear from the racial and ethnic disparities collected by the Missouri Foundation for Health (MFH) in two of its reports: ***“Minority Health Disparities in Missouri: 2009 African American Data Book”***; ***“Minority Health Disparities in Missouri: 2009 Hispanic Data Book”***. These reports give a view of the health status of African-Americans and Hispanics (the two largest minority populations) in the State of Missouri. The findings document the continued health disparities that exist between minorities and whites in the State of Missouri. The numbers in these studies speak for themselves and exemplify the need now, more than ever, for a specific focus on the health of minorities in the State of Missouri. According to the MFH disparity reports:

- “Hispanics have less education than the overall population, are less likely to have access to preventative care, and are more likely to be without health insurance. Moreover, Hispanics are less likely to focus on prevention and health promotion and more likely to report no usual place of health care compared to whites. These factors all work against the overall health picture for Hispanics in Missouri.”
- Disparities between blacks and whites in Missouri are wide spread and are documented in a wide-range of disease and treatment categories, which culminates in a disparity in life expectancy. “Life expectancy at birth was 77.7 years for white residents of Missouri in 2006 and only 71.9 for African Americans.”

The case for equity in healthcare nationally is made in the book ***Improving Quality and Achieving Equity: A Guide for Hospital Leaders*** (Betancourt, et. al., 2008). The Report highlights that there is a significant gap between the quality of health care people should receive and the quality of health care people do receive. This highlights a large quality chasm for racial/ethnic minorities in the United States.

Equity is a key essential component of quality. Despite this awareness of equity, few hospital leaders have made equity (and identifying and addressing disparities) a key guiding principle or value for their health care organizations. Quality is a system property and to truly achieve quality of care, health care systems must focus on six key elements — efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Equity is only achieved by providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status.

Recent studies examining racial and ethnic disparities in quality of care have demonstrated that even when controlling for insurance status, socioeconomic status, comorbidities, stage of presentation and other confounders; minorities often receive a lower quality of health care than do their white counterparts. Additionally, racial and ethnic disparities have been found in the quality of care delivered to patients with cardiovascular disease, diabetes, and cancer screening and management. Research has shown that racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management.

There are at least three basic things that can be done to address the issue of disparities. First, develop a system to routinely collect patient race and ethnicity data. Second, begin to stratify quality measures by race and ethnicity to assess equity; this should be formalized into a disparities equity report that can be monitored routinely by the leadership. Third, if a disparity is identified, develop an intervention to address it. All of this work should be done in collaboration with, and supported by, the hospital Board, hospital leadership, faculty and staff.

Steering Committee Recommendations

After much thought and careful consideration, it is suggested that the Health Care Cultural Competency Steering Committee primarily focus its recommendations on projects related to assessments, trainings and workshops. Specifically, the Steering Committee approves the following recommendations under a patient-centered care framework:

Recommendations

- 1. Within willing health care organizations located in Greene County, assist in determining health care leaders' perceptions of the importance of cultural competency and diversity.**

Targeted organizations include, but are not limited to: St. John's Health System, CoxHealth, Ozarks Community Hospital, Jordan Valley Community Health Center, The Kitchen Clinic, Springfield-Greene County Health Department and Burrell Behavioral Health. Methods are to be decided by the Patient-Centered Care Task Force but could include structured interviews and/or surveys with health care administrators from participating organizations.

- 2. Using information from the health care leaders' assessment above, assist by creating and presenting a strong business case for the benefits of allocating resources to projects that promote diversity in the workplace, cultural competency in practice and/or general patient-centered care.**

The buy-in of local health policy makers and health care leaders is vital to achieving successful implementation of Health Care Cultural Competency Steering Committee recommendations. The business case will be distributed to local health care leaders and the Springfield Area Chamber of Commerce as part of recruitment efforts to identify health care organizations willing to participate in future assessments and training programs. Careful crafting of a business case that speaks to the identified issues and needs of local health care organizations will strengthen collaboration and increase promotion and participation.

- 3. Assist in determining what cultural competency education and training currently exists in health care organizations located in Greene County.**

This assessment would include a resource inventory of education training and programs offered and required by local health care organizations. It is recommended that the inventory include some form of assessment of the programming by staff, health professionals and administrators. This will allow a gap analysis to be conducted between how health care organizations perceive the effectiveness and how they are perceived by others.

- 4. Within health care organizations located in Greene County, assist in determining minority and Caucasian consumer perceptions related to diversity and cultural competency in health care services.**

The way consumers perceive the cultural sensitivity of their health systems and providers has not been systematically assessed in the Springfield region. This information would highlight consumer needs and can be used to ensure that identified training programs truly meet the health care needs of consumers. Methods could include community surveys, structured interviews with individuals, focus groups with culturally similar individuals or any combination of these methodologies.

- 5. Within health care organizations located in Greene County, assist in determining minority and Caucasian employee perceptions related to diversity and cultural competency at their work environment and in the local community.**

Like consumers, health care employee perceptions have not been systematically assessed in Greene County. Possible methods include incorporating standardized questions on cultural competency and diversity into existing employee satisfaction surveys, conducting structured interviews with a sample of employees or holding employee focus groups. To ensure participation, all data collected would remain confidential and would be publicly reported without identifying specific health care providers.

- 6. Develop and promote an ongoing, research-based public education and awareness marketing campaign related to diversity and cultural competency for health care providers, employees and the general community.**

Communication buy-in is vital to sustaining cultural competency efforts. It is recommended that a social marketing campaign be developed to promote activities and encourage health care organizations to participate through grassroots reinforcement. To be effective, the social marketing campaign must be based on the tenets of health literacy and provide information in plain language with clear communication strategies.

- 7. Report to community leaders, agencies, organizations and the media to assist in formulation, development and implementation of policies, practices and programs that promote, improve and implement cultural competency in health care organizations.**

As with all community-based initiatives, transparency is of key importance. Health care organizations, their employees and the public must be able to attain a clear understanding of the roles cultural competency and diversity play in the health of themselves and their community. All activities, minutes and reports will be available and open to the public. Once again, reports will follow health literacy principles and be written clearly in plain language.

8. Adapt and develop patient-centered care training programs and/or workshops for health care employees in Greene County, including sessions that speak to core competencies related to cultural competency.

Training should be offered in numerous formats and be adaptable to the individual needs of collaborating health care organizations. Furthermore, programs should be tailored specifically to address any gaps or issues uncovered by the assessments in recommendations one, three, four and five. Interactive training that fully engages the learner in a real life practice setting has been found to be most effective. For example, clinic simulation workshops can engage health professionals in real-life scenarios in their own practice setting.

In the future, additional recommendations could be made to address appropriate needs identified from the assessments listed above.

Implementation

It is recommended that an ad hoc Patient-Centered Care Task Force, consisting of 12 members, be established and officially begin its work in the fall of 2010. The committee would be an autonomous community task force with administrative, research, budget and fundraising assistance provided by the University of Missouri Extension. Expertise and resources from other local, state and national organizations could also be drawn upon throughout the implementation process.

The Patient-Centered Care Task Force would oversee and be responsible for the implementation of the recommendations approved by the Health Care Cultural Competency Steering Committee. Specifically, the Patient-Centered Care Task Force would do the following:

- Develop and agree on a working definition of Patient-Centered Care (with a focus on cultural competency) that will be used to guide the work of the Task Force;
- Select and approve all processes, scope, timing, methodology, and organizations used to implement each project initiated to successfully complete Health Care Cultural Competency Steering Committee recommendations;
- Establish appropriate timelines and coordinate communications to ensure that all recommendations will be completed on time and budget by the fall of 2012;

- Coordinate and facilitate assessment data collection, compilation and analysis. Provide an interim report (with executive summary) immediately following each project;
- Disseminate and promote a strong business case that promotes diversity in the workplace, cultural competency in practice and/or general patient-centered care.
- Coordinate promotion and implementation of training programs and workshops. Work closely with local clinics and health systems to encourage participation in training.
- Oversee, be responsible for, and/or work with other organizations to complete a final comprehensive report (including an executive summary) by December 31, 2012 specifying the findings and work of the Patient-Centered Care Task Force;
- Ensure that appropriate funding is in place to complete each project and successfully implement each recommendation;
- Coordinate each project with local organizations to enhance community-wide efforts designed to address patient-centered care;
- Distribute reports and important information to all stakeholders.

It is suggested that members of the Patient-Centered Care Task Force, including the Chair and Vice Chair, be selected by an independent three-member Selection Committee appointed by the Co-Chairs of the Health Care Cultural Competency Steering Committee. An application process could be used to assist the Selection Committee during the screening of candidates. Membership of the Patient-Centered Care Task Force could include, but not be limited to, representation from health care, education and government. Additionally, it is suggested that the Task Force composition include at least two physician health care providers, three or more minorities, three or more representatives from the general community and a non-voting ex officio member from the University of Missouri Extension that does not serve as the Chair or Vice Chair. Members of the Patient-Centered Care Task Force would agree to the following responsibilities and processes:

- Members shall attend all monthly meetings and understand that if two consecutive meetings are missed, a member may be replaced by a vote of the Task Force;
- Members shall take a sincere interest in the work of the Task Force and be thoroughly engaged throughout the entire implementation process;
- Members shall prepare in advance for, and bring supporting materials to, each meeting;

- Members shall be respectful of one another, listen attentively to peers and others in the community, be open to various viewpoints and actively work toward consensus;
- Meetings shall be conducted using Roberts Rules of Order and majority rule of voting members physically present at each meeting to make decisions;
- A minimum of six voting Task Force members shall be physically present at a meeting to achieve a quorum so that official business can be conducted;
- Each member, Chair and Vice Chair of the Task Force (excluding the University of Missouri Extension representative) shall receive one vote and the Chair's vote shall break any tie that may occur;
- The Task Force Chair shall schedule all meetings and be responsible for distributing task force agendas and minutes to task force members;
- The Vice Chair shall serve as Task Force Chair when the Chair is absent and also be responsible for taking minutes at each meeting.

Appendix A

Health Care Cultural Competency

Steering Committee Members

- Carmen Parker Bradshaw (Co-Chair) – Executive Director, Springfield-Greene County Regional Health Commission
- Dr. Tim Siebert (Co-Chair) – County Program Director and Urban Program Specialist, University of Missouri Extension
- Dr. Jim Wirth – Human Development Specialist, University of Missouri Extension
- K. Brooks Miller – President and Chief Executive Officer, Jordan Valley Community Health Center
- Dr. Anne Brett – President, Cox College
- Dr. Martha Baker, Director of the BSN Program, St. John’s College of Nursing and Health Sciences of Southwest Baptist University
- Bill Dowling – City of Springfield Director of Workforce Development, Missouri Career Center
- Harold Bengsch – Associate Commissioner District I, Greene County Commission
- Dr. Todd Schaible – President and Chief Executive Officer, Burrell Behavioral Health
- John Wilson – Springfield Area Chamber of Commerce Board Member and Regional President, U. S. Bank
- Jennifer Kennally – President and Chief Executive Officer, United Way of the Ozarks
- Yolanda Lorge – President, Grupo Latinoamericano
- Dr. Michael Nietzel – President, Missouri State University
- Rita Wright Gurian – Vice President Organizational Development, Administration, CoxHealth
- Jim Brookhart – Senior Vice President of Human Resources, St. John’s Health System
- Renette Wardlow – Human Development Specialist, University of Missouri Extension
- Dr. Hal Higdon—President, Ozarks Technical Community College.
- Kathryn Wood—Human Resources Generalist, Ozarks Community Hospital
- Dr. Robert Spence—President, Evangel University
- Misty Jordan—Community Education Coordinator (Southwest Missouri Area Health Education Center), Missouri State University
- Rebecca Ray—Health Educator, Springfield-Greene County Health Department
- H. Wes Pratt—Coordinator, Diversity Outreach & Recruitment, Missouri State University

Appendix B

Recruitment & Retention Subcommittee Members

- Jim Brookhart (Co-Chair)—Senior Vice President of Human Resources, St. John’s Health System
- Bill Dowling (Co-Chair)—City of Springfield Director of Workforce Development, Missouri Career Center
- Dr. Anne Brett—President, Cox College
- Dr. Jim Wirth—Human Development Specialist, University of Missouri Extension
- Tim Siebert—County Program Director and Urban Program Specialist, University of Missouri Extension
- K. Brooks Miller—President and Chief Executive Officer, Jordan Valley Community Health Center
- Harold Bengsch—Associate Commissioner District 1, Greene County Commission
- Dr. Michael Nietzel—President, Missouri State University
- Rita Wright Gurian—Vice President Organizational Development, Administration, CoxHealth
- Dr. Hal Higdon—President, Ozarks Technical Community College
- Dr. Martha Baker, Director of the BSN Program, St. John’s College of Nursing and Health Sciences of Southwest Baptist University
- Dr. Robert Spence—President, Evangel University
- Dr. Helen Reid—Dean of the College of Health and Human Services, Missouri State University.
- Dr. Judith Gonzalez—Associate Professor of Psychology, Forest Institute of Professional Psychology

Appendix C

Education & Training Subcommittee Members

- Misty Jordan (Co-Chair) —Community Education Coordinator (Southwest Missouri Area Health Education Center), Missouri State University
- Rebecca Ray (Co-Chair)—Health Educator, Springfield-Greene County Health Department
- Renette Wardlow—Human Development Specialist, University of Missouri Extension
- Carmen Parker Bradshaw—Executive Director, Springfield-Greene County Regional Health Commission
- Dr. Todd Schaible—President and Chief Executive Officer, Burrell Behavioral Health
- John Wilson—Springfield Area Chamber of Commerce Board Member and Regional President, U. S. Bank
- Jennifer Kennally—President and Chief Executive Officer, United Way of the Ozarks
- Yolanda Lorge—President, Grupo Latinoamericano
- Kathryn Wood—Human Resources Generalist, Ozarks Community Hospital
- Karla Myers, Chief Nursing Officer, Ozarks Community Hospital
- Pam Bryant—Maternal, Child & Family Health Programs Administrator, Springfield-Greene County Health Department
- Becky Quinn—Grant Writer, Missouri Career Center
- Dr. Mark Wood—Professor of Chemistry, Drury University
- Elisa Coonrod—Southwest Missouri Program Coordinator, Show Me Healthy Missourians
- H. Wes Pratt—Coordinator, Diversity Outreach & Recruitment, Missouri State University

Appendix D

Promising National Practices in Cultural Competency and Diversity

Cultural Competence Model Academia: Duke University

- *Diversity and Equity Program*¹
 - Offers consultation and training designed to assist staff in ‘deepening diversity awareness, enhancing skill development, and providing information related to a broad range of diversity topics, cross-cultural understanding, and institutional equity’
- *Multicultural Resource Center*²
 - Resources include cultural competency education, support and guidance for young minority physicians and medical students, community health initiatives that connect medical student volunteers with community agencies that serve minority and underserved population, a summer medical and dental education program to help talented underrepresented minority and disadvantaged students to prepare for medical school, and minority faculty development
- *Duke University School of Nursing together with the El Centro Hispano-Linguistic Center offer Global Enhancement Courses*³
 - These classes include aspects of Latin American culture, especially those areas most pertinent to health care. They focus on medical terminology, professional patient-clinician interaction, and simulation scenarios

Cultural Competence Model Academia: Medical University of South Carolina⁴

- The Medical University of South Carolina has developed a cultural competency curriculum. The curriculum includes orientation diversity training, cultural competency reading assignments and video presentation, problem based learning classes, rural medicine clerkship home visit assignment, clinical experiences in third and fourth clerkships, and culturally sensitive interviewing techniques

Cultural Competence Model Academia: University of Medicine and Dentistry of New Jersey⁵

- *Participant in the New Jersey Campus Diversity Initiative and are involved in a project entitled Developing Cultural Competency*
 - They conduct focus groups and interviews with administrators, faculty, staff, students, and community representatives to gather information about diversity-related issues in education, clinical care, research, and community service
- *Developed a core curriculum*
 - The first year consists of six three-hour sessions focusing on a broad spectrum of core cultural competency topics
 - Large group didactic component
 - Videos
 - Small groups of ten students with a trained faculty facilitator
 - The second year consists of cross-cultural standardized patient exercises
 - The third year consists of a one-and-a-half hour core cultural competency session and a one-and-a-half hour clerkship specific session which allows students to explore topics and issues that they may confront while completing a specific discipline

Cultural Competence Model: Michigan State University⁶

- *Cultural Competency Series*
 - A five-module series that focuses on,
 - Building Foundations for Growth and Change
 - Exploring Identity, Oppression and Privilege
 - Developing Authentic Relationships across Difference
 - Exploring Transformational Leadership and Multicultural Change
 - Moving Toward Sustainable Multicultural Change
- *MSU also holds a two-day, multicultural self-awareness workshop five times a year in different locations across the state*
- *Staff at MSU also have established an ongoing series of podcasts where they discuss diversity matters and the essential competencies for diversity leadership*
- *Other programs at MSU include;*
 - A Call to Men – helps men reconsider their beliefs about women in an effort to create a more just society
 - Class Action – a national non-profit that provides resources to explore issues related to class
 - Family Acceptance Project – an initiative to study the impact of family acceptance and rejection on the health of lesbian and gay youth

Cultural Competence Model: Community Health⁷

- *Sunset Park Family Health Center Network of Lutheran Medical Center, Brooklyn NY*
 - This facility consists of primary care sites, a behavioral health center, literacy programs, wellness centers, and other supportive programs for underserved neighborhoods
 - Sunset Park attracts many kinds of immigrants by offering adequate housing, jobs, and reducing illness
 - They have created an environment that celebrates diversity by expanding relationships with community groups

Cultural Competence Model: Managed Care⁷

- *Kaiser Permanente, San Francisco CA*
 - Developed a department of multicultural services that provide onsite interpreters in the San Francisco Medical Center
 - A call center was also developed to help Chinese-speaking patients make appointment, navigate the system, and obtain medical advice and services
 - Kaiser has also established a director of linguistic and cultural programs on a national level

Cultural Competence Model: Aetna^{8, 9, 10, 11}

- *Vision and Strategy to achieve diversity in the workforce to better serve a diverse population*
 - Develop a diverse supplier base reflecting a multicultural environment that supports innovative ways to deliver best-in-class services
 - Build a workforce that fully understands diverse communities and where they do business
 - Foster a culture of inclusion that grows a diverse talent pool and recognizes and rewards the contributions of every employee
- *Employee Resource Groups (ERGs) were developed to understand the growing diverse population and their employees*
 - These groups were formed to support and sustain workforce diversity efforts
 - The focus of these groups are
 - An opportunity for employees to share experiences and network
 - A way to give back to their communities
 - Learn career-building skills
 - Aetna's has established the following ERGs: African American ERG, Hispanic ERG, Native-American ERG, ERG of Gay, Lesbian, Bisexual and Transgender, Women's ERG, Mother's ERG, Asian-American ERG, Boomers ERG, Caregivers ERG, Telework Community ERG

- *Aetna Diversity Statistics*
 - Aetna currently has approximately 35,200 employees. Of these:
 - 32% are people of color
 - 15% of management are people of color
 - 10% of senior leaders are people of color
 - 76% are women
 - 62% of management are women
 - 30% of senior leaders are women

Cultural Competence Model: Chubb Insurance¹²

- *Chubb has strived to create a more diverse workforce that accurately reflects the country's population*
 - They have appointed a Chief Diversity Officer
 - They have established Employee Resource Groups
 - They have defined their diversity vision through objectives, policy, and a clear business case
- *Message from the CEO on Diversity*
 - 'A company all of whose people share the same background, culture and ways of looking at the world is likely to stagnate. On the other hand, a company whose employees bring different perspectives on their jobs is one that will always find more efficient ways to operate and new ways to grow.' – John D. Finnegan, President, Chairman and CEO
- *'Diversity Objectives to integrate tactics for diversity into every aspect of the organization's activities, from growing business and increasing shareholder value to maintaining the ability to attract and employ top talent'*
 - Ensure a diverse representation of talent throughout the company
 - Drive profit and growth from diverse markets
 - Embed diversity in learning opportunities at Chubb
 - Implement management practices that enhance diversity
- *In 1994, Chubb's Policy Team created the Culture of Inclusion Policy for the company's position on diversity*
- *Business Case for Diversity*
 - Chubb looks at diversity as a competitive advantage and makes it a top business priority to achieve a diverse workforce
 - 'In order for Chubb to remain competitive for talent and for customers, it is imperative that we attract and value diverse talent and enable that talent to attract and value diverse customers'

- *Chubb Insurance also created Employee Resource Groups. These groups were formed to create an inclusive environment and play an essential role in influencing progress on diversity issues*
 - Current Employee Resource Groups include:
 - Asian American Business Network
 - Gay and Lesbian Employee Network, including bisexual, transgender, and straight allies
 - Minority Development Council
 - Women’s Development Council
 - Working Parent Network

Cultural Competence Model: Government

- *Language Interpreter Services and Translations, Washington State⁷*
 - This program was developed in 1991 due to many Civil Rights lawsuits
 - Offers free translation to Limited English Proficiency individuals in order to guarantee ‘equal access’ to services
 - An extensive certification and quality control system is in place for interpreters to ensure the program’s success
- *The Department of Defense – Military Leadership Diversity Commission¹³*
 - The National Defense Authorization Act for Fiscal Year 2009 established the Department of Defense (DoD) Military Leadership Diversity Commission (MLDC)
 - The creation of MLDC allows for the evaluation and assessment of policies that ‘provide opportunities for the promotion and advancement of minority members of the Armed Forces, including minority members who are senior officers’
- *The Military Leadership Diversity Commission was assigned with twelve charter tasks¹³:*
 - Develop a uniform definition of diversity
 - Incorporate private sector practices found to be successful in diverse leadership
 - Assess the ability of current organizational structures to ensure effective diversity management
 - Explore options available to improve the current plans of the Department of Defense
 - Re-examine existing milestones for evaluating diversity plans
 - Evaluate efforts to develop and maintain a diverse leadership at all levels of the Armed Forces
 - Analyze successes and failures of efforts to develop diverse leadership

- o Determine the status of prior recommendations made by DoD and Congress concerning diversity initiatives
- o Consider the benefits of conducting an annual conference focused on diversity
- o Examine the possible effect of expanding DoD secondary educational programs to diverse civilian populations
- o Evaluate the ability of current recruitment and retention practices to attract and maintain a diverse pool of individuals
- o Measure the ability of current activities to increase continuation rates for ethnic and gender-specific members of the Armed Forces

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Appendix E

Promising Cultural Competency and Diversity Practices in Missouri

SSM Health Care¹

- *Diversity Strategic Initiatives*
 - Enhance their ability to meet the needs of diverse patients and customers
 - Improve support to and alliances with organizations whose missions call for rigorous pursuit of fairness and equality for all people
 - Improve the work environment and professional development activities to attract and retain a diverse workforce
 - Increase business partnerships with minority and women suppliers
- *Diversity Scorecard*
 - A diversity scorecard was developed for SSM Health Care by its employees to help achieve the organization's Diversity Strategic Goals
 - Employs a web-based metrics measurement system for standardized reporting of how actions and efforts help achieve diversity
 - Report cards help SSHC track progress and identify additional areas, which are not up to expectations
 - SSM also uses the report card to benchmark their work against internal and external efforts in order to determine best practices and develop new programs

Health Literacy Missouri²

- *Health Literacy Environmental Assessment*
 - Provides on-site assessment of clinics and hospitals based on five health literacy domains including cultural and linguistic competency
 - Provides detailed baseline data accompanied with recommendations for further system improvements
- *Educational Workshops and Trainings*
 - Workshops and trainings take a variety of forms and can be tailored to meet the specific needs of the client and achieve audience objectives
 - *Clinic Simulation Workshop*- The session employs standardized patients in a simulated environment to provide practice-based learning in a controlled, clinic setting. Targeting health and medical professional in training or in practice, participants go through a series of cases tailored to address specific cultural competency issues

- *Standardized Doctor Workshop*- This unique and innovative workshop intends to flip the clinic simulation model on its head by providing patients the opportunity to overcome barriers presented by health professionals who practice no or poor health literacy skills. Learners are taught and given the opportunity to practice tools and techniques to empower them in provider interaction

Barnes Jewish Hospital³

- *Refugee Health and Interpreter Services*
 - A multicultural team of 30 interpreters, a women’s health coordinator and a nurse to provide service to patients in more than 32,000 encounters per year
- *Residents and Fellows Diversity Initiative*
 - Designed to mentor, recruit, and retain under-represented minority residents and fellows. The program strives to create a culture for the residents by providing programs and activities that create a sense of community and reduce barriers making St. Louis more attractive to remain after training
- *Programs in Development*
 - Supporting research into and the reduction of health-care disparities
 - Designing innovative programs in diversity education for all Barnes-Jewish Hospital employees
 - Improving diversity-related related relations within the greater St. Louis community’

University of Missouri – Kansas City⁴

- *Diversity Empowerment Workshop*
 - The goal is to empower the UMKC community to live the core value of diversity by:
 - Providing tools and demonstrate uses of language to effectively deal with bias
 - Provide a safe environment to recognize bias and educate others
 - Provide a diversity lecture and movies series
- *Saturday Academy*
 - Enhance pre-college education for high school and middle school students belonging to groups traditionally underrepresented in medicine and scientific careers. This includes African Americans, Native American, and Hispanics
- *Summer Scholar Program*
 - A program designed to identify talented minority and economically disadvantaged high school juniors and seniors to encourage them towards careers in medicine

University of Missouri –St. Louis⁵

- *Professional Development Workshops*
 - Mapping Across the Curriculum
 - Africa and Its Many Languages and Cultures
 - Multicultural pedagogy
 - Culture, what is it and why is it important?
- *Diversity Initiative*
 - The University is devoted to “fostering a campus and regional culture of inclusion where diversity of all types is embraced and recognized as the strength of the communities, state, nation, and world we live, work, and learn in”
 - Includes cultural diversity courses to expand cultural awareness. Students in some academic units may need to complete a course that emphasizes Asian, African, Middle Eastern, Latin American, or a comparable culture

University of Missouri – Columbia⁶

- *Programs and Projects*
 - *Difficult Dialogues* – designed to stimulate and empower students to express opposing views respectfully and in the spirit of open-mindedness
 - *MU Equity* – provides campus-wide leadership, coordination, and assistance on matters of equity, equality, and compliance
 - *Diversity in Action: Bridging Research and Practice* – a brown bag series of research-based presentation is designed to inform students and practitioners of diversity-related research

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