# Cultural Competency in Healthcare Services

## Breakout Session A

Mayra E Alvarez
April 24, 2024

2024 *Virtual* HEALTH SUMMIT

## To Access Interpretation via Your Computer

## Para acceder a la interpretación a través de su computadora

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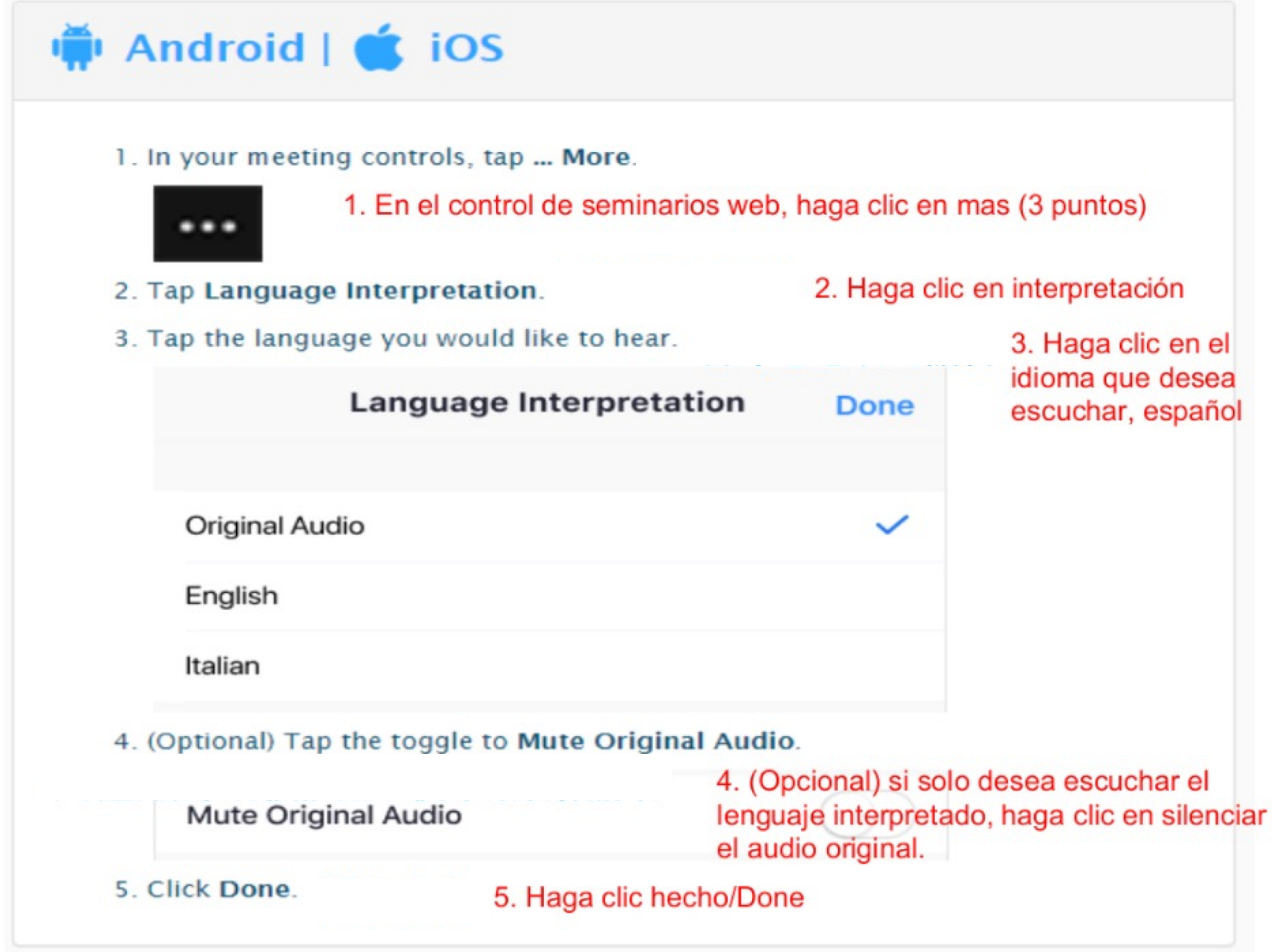


# Who We Are

The Children's Partnership is a California advocacy organization advancing child health equity through research, policy and community engagement.

# Core Beliefs

**1 A child is a child.** Regardless of their race, ethnicity or place of birth, all children have equal value and potential. All children require our greatest efforts to expand the resources and opportunities they need to reach their full potential.

**2 Dismantling systemic racism is a necessity for children to thrive.** Disrupting cultural norms and values rooted in white supremacy will lead to our collective well-being. In taking a targeted universalism approach to our work, we center the needs of the most marginalized children so all children ultimately benefit from the targeted removal of systemic barriers.

**3 Community input must guide our work.** Communities know best the solutions to the challenges they face. We invite, engage and design solutions and co-produce knowledge in partnership with them, knowing policies will be strongest if solutions come directly from impacted communities themselves.

**4 Our work is intersectional.** Families do not lead single-issue lives, and therefore, our work must also be intersectional. We take into account the many identities children and families have, understanding the cumulative impacts of marginalization. We recognize that the success of children is dependent on the well-being of their families and communities.

**5 Effective partnerships are transformational, not transactional.** Partner relationships are most meaningful when they share power, listen and create a space for creativity, belonging and collective action. Through partnerships and coalitions, community power is multiplied. Working in partnership across issue areas is endemic to our work and helps us meet the needs of the whole child and family.

**6 A feedback loop allows for continuous improvement.** Public investments, evidence-based policy and systems change are essential levers for improving the lives of children, and successful policy implementation is a vital component of systems change. It is essential to ensure that policies are implemented in, by and for communities of color. It is equally essential that the impacts of those policies are measured and that the feedback of the communities impacted by such policies informs their implementation and continuous improvement.

**7 Priorities change as social conditions change.** The biggest issues impacting children change as social conditions change. Centering child health equity requires us to recognize that systemic barriers impact communities differently based on numerous factors, including race, ethnicity, gender, income, language, immigration status, identity and ability. We must be responsive to social, economic and environmental changes and adjust our priorities as necessary.

The Children's Partnership

# THANK YOU TO OUR PARTNERS

Mentone Family Resource Center

Franklin Family Resource Center

St. Lourdes Church - Special Needs Children Support Group

# Overview

1. Cultural Competence in Health Care
2. Intersection of Cultural Competence and Care for Children with Special Health Care Needs
3. Lessons from TCP's Reports: *Telehealth and Children of Color with Special Health Care Needs: Lessons from the Pandemic* and *Equity through Engagement*
4. Moving Forward to Promote Inclusivity and Equity in Health Care
5. Q&A

# Cultural Competence in Health Care

# Racism as a Root Cause of Child Health Inequities

The Pair of ACEs

Adverse Childhood Experiences

Maternal Depression

Physical & Emotional Neglect

Emotional & Sexual Abuse

Divorce

Mental Illness

Substance Abuse

Incarceration

Domestic Violence

Homelessness

Adverse Community Environments

Poverty

Violence

Discrimination

Poor Housing Quality & Affordability

Community Disruption

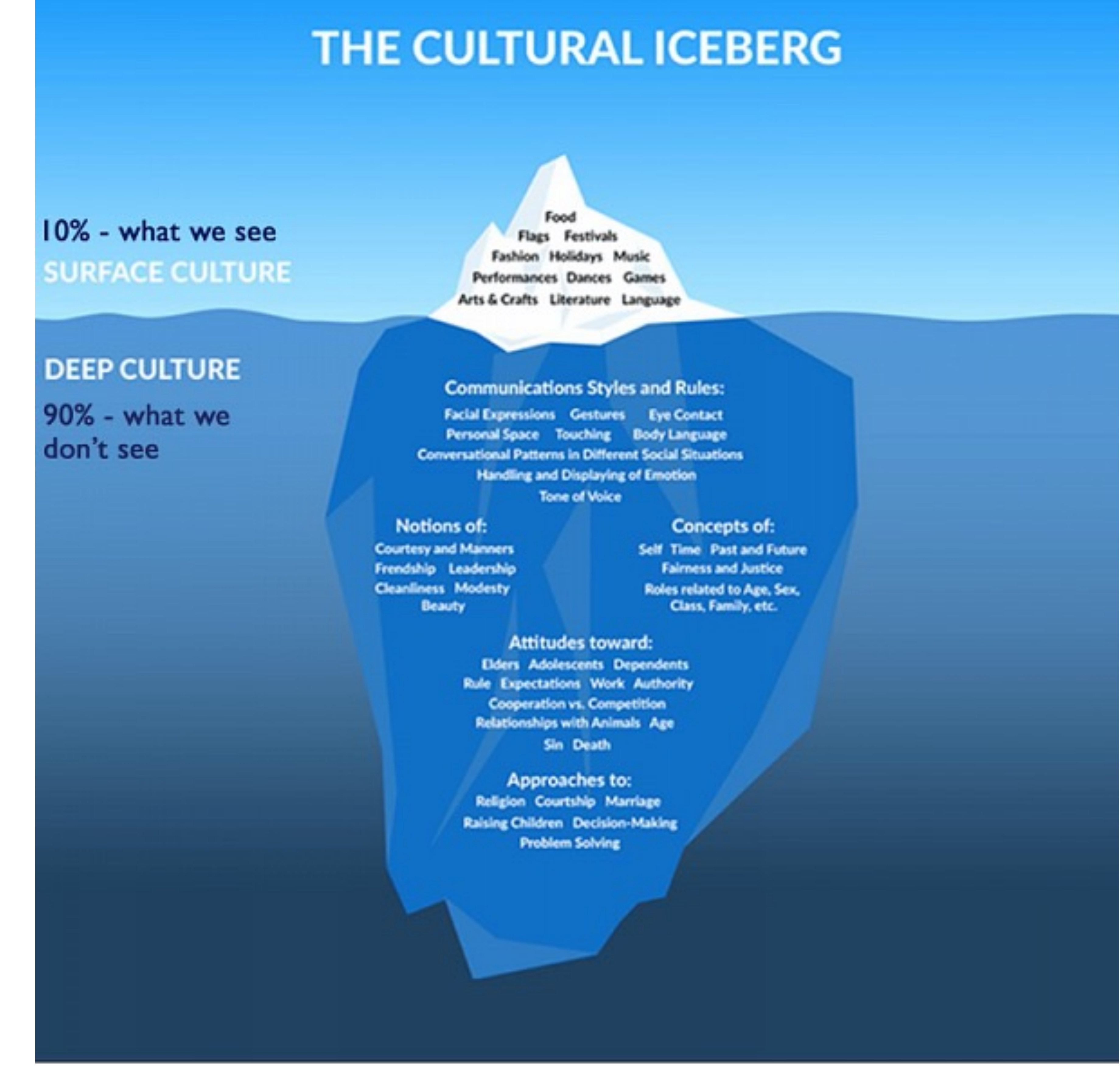
Lack of Opportunity, Economic Mobility & Social Capital

Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

# Defining Cultural Competence, Moving to Cultural Humility

* **Cultural competence** is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment.

* **Cultural humility** involves understanding the complexity of identities — that even in sameness there is difference — and that a clinician will never be fully competent about the evolving and dynamic nature of a patient's experiences.



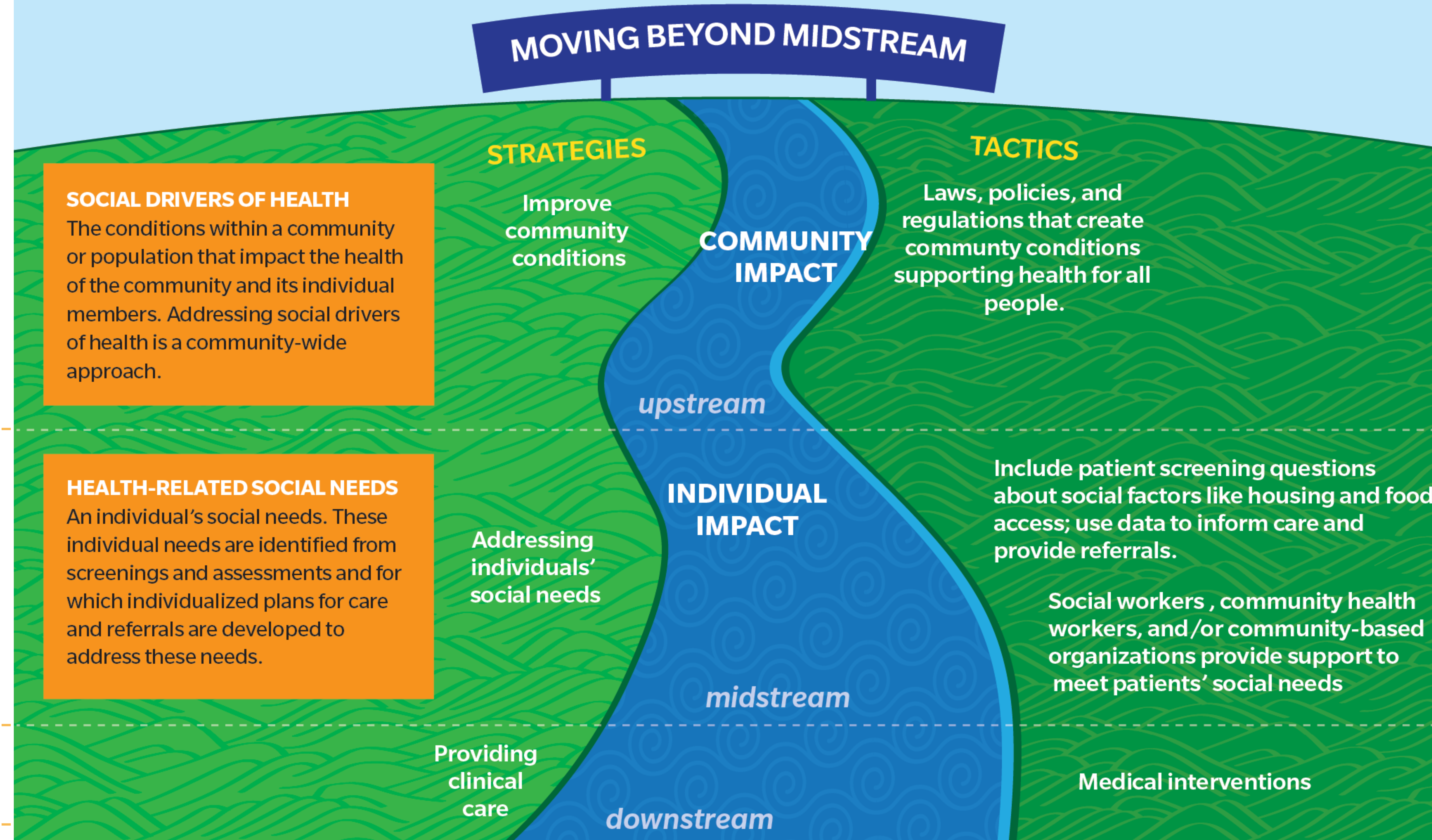
Source: National Center for Cultural Competence: https://nccc.georgetown.edu/curricula/culturalcompetence.html; Yeager, Katherine A., and Susan Bauer-Wu. 2013. "Cultural Humility: Essential Foundation For Clinical Researchers". Applied Nursing Research 26 (4): 251-256; Bennett, Milton J. The Developmental Model of Intercultural Sensitivity, Summary. Intercultural Development Research Institute, Revised 2014..

# Meeting Children’s Health Needs:

UPSTREAM

MIDSTREAM

DOWNSTREAM



# Community Engagement Integral to Health Equity

## HEALTH EQUITY:

- More than just reducing health disparities
- Includes shifting power to community, families and youth
- Community's agency is central to understanding and responding to their population's needs and strengths
- Families are experts in their own experiences and children's conditions

# Intersection of Cultural Competence & Humility and Care for Children with Special Health Care Needs

# California's children are diverse and make up a significant portion of our state's population.

- **Nearly 9 million children under 18, 75% of whom are Latinx, Black, Asian American, or Native American.**

**Race & Ethnicity of CA's Children**

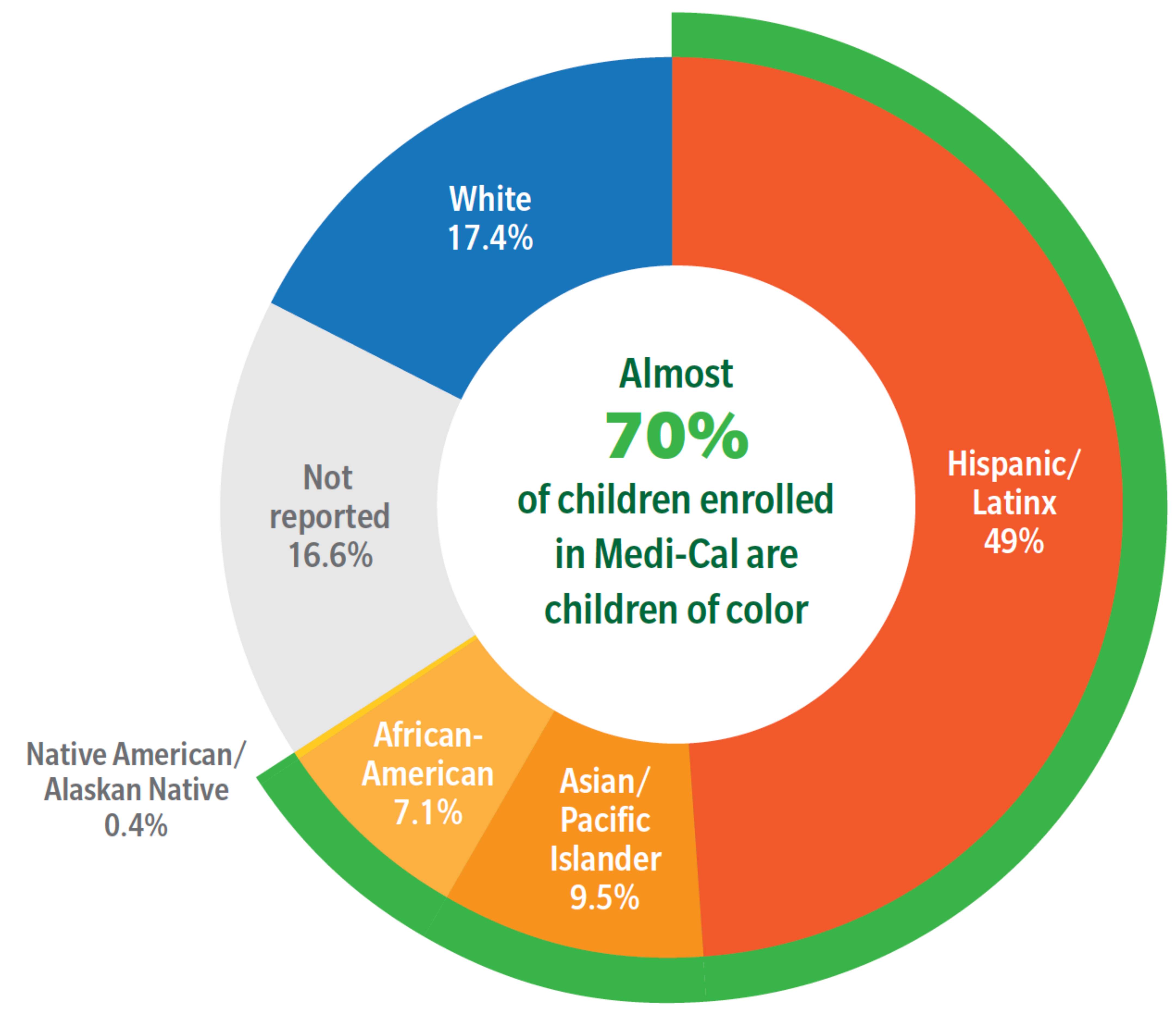
| Category | Number |
|---|---|
| TOTAL | 8,931,000 |
| OTHER OR MULTIRACIAL | 511,000 |
| WHITE | 2,273,000 |
| NATIVE AMERICAN | 24,000 |
| LATINX/HISPANIC | 4,655,000 |
| BLACK/AFRICAN AMERICAN | 441,000 |
| ASIAN | 1,027,000 |

Axis: 0 2000000 4000000 6000000 8000000 10000000

Source: 2018-2019 American Community Survey

# Half of CA Children are Covered by Medi-Cal

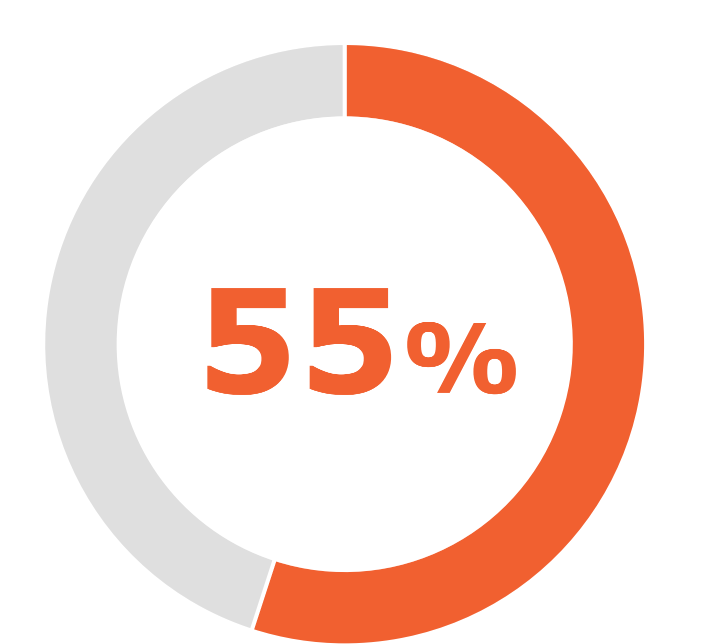
Of whom, nearly three-fourths are children of color.



# Unfulfilled Promise: Childhood Benefits in Medi-Cal

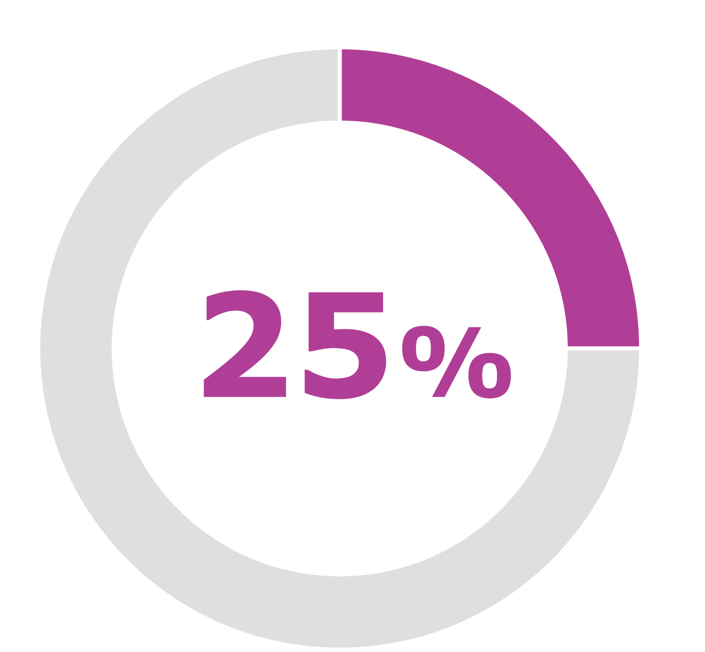
All children covered by Medi-Cal are entitled to the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. And yet…

**Well-child visits (first 15mo):**



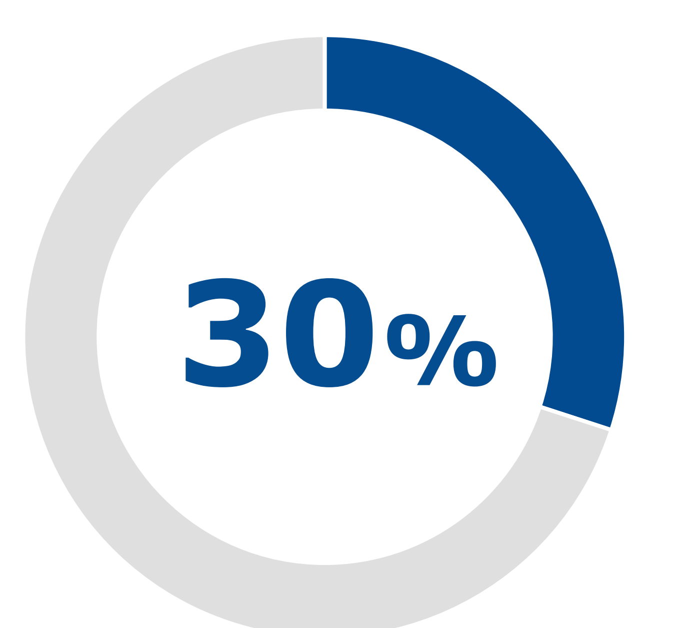

48th
in the nation

**Developmental screenings:**



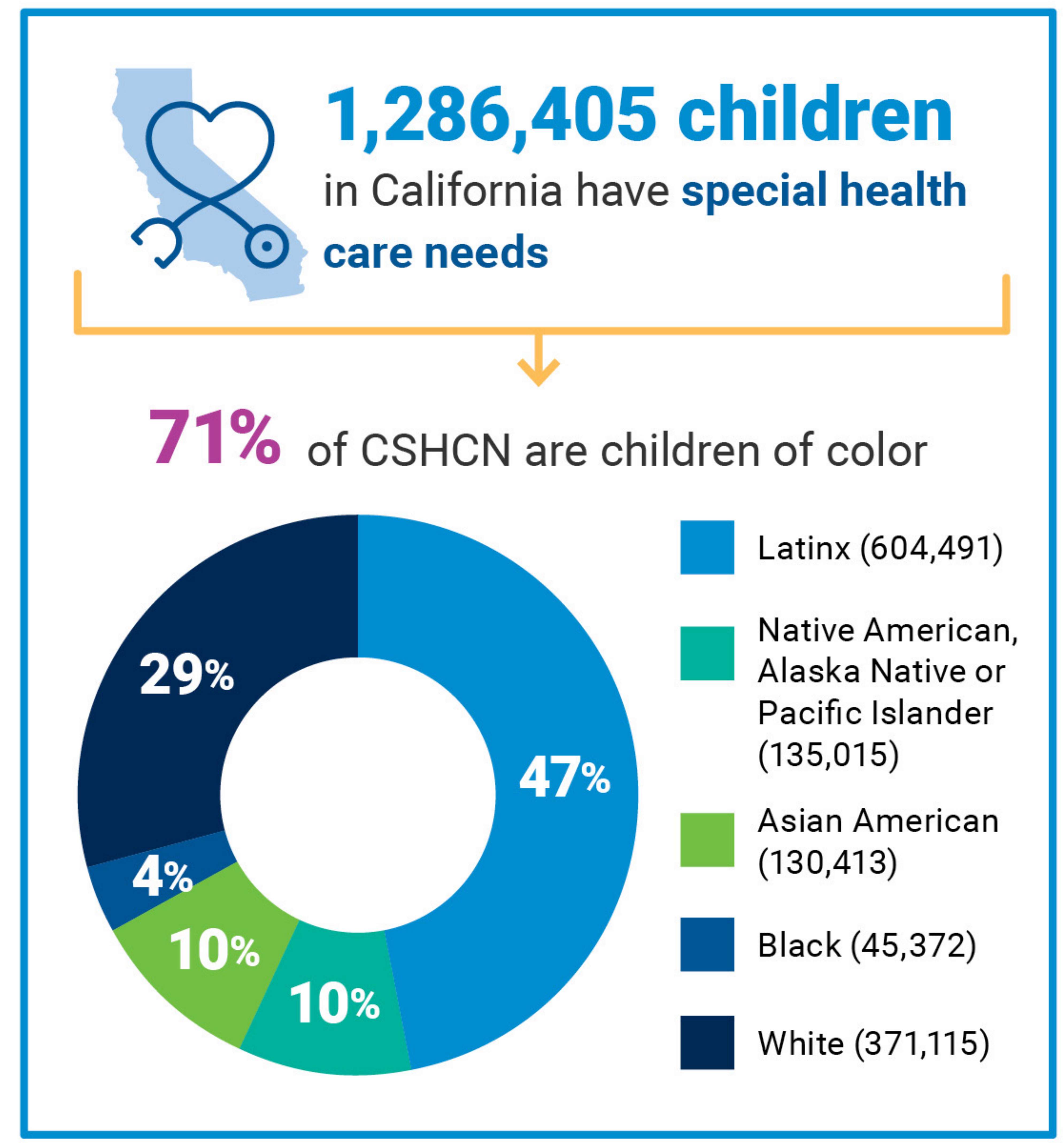

43rd
in the nation

**Receiving needed mental health care:**




48th
in the nation

# Children of Color with Special Health Care Needs



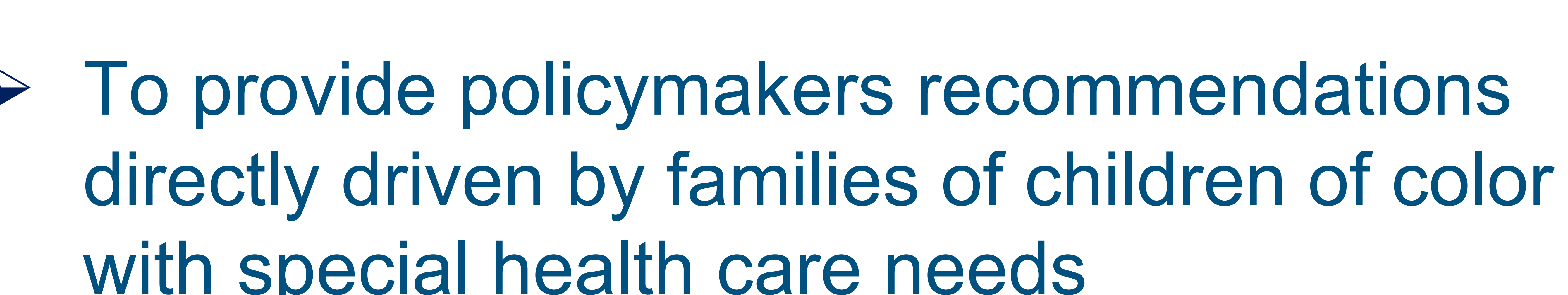
Source: 2018-2019 National Survey of Children Health, 2016-2019 Kids Data, 2001 National Survey of Children's Health

# Lessons from TCP's Report: Centering Families' Expertise and Experience

# Why We Did This Report – Community-centered Approach

- To learn if telehealth increased access to care for children of color with special health care needs

- To conduct community-centered research by centering and directly learning from families of color who have children with special health care needs



- To provide policymakers recommendations directly driven by families of children of color with special health care needs

**California ranks last**

in the nation in the percentage of children with special health care needs whose families experience shared decision-making with health care providers.[51]

# Who We Talked With

TCP hosted **9** convenings that included

**21** listening sessions with families of color with children with special health care needs.

**11** of the listening sessions with families were conducted in Spanish.

## TYPES OF STAKEHOLDERS

Families

Health and Mental Health Providers

Community Health Clinics

County Health and Mental Health Agencies and Public Health Depts

Parent Leaders from Local Student & Family Advocacy Orgs

Wellness Centers

Community Health Workers & Promotores

Schools

Regional Centers

Churches

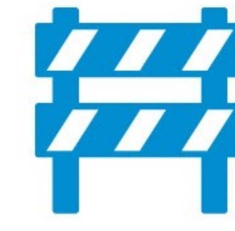
Family Resource Centers

# Learnings

**1.** Telehealth helped keep children of color with special health care needs connected to health services during the pandemic.

**2.** Telehealth addressed some challenges children of color with special health care needs typically face when accessing care, including lack of transportation, long wait times for appointments, and lack of child care.

**3.** Families indicated a strong interest in the option of having telehealth appointments for their children while at the same time noting that telehealth did not adequately address all of special health care needs.



4. Families continued to face unique systemic challenges that limited their ability to access care for their children using telehealth, including digital, educational, language and cultural barriers.

**5.** The pandemic caused instability, compounding and creating mental health issues and challenges for children of color with special health care needs and their families.

# Families faced digital, educational, cultural and language challenges.

- The digital divide – including lack of Wi-Fi or devices – greatly limited the benefit of telehealth.
- Insufficient information, education and tools provided to families around accessing health care services using telehealth.
- Families experienced language barriers in accessing care and services for their children using telehealth.
- Lack of providers/doctors who reflect the identities and experiences of the families they serve.

# Challenges Families Faced in their Own Voices

*I live in a zone where the wifi fails a lot and the school has given us internet devices that are not that great. My daughter is in a medical program and she struggles a lot with the hotspots. I do not have another source of internet because the companies tell me that they are not available in my location. — Mother from Tulare*

*It was difficult because I wasn't taught how to use computers or technology. My kids helped me. But it was a challenge. My screen would freeze. My internet would drop because there were so many people using internet at the same time. — Mother of son with speech delay*

*CCS [California Children's Services] has never provided [me] a report in Spanish in 25 years. My child's doctors will take notes with codes and it's sometimes difficult to understand the next steps. Every health or social service] professional speaks a lot in code which is not easy for parents to understand.*

*I think non-English speakers should be given more time for telehealth appts. I have translated for my mom during telehealth appointments with my sibling [who has a special need] at least 7 times. The doctor has never once asked my mom if she needs translation services, there's an expectation that me or my siblings will translate for my mom. — Mother of young daughter with Down syndrome*

*Families need access to interpreters. It takes a long time to get a telehealth appointment when I request Spanish interpretation, longer than if I don't [request an interpreter].*

*I don't speak English and sometimes when I tell the interpreter what to ask the doctor the doctor never responds to my question and I don't know if it's because I am not explaining myself well or if the interpreter is not translating what I am asking. — Mother of teen daughter with behavioral health needs*

# Recommendations

**1.** Treat families of color with CSHCN as experts and center them in their children's care.

**2.** Allow CSHCN of color and their families to use multiple telehealth modalities to access health care.

**3.** Expand use and coverage of telehealth services to trusted places in the community including schools and early learning and care centers.

**4.** Provide families with outreach, education and resources that make it easier for them to use telehealth to access services and care for their children.

**5.** Use community health workers and promotores (CHW/Ps) to help families navigate telehealth and ensure CHW/Ps can leverage telehealth to provide outreach, education, navigation and other services to children and their families.

**6.** Ensure telehealth is racially, culturally and linguistically concordant.

**7.** Increase access to mental health services using telehealth.

# ETE Project Premise

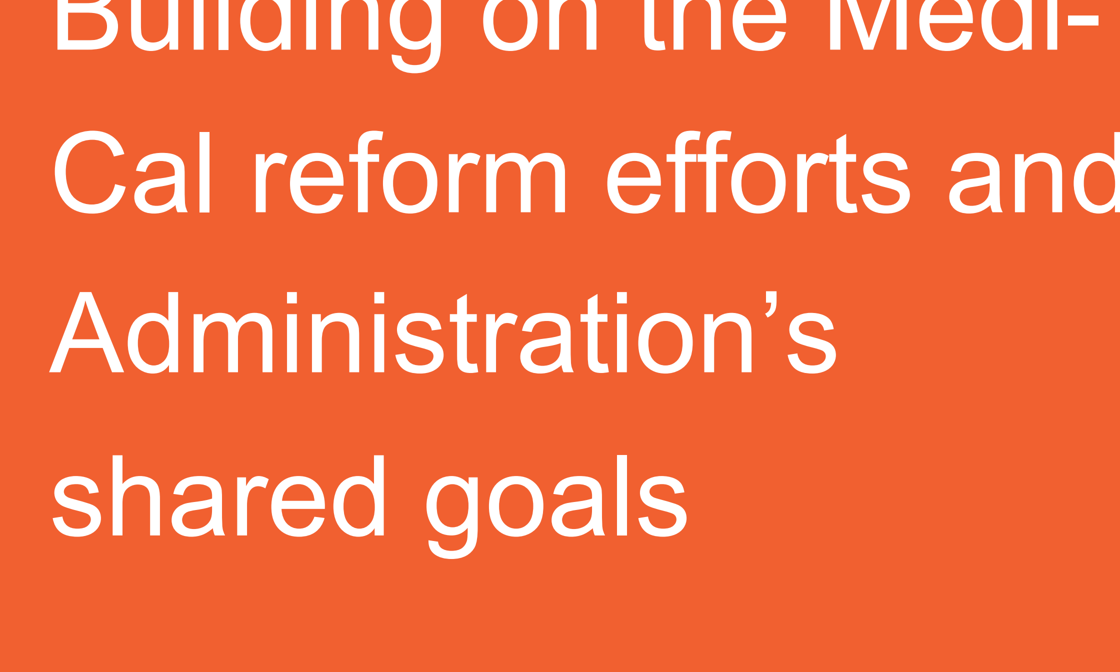
Medi-Cal managed care as a tool to advance child health equity

Community and Family Engagement is pivotal to child health equity

# Project Goals

Examine the role of Medi-Cal MCPs in responding to social drivers of health and health-related social needs, particularly for children's health

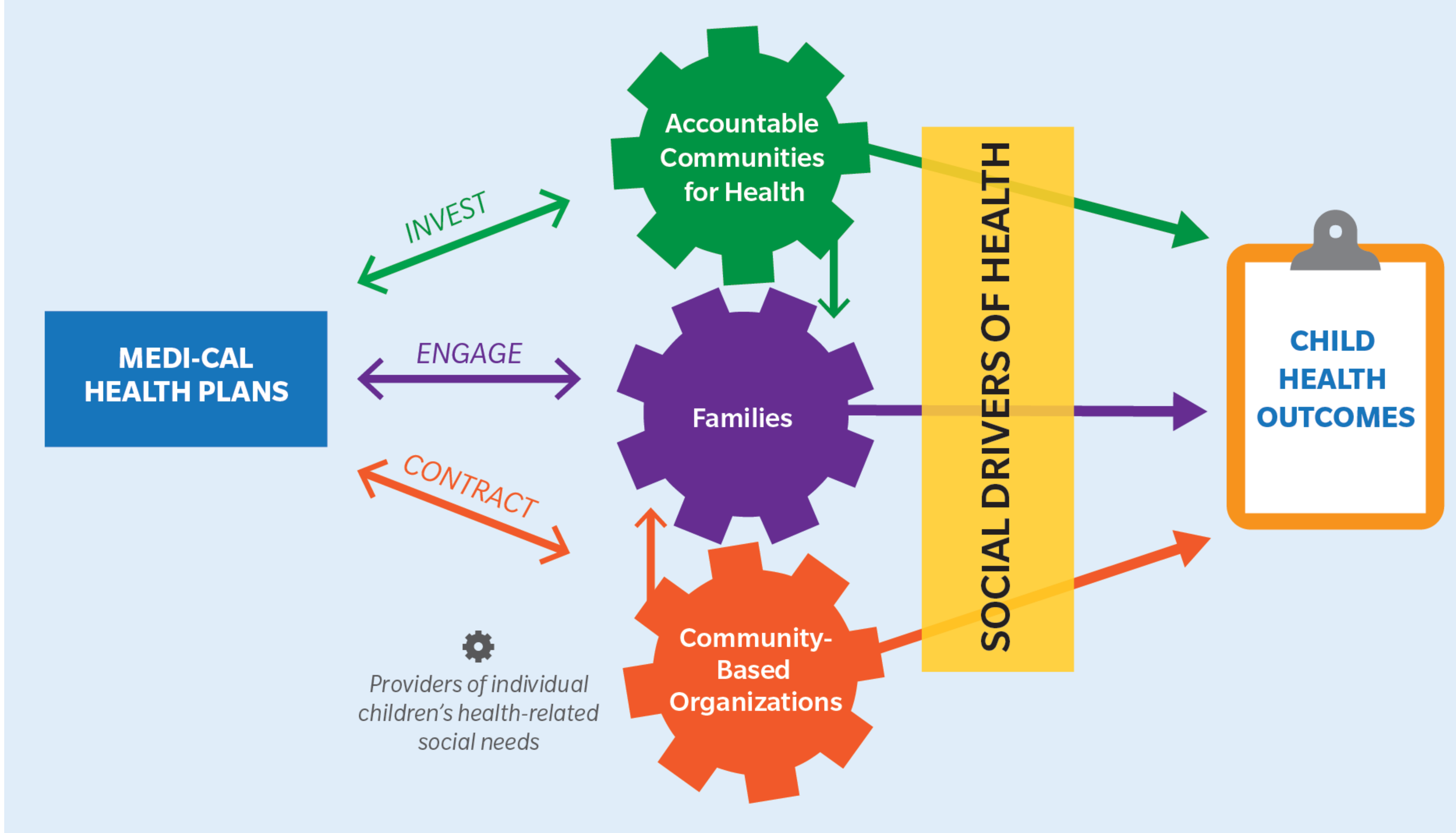
How communities and families can be better centered in children's health care



Building on the Medi-Cal reform efforts and Administration's shared goals

# Child Health Equity Centers on Community Partners

*Medi-Cal health plans can help address social drivers of health to improve child health outcomes*



# Parent Focus Groups

## FREQUENT CHALLENGES WITH CHILDREN’S MEDI-CAL

- Maintaining Medi-Cal coverage is cumbersome and time-consuming
- Need more holistic care, with greater access to mental health care
- Difficulty transitioning to adult coverage
- Relevance of Medi-Cal informational materials for children is unclear
- Need more support choosing a health plan
- ***Not aware nor able to access care coordination services***
- Lack of accurate interpretation services
- ***Parents not recognized as experts in their children’s condition and care***

# Key Findings from Parent Focus Groups

**Parents/families:**

- Are experts in their child's experience
- Are not aware of or do not receive care coordination
- Prefer a person to help navigate their child's health care, not informational material
- Want to participate in MCP engagement strategies but need support (childcare, interpreters, flexible scheduling and compensation for their time and expertise)

**Family engagement is more than data points:**

- It is iterative, relational, and collaborative—and must be culturally competent

# Moving Forward to Promote Inclusivity and Equity in Health Care

# Meeting Children's Health Needs:

MOVING BEYOND MIDSTREAM

| | SOCIAL DRIVERS / NEEDS | STRATEGIES | IMPACT | TACTICS |
|---|---|---|---|---|
| UPSTREAM | **SOCIAL DRIVERS OF HEALTH** The conditions within a community or population that impact the health of the community and its individual members. Addressing social drivers of health is a community-wide approach. | Improve community conditions | COMMUNITY IMPACT (upstream) | Laws, policies, and regulations that create commmunty conditions supporting health for all people. |
| MIDSTREAM | **HEALTH-RELATED SOCIAL NEEDS** An individual's social needs. These individual needs are identified from screenings and assessments and for which individualized plans for care and referrals are developed to address these needs. | Addressing individuals' social needs | INDIVIDUAL IMPACT (midstream) | Include patient screening questions about social factors like housing and food access; use data to inform care and provide referrals.<br>Social workers , community health workers, and/or community-based organizations provide support to meet patients' social needs |
| DOWNSTREAM | | Providing clinical care | (downstream) | Medical interventions |

# The Spectrum of Community Engagement to Ownership

| STANCE TOWARDS COMMUNITY | 0 IGNORE | 1 INFORM | 2 CONSULT | 3 INVOLVE | 4 COLLABORATE | 5 DEFER TO |
|---|---|---|---|---|---|---|
| IMPACT | **Marginalization** | **Placation** | **Tokenization** | **Voice** | **Delegated Power** | **Community Ownership** |
| COMMUNITY ENGAGEMENT GOALS | Deny access to decision-making processes | Provide the community with relevant information | Gather input from the community | Ensure community needs and assets are integrated into process & inform planning | Ensure community capacity to play a leadership role in implementation of decisions | Foster democratic participation and equity through community-driven decision-making; Bridge divide between community & governance |
| MESSAGE TO COMMUNITY | ***Your voice, needs & interests do not matter*** | ***We will keep you informed*** | ***We care what you think*** | ***You are making us think, (and therefore act) differently about the issue*** | ***Your leadership and expertise are critical to how we address the issue*** | ***It's time to unlock collective power and capacity for transformative solutions*** |
| ACTIVITIES | Closed door meeting<br>Misinformation<br>Systematic | Fact sheets<br>Open Houses<br>Presentations<br>Billboards<br>Videos | Public Comment<br>Focus Groups<br>Community Forums<br>Surveys | Community organizing & advocacy<br>House meetings<br>Interactive workshops<br>Polling<br>Community forums | MOU's with Community-based organizations<br>Community organizing<br>Citizen advisory committees<br>Open Planning Forums with Citizen Polling | Community-driven planning<br>Consensus building<br>Participatory action research<br>Participatory budgeting<br>Cooperatives |
| RESOURCE ALLOCATION RATIOS | **100%** Systems Admin | **70-90%** Systems Admin<br>**10-30%** Promotions and Publicity | **60-80%** Systems Admin<br>**20-40%** Consultation Activities | **50-60%** Systems Admin<br>**40-50%** Community Involvement | **20-50%** Systems Admin<br>**50-70%** Community Partners | **80-100%** Community partners and community-driven processes ideally generate new value and resources that can be invested in solutions |

Source: *Facilitating Power*

# Federal Opportunities

Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society.

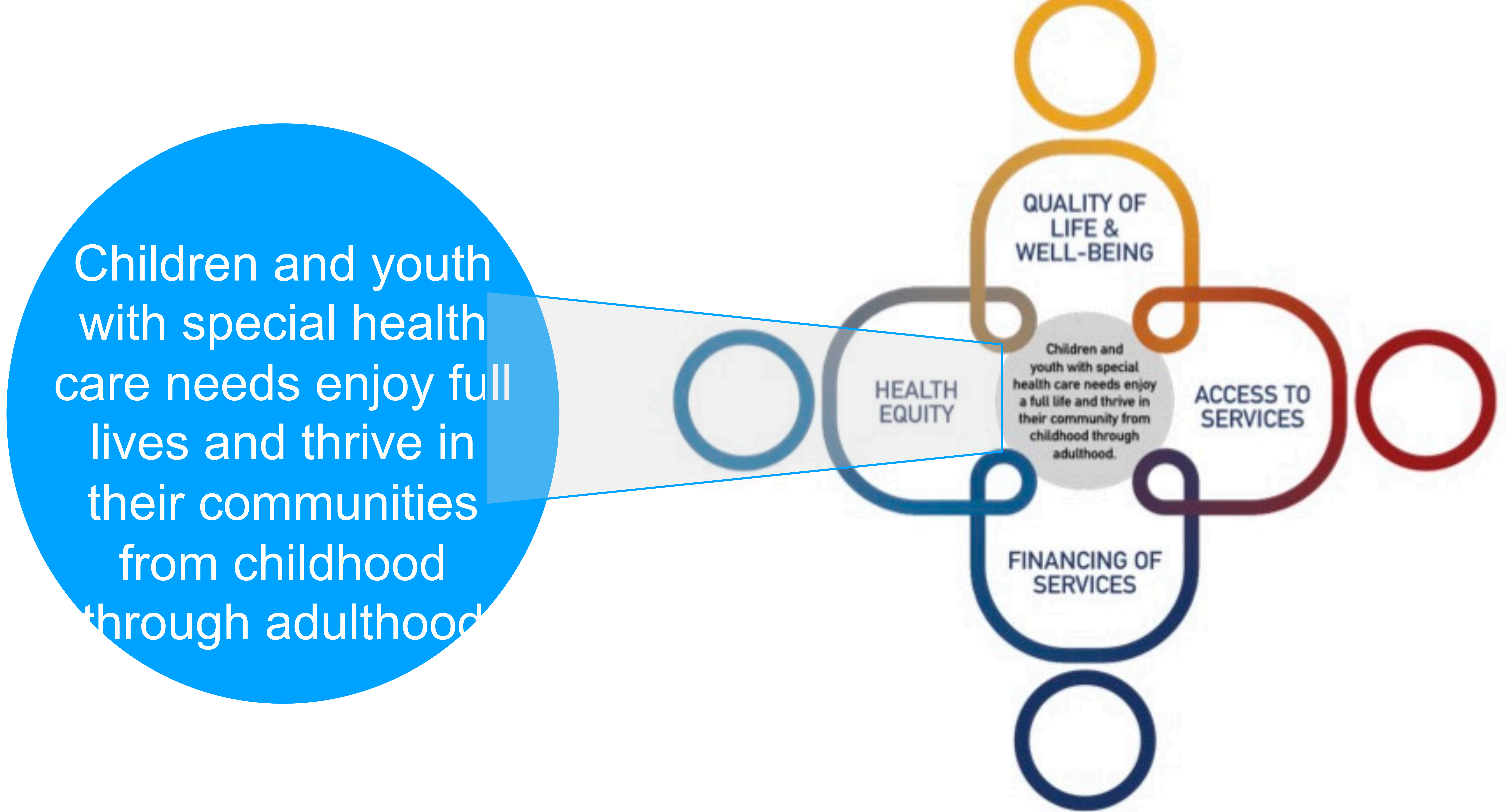
Racism is a social risk factor that has a profound impact on the health status of children, adolescents, young adults, and their families.

CYSHCN require more and different types of services than those for typically developing children and youth, yet the current system is not ensuring access to these services, particularly for CYSHCN impacted by poverty and discrimination.

CYSHCN are more severely impacted by the adverse effects of social determinants of health and inequities.

***A Blueprint for Change*: Guiding Principles for a System of Services for Children and Youth with Special Health Care Needs (CYSHCN) and their Families**

# HRSA Blueprint Focus Areas and Vision



# Leveraging Statewide Reforms

- Medi-Cal's Strategy to Support Health and Opportunity for Children and Families
  - Continuous coverage for young children (age 0-5)

- CalAIM Population Health Management
  - New CHW benefit

- Developing performance measures for equity, care coordination, child mental health utilization patterns, and child health outcomes
  - NCQA Health Equity Accreditation required in 2024 contract (by 2025)

- Health Equity Roadmap Initiative

- Digital Equity advocacy

https://bit.ly/ProtectMediCal

**"I think we have to push back on an instinct that the fixes are quick. There is not a checkbox, where we can say 'do these three things.' But it is a process, and if we can do more in partnership, genuinely, with the communities that have been most affected, that's how we begin to establish trustworthiness."**

— Marcella Nunez-Smith, M.D., senior adviser to the White House COVID-19 Response Team and associate dean for health equity research and professor of internal medicine, epidemiology and public health at the Yale School of Medicine

# Discussion and Q & A

# Resources

APRIL 2020

School-Based Telehealth:

Advancing Whole Child Health and Well-being

# THANK YOU!! ¡GRACIAS!

## Contact Us

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# Thank you for joining us!

**When this session ends, you'll see the Event Lobby webpage.**
**Join us for the 1:30 pm Closing Session.**