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NPA PARTNERS WEBINAR SERIES
FEATURING THE NATIONAL HISPANIC MEDICAL ASSOCIATION
DIVERSIFYING THE HEALTH WORKFORCE FOR AN EQUITABLE FUTURE

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>> ELENA RIOS: Good afternoon, and welcome to the NPA Partners Webinar Series entitled Diversifying the Health Workforce for an Equitable Future. This webinar is presented by the National Partnership for Action to End Health Disparities, a strategic initiative of the Office of Minority Health of the U.S. Department of Health and Human Services and the National Hispanic Medical Association. I am Elena Rios, the President and CEO of the National Hispanic Medical Association, and it is my privilege to moderate the beginning of today's webinar.

The objectives of this webinar are to highlight strategies to diversify the health workforce in order to create a more equitable future for all Americans. We want to share resources, recommendations, and tools for increasing the

diversity of the health workforce to meet the needs of, again, all Americans, and specifically communities of color.

Before we get started, I'd like to provide a few housekeeping notes. One, this webinar is scheduled to last one hour, and it will include a question-and-answer session after the presentations are completed. You can ask questions throughout the webinar on the Chat function. To pose questions to the presenters or questions related to technical difficulties, please enter the question in your Q&A pod.

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And we truly welcome your feedback. At the end of the webinar, we will provide a brief assessment that we encourage you all to complete. We want to provide you with webinars that are most helpful, and your feedback is invaluable in this regard. Please use three to four minutes during the Q&A session to respond to the assessment questions.

Finally, if you are joining the webinar by phone, you will not be able to hear the videos provided during today's webinar. Use the link you received following the webinar to view each presentation at your convenience.

In terms of today's webinar, I would just like to make one opening comment, and that is how important it is to consider that all the next generation of students, whether they are in high school, middle school, college, need mentors and need to be inspired. They can all become doctors, nurses, dentists, public health officials, but they need help in opening their eyes to the opportunities in our society. In our society, the healthcare industry is the largest industry that has many, many opportunities for our families and our communities to have good-paying jobs and careers that, most importantly, help our own communities get healthy and not have so much health disparities.

We are going to hear today from leaders, not only about minority health, but about workforce strategies and also cultural competence strategies in training the next generation of workforce.

Without further delay, I am pleased to introduce our panel of esteemed speakers. Dr. Matthew Y.C. Lin is the Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health. He was appointed in August of 2017, and the Office of Minority Health is dedicated to improving

the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities, provide access to quality care, and advance health equity. An orthopedic surgeon, Dr. Lin has spent most of his professional career serving a primarily minority population in the San Gabriel Valley of California.

We also have with us, after Dr. Lin, Dr. Wilma Alvarado-Little, Associate Commissioner of the New York State Department of Health and Director of the Office of Minority Health and Health Disparities Prevention for New York State. Ms. Alvarado-Little joined the office in 2017, and she has focused on health equity issues from a linguistic and cultural perspective, in addition to her interest in public policy, research, health literacy, and health disparities prevention.

And then our last speaker will be Mr. Godfrey Jacobs. He is the Director of the Think Cultural Health initiative at the Office of Minority Health at the U.S. Department of Health and Human Services. With more than 40 years of experience directing and managing activities in the healthcare field, Godfrey is an expert in cultural competence and the needs of ethnic populations, with a focus on health disparities.

Dr. Lin, you're first up. Are you ready?

>> MATTHEW Y.C. LIN: Yes, thank you, Elena. Good afternoon, everyone. Hello. I am Dr. Matthew Lin. I am Deputy Assistant Secretary for Minority Health and the Director for the Office of Minority Health at the U.S. Department of Health and Human Services. Thank you for joining us today for this webinar on workforce diversity. I am pleased that the Office of Minority Health, National Policy for action, and the National Hispanic Medical Association worked together to host this event.

The NPA is a national network of public and private organizations that are addressing health disparities through the lens of the social determinants of health. It consists of volunteer organizations to help address health disparity and advance health equity in their community. The National Hispanic Medical Association is one of OMH's longest and strongest partners. I want to thank the organization and its president, Elena Rios, for participating in this NPA Partners Webinar Series event.

At the Office of Minority Health, we work to reduce health disparities and advance health equity for racial and ethnic minorities. Our objective is to make sure that all Americans have the best possible opportunity to reach their full potential for good health.

When we are successful, prevention is very often the path to reducing disparities. And getting there usually involves

collaboration with partners and other community, state, and federal stakeholders. And to you on this call, who have not worked with us in the past, now is a good time to make that happen. Visit our website at OMH, sign up for our reports, and contact us about what we can do together to eliminate barriers to good healthcare for racial and ethnic minorities. There are many ways that we can accomplish this. Workforce diversity, for example, is becoming more and more important, particularly as we move closer to becoming a minority majority nation over the next 25 years. A diverse healthcare workforce will help expand healthcare access for the underserved and promote research in areas that have been neglected. It can also lead to more policies and programs that focus on social and economic factors that impact our health and healthcare.

Right now, the percentage of Asian primary care physicians is almost double the population of Asians in the United States; however, for all other minorities, the percentage of primary care physicians total around 13%. That's including African Americans, 6.8%; Hispanic, 5.9%; American Indian/Alaska Native, 0.7%. Just 2% of all higher education institutions account for 33% of Hispanic who earn STEM degrees, and most of them are Hispanic-serving institutions. 9 out of 10 institutions, the most African American STEM doctorate are historically black colleges and universities. If we are going to achieve the level of diversity in healthcare that we need, we are going to have to do much, much better.

So I am looking forward to hearing today's speakers talking about ways that we can help make the healthcare workforce more diverse to create a more equitable future for all. Again, thank you for joining us. Looking forward to contact with you. Thank you.

>> ELENA RIOS: Thank you, Dr. Lin. Our next speaker, Dr. Alvarado-Little.

>> WILMA ALVARADO-LITTLE: Hello, Dr. Rios, and good afternoon, everyone, or good evening, depending on where the audience is.

I am looking at the clock, and so in the interest of time, I'll be speaking quickly. That doesn't mean that I am not taking our topic today lightly. I just want to make sure I am respectful of the time that's involved.

So my name is Wilma Alvarado-Little, and as Dr. Rios described, I am with the New York State Department of Health with the Office of Minority Health and Health Disparities Prevention.

I'd like to start by giving you an overview of the Office of Minority Health. Our initiatives focus on impacting workforce development and policy as well. In the beginning,

as I give you an overview of the work we do, the question might be how is this relating to the workforce, and it is my intention at the end of the presentation I will be wrapping it up so that it becomes clearer. Also, I'll be referring to my colleague here, Godfrey Jacobs, regarding the CLAS standards as well.

Okay. So you have a slide in front of you that talks about some of the information regarding New York State by race and ethnicity based on the 2016 American Community Survey data. Each area identifies an increase from the 2015 data. Each of the categories has increased by a percentage, with the white population having a slight decrease. So there is quite the diversity continuing in New York State. And when people think of New York State, sometimes they think of the five boroughs, and the areas outside of those five areas can be very diverse as well, each having their own needs. So when we think about diversity, we need to think of -- and culture, we need to think beyond the areas of race, ethnicity, and language. So we have a culture of adolescence. We have a culture of the rural community. We have a culture of the aging community. So these are some of the things that the Office of Minority Health takes into consideration when we are addressing the needs of those whom we serve and with whom we partner.

So the Office of Minority Health. A little bit of background of our Office. We were established in 1992 by legislation, became operational in 1994. In 2011, there was an administrative expansion to the Office of Minority Health and Health Disparities Prevention. This aligned better with the work we do and the communities we serve across the state.

So our role is in identifying minority areas based on public health law, which defines a minority area as a county or service area with a 40% or greater non-white population. So we assess the health status of minority areas. We identify the health disparities and implement and evaluate health equity initiatives. Our office is charged with working across the Department's programs to advance policies and support programs and initiatives so that it will promote high-quality and care that is culturally and linguistically appropriate for all New Yorkers. We partner with just about everyone across the systems in order to achieve health equity. We also have a Minority Health Council, which assists in developing policy to broaden the social and economic factors that lead to poor health. And we identification the Section 240 Minority Areas which I explained a moment ago to facilitate focusing resources to those areas.

So this is -- according to Public Health Law 240, minority areas by MCD. Historically we produce reports at the county level. However, we know that there are racial and ethnic

populations throughout the State of New York and that these populations systematically experience greater obstacles to health and as such may be adversely affected by health disparities and health inequity. So to better identify the locations of these populations. To increase the granularity of the data provided, the Department applied minor civil divisions as the unit of analysis to identify service areas that are within a 40% or greater nonwhite population. So minor civil divisions, or MCDs, were created to govern or administer an area regardless of the population. The nice thing about this is that they don't cross county boundaries, and they are delineated with the intention of being maintained over a long time so that statistical comparisons can be made. You'll see that we identified 44 communities and 26 counties across the state that met that statute. So in this report, what we were able to do in our health equity report was to go beyond county-level data and looked at sub-county-level data.

So using this information, we focused on intervention and activities in these communities. One of the things we did was utilized these areas to develop our Health Equity Report. It was helpful in explaining the following information, and I will provide a very brief example. Because one of the things, as we know, regarding the class standards, we need to know from a leadership perspective who is in our communities because that will help guide the leadership of our workforce and help train the leadership and workforce in a way that's culturally and linguistically appropriate.

Here what you see are the areas regarding our 28 New York minority areas. The data utilized was the ACS 2010 to 2018 sociodemographic indicators and the Department of Health data with health-related indicators. Now, these helped identify the social determinants of health, which is the cornerstone of the initiatives of the OMH HDP. So for example, we were able to rank the 44 minority areas by Hispanic/Latino population, so this is how we found that the Bronx had the highest percentage, followed by the City of Newburgh and the Town of Haverstraw. So we supported each of these areas to not only support the achievement of health equity and also to be able to identify the challenges that will -- identify challenges that keep our communities and those whom we serve from achieving health equity.

So I am going to give you a very, very quick example as to how this works because this was -- this can be quite the challenging situation. So having the data for a more complete and comprehensive understanding of the City of Newburgh community -- and these are one of the areas that we found had a high Latino community as well with some challenges. And the

city of Newburgh is a city located in Orange County, New York. It's about 60 miles north of New York City and about 90 miles south of Albany on the Hudson river. What we found here looking at some of the social determinants were areas such as economic stability, education, health and healthcare, neighborhoods, and the social and community context. And all of these factors can play a role in people's decision to enroll or use health insurance. So if they are not insured, then these are going to be challenges once we try to diversify our workforce in any capacity, specifically a healthcare capacity and a healthcare workforce.

This is he this is a very basic example. If you look at the purple arrow, we are looking at median income. The median income in Newburgh is a little lower than 35,000, which is approximately $70,000 in Orange County, and the state level close to $59,000. In fact, the median income of Orange County is over two times that of Newburgh. So what does this do? This reflects almost a $38,000 difference. This is enough to pay for almost three years of rent. If you have enough to spend on basic things like health insurance, healthcare, this is going to be problematic. This is some of the information that our healthcare providers need to be aware of as to why is an individual giving the appearance of not being compliant when, in fact, it is financially challenging to seek healthcare services.

Then this is just another brief example for you, if we looked at unemployment, Newburgh has an unemployment rate of 11.5. This is approximately two times higher than the rate at the county and the state level. So these are some of the things that we need to look at and take into consideration from a provider perspective.

I am looking at the time here, so I am going to speak quickly.

So what do we do with this information? My button isn't -- okay. So we are looking at the six outcome health areas. We are promoting a health and safe environment and preventing chronic diseases, preventing HIV/STDs. We are promoting healthy women, infants, and children's services, and mental health. And also addressing workforce development issues because all of these are going to be going hand in hand.

We obtained feedback from our communities as well because if we don't hear from them as to what the challenges regarding workforce from their perspective, then it doesn't matter what great services we have; they are not going to be able to access them.

So these are some of our programs where we have woven in the tenets and principles of class standards. Regarding

healthcare and the workforce diversity, we have looked at programs such as our core programs of the minority male wellness and screening initiative. How can we bring our communities of color to the workforce so that they do feel comfortable in receiving the services that are being provided? How can we address some of our other pieces. Our mentorship in medicine and other health professions, this program was established to promote diversity in the health profession by identifying and engaging racial, ethnic, and underrepresented students pursuing or interested in pursuing careers in medicine and other professions. Doing this early in their careers because sometimes our communities of color are unaware of the programs that exist regarding healthcare. You know, there's so much more other than and in addition to being a physician or a nurse or a nurse practitioner or anywhere within that clinical ladder. So we've partnered with -- we currently provide support to students engaged in the Arthur Ashe Institute for Urban Health Ninth Grade Bridge Program as they transition into and through the Health Sciences Academy. They complete six clinical curriculum modules and are exposed to future careers in medicine and health and receive training in the fields of science and technology. Our funding supports college preparatory curriculum to increase capacity and also the ability to perform well on mandatory exams, such as the PSAT and the SATs.

So these are some of the things we are looking at regarding workforce development. Our research also influences that as well, so there is a better connection between the policy and the actual practice in providing information to our workforce and workforce development. It's very important for us as an office to ensure that the tenets of the class standards are woven into our program. So with programs that we are supported language access issues in our community, we look at the language assessment piece as well because sometimes when we are looking at organizations that say they provide information in say, for example, Spanish, sometimes the staff there, their skills may be a little bit different than what is actually the perception versus the practice of the fluency involved. So this is something that we need to be able to address.

With one of our Latino health outreach initiatives, we utilize funding from some of our community listening sessions to provide support in the development of bilingual -- meaning Spanish/English -- Latino health English Goods Guides for the City of Albany, New York, the City of Amsterdam, and Haverstraw, New York, as well. We were able to do this by ensuring that within our contracts the language access piece was addressed so the proficiency in English and Spanish had been assessed

so that those whom we serve are truly receiving services in a language which resonates with them and creating that awareness with providers. So these are some of the pieces that we need to be aware of when we are addressing linguistic issues. Also with the engagement, continuous improvement, and accountability, we need to also ensure that the CLAS standards are woven throughout our program. This is part of what is included in our contracts with our partners so that they are able to design and implement and evaluate policies to ensure that cultural and linguistic appropriateness is involved.

So the health equity reports really helped us provide information, not only to ourselves, but to -- and to also other community-based organizations and other levels, whether it be at the county or the city level, so that there is a good understanding of, you know, it's great that there's a service available. Is it really resonating with the community? Are the providers aware of some of the strengths and challenges of their constituencies and those whom they serve? Because, you know, the arrow points both ways when we are trying -- we are addressing issues that will support health equity. It truly is a partnership. We at the Office of Minority Health and Health Disparities Prevention really strive to continue to keep that message at the forefront and weave it into our efforts and initiatives and also across the program.

So I am going to stop there because, as I said, I wanted to be sure that I was respectful of my time. So I turn it over to our colleagues. Thank you very much.

>> PEDRO MONTENEGRO: Thank you very much, Wilma. My name is Pedro Montenegro, and I am the program officer here at NHMA, and I will be taking over as the moderator. Our next presenter is Godfrey Jacobs.

>> GODFREY JACOBS: Thank you, Pedro, and hello, everybody. It's my pleasure to be with you today to talk about the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. These are more simply known as the National CLAS Standards.

I work with a company called GDIT and serve as the program manager for Think Cultural Health, which is sponsored by the Office of Minority Health.

I will talk about CLAS as they relate to diversifying the health workforce for an equitable future.

So let's move the slides forward and ask the question: What is CLAS? As most of you, if not all of you on the line, know, it's an acronym that stands for culturally and linguistically appropriate services. CLAS is defined as services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages,

health literacy levels, and communication needs. CLAS should be employed by all members of an organization, regardless of size, and at every point of contact. We know that a one-size-fits-all approach is not the best approach to healthcare, and implementing CLAS helps health and human services professionals treat individuals with respect and be mindful of their culture and language.

So that's a quick piece about CLAS. But how do you actually go about providing CLAS? To operationalize CLAS, we developed guidelines called the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare, as you see on the slide here. These standards and an accompanying guidance document are housed on the Think Cultural Health website. Now, I can't go through these in great detail, but I will say that the standards are an important tool that health professionals can use to promote and implement CLAS. There are 15 of these standards, each of which is an action step that guides professionals and organizations in their implementation of culturally and linguistically appropriate services. We believe that these standards can, indeed, not only relate to but help in the diversification of the health workforce for an equitable future.

The principal standard, which is the one I am going to focus on along with the leadership ones because those are the ones that have to do with recruitment and retention of a workforce, the principal standard shown here frames the essential goal of all the standards. Conceptually, if the other 14 standards are adopted, implemented, and maintained, then the principal standard will be achieved. Providing effective, equity, understandable, and respectful quality care and services helps first of all to create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient and family-centered care. It also ensures that all individuals receiving healthcare and services experience culturally and linguistically appropriate encounters. It meets communication needs so that individuals understand the healthcare and services they are receiving, can participate effectively in their own care, and make informed decisions. And finally, this standard, the principal standard and all the standards, will help eliminate discrimination and disparities.

Moving on to the next slide, here we have the themes of the National CLAS Standards. As you see, the principal standard, and this slide shows a snapshot of the standards, which are structured to include that principal standard, and then the rest of the standards fall under three themes --

governance, leadership, and workforce. And this one is one I want to emphasize today because this theme emphasizes that implementing CLAS is a responsibility of the entire health system. And implementing CLAS requires the investment, support, and training of all individuals within an organization.

The other two themes are communication and language assistance; and engagement, continuous improvement, and accountability, which also relates to workforce diversity, equity, and accountability.

The next slide here, the governance, leadership, and workforce theme emphasizes that implementing CLAS, as I said before, is a responsibility of the entire system. Implementing CLAS really requires the investment, support, and training of all individuals within an organization. The impetus for implementing CLAS can and often does come from the bottom up; however, it is the organization's leadership that shapes the culture of the organization through its priorities, expectations, and the behavior that it models. Therefore, the impetus for implementing CLAS should also come from the top down.

Now, Wilma alluded to this slide, to this piece of governance, leadership, and workforce. Because -- and I want to spend just a few minutes on -- a little time on this. Because standard 2 of the 15 standards -- and I am not going to go through all 15 -- but standard 2 addresses governance and leadership. And it will help organizations ensure the provision of appropriate resources needed to support and sustain CLAS initiatives and model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices. Standard 3 within the governance, leadership, and workforce theme addresses recruiting, promoting, and supporting a diverse governance, leadership, and workforce. And this standard will help organizations create an environment in which culturally diverse individuals feel welcome and valued, and it will infuse multicultural perspectives into planning, designing, and implementation of CLAS.

And within this theme, standard 4 addresses educating and training governance, leadership, and workforce. It will help organizations to prepare and support a workforce that works well with diverse populations and also assess the progress of staff in developing cultural, linguistic, and health literate competence.

I want to share with you a couple of slides here from the Institute for Diversity in Health Management and Health Research & Educational Trust. This slide breaks down the racial and ethnic representation of patients versus boards

versus executive leadership. And as you can see, there's a vast disparity among the different minority groups represented here. The vast majority of people in leadership and governance roles are of -- from the white population, and you see here the black or African American population, Hispanic or Latino, and the other groups across the bottom there have very low representation.

Then the next slide also illustrates another real issue in this whole business of retention, recruitment, and representation of ethnic groups in healthcare. This talks about physicians. And by 2025, we understand that there will be a shortage of up to 90,000 physicians in the United States. And why does diversity among physicians matter? In multiple studies on race, gender, and social concordance between patients and physicians, Dr. Lisa Cooper has documented improved patient outcomes; more positive communication behaviors such as longer encountered time and increased trust, which leads to greater adherence; and improved patient satisfaction experience. This slide presents the breakdown of physician by race, ethnicity, and sex I have also added each group's percentage of the overall population.

What's interesting about this slide, and I heard I think it was Dr. Lin who said earlier that the percentages of minority populations in the various -- from the various groups remains very low, and indeed, these percentages, 12.5% Asian, which has grown in the last 15 years, but black or African American, American Indian, Hispanic or Latino has remained exactly -- almost exactly the same for the past 40 -- I repeat, four-zero -- years. And this really is an unacceptable sort of situation.

So although this slide does not depict this, another area of concern is the representation of minorities in academia. Faculty at all levels, administrators, residency directors, et cetera. According to Dr. Jose Rodriguez, Associate Professor and Co-Director of the Center for Underrepresented Minorities in Academic Medicine, at Florida State University, College of Medicine, minority faculty members are subject to what he calls "the minority tax" of having to participate in the three pillars of academic medicine -- research, teaching, and service -- with disproportionately high demands in the area of service, such as often being the only minority on admissions committees; asked to recruit and mentor minority service; serve on diversity-related committees, et cetera, all of which are not valued and do not support promotion of activities. I am sure all of you in the audience know people in this situation. Thus, racial and ethnic minorities and women are disproportionately represented at the lower ranks of

instructor, lecturer, and assistant professor.

So let's move on to very briefly talking about another -- theme three in the CLAS standards, engagement, improvement, and accountability. This underscores the importance of establishing both individual and organizational responsibility for implementing CLAS. And in terms of things like recruitment and retention, all individuals are accountable for upholding the values and intent of the National CLAS Standards.

Finally, I want to quickly go through this engagement, continuous improvement, and accountability. Without going through all of the standards by number, I mean, hear we have the ability, using the CLAS standards as a tool, to establish culturally and linguistically appropriate goals; to conduct ongoing assessment of an organization's CLAS-related activities; to collect and maintain accurate and reliable demographic data in order to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery; and to conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. That, of course, would improve -- that would include service deliverers, those who deliver the service.

So I see I am getting a yellow warning sign here, and I just want to do a little promotion of what we have available on our website. You see here that the Think Cultural Health suite of eLearning programs are completely free and available to anyone. Free in the sense that you don't have to pay anything, but you do have to put in your time in order to take the courses.

As you can see listed on the slide, Think Cultural Health houses accredited eLearning programs designed specifically for physicians, nurses, first responders, and other disaster personnel and oral health professionals. These eLearning programs are grounded in the National CLAS Standards. They are designed to equip health professionals with the awareness, knowledge, and skills to treat diverse patients and improve quality of care.

In addition, we offer an eLearning program for Promotores de Salud & community health workers. In the very near future, we will be launching a program for behavioral health professionals.

So I now have the red light, which means I must end, but I invite you to become a CLAS champion at your organization and share why CLAS matters for patient safety and satisfaction and how CLAS can improve quality and equity.

And with that, I will close with our website. Please feel free to come to this website, and hopefully you will find whatever you need about CLAS standards and other cultural and linguistic issues. Thank you very much.

>> PEDRO MONTENEGRO: Thank you, Godfrey, and thank you all for listening to these informative presenters. We will now proceed with our Q&A session. Please send your questions see why the Q&A pod. Also, by now you should see a window with the session evaluate questions. Please provide us with feedback on this website as we go through your questions.

Okay. So the first question is: How do you obtain feedback from community members? Can you provide examples?

>> GODFREY JACOBS: Yes, I can. In order to provide feedback from community members, the organization has to have a mechanism to do that. There are lots of ways to do that. I see questionnaires that are put out by various health institutions, by hospitals, by private practices. These questionnaires are used to find out issues of concern to the community. That's one way to do it. Another way is to have regular community meetings with the communities that are being served. And several other kinds of things. I know hospitals that hold a yearly picnic for all community members. I have seen that in Baltimore, Maryland. So there are a series of different things that can be done.

>> PEDRO MONTENEGRO: Great. The next question is actually for Wilma: How do you determine priorities and what areas to address, and how far upstream do you go with your health equity projects that your department undertakes?

>> WILMA ALVARADO-LITTLE: Oh, well, thank you for that question.

Well, what we do is we look at the information that we get from our health equity reports, and we look at the minority areas primarily because that's our legislative charge. Not to say that we don't work in other areas as well. We have supported other communities. We have a certain charge that we are mandated to do, and so one of the first things that we'll look at is who is coming -- who is knocking on our door, quite honestly. What challenges are out there? Is there something that we, as an Office of Minority Health, can support? Or is our role not to be the facilitator of the process directly with the community and/or that partner? Is there a department within, is there an area within the Department of Health for which we can support guidance and expertise?

So for example, one of the things we've done is -- and it's on the website for the Office of Minority Health and Health Disparities Prevention -- is our listening sessions which were conducted in approximately 2015-2016. What we were able to

do there from that information was we held listening sessions with the communities in various areas throughout upstate New York -- Buffalo, Rochester, and Syracuse -- and I use the term "upstate" very carefully because could you walk out of Penn Station some kind of way and you are on your way upstate; right? So we looked at three areas to start off with, which were Rochester, Buffalo, and Syracuse, then looked at Albany, then conducted listening sessions within the five boroughs and expanded areas.

From the information obtained during the listening sessions, the concerns that the communities presented, right -- so some of the topics ran the gamut from taking charge of why you are health, women's health, men's health, violence and trauma, spirituality, youth and adolescence -- we were able to identify the areas which the communities felt was the priorities. So as much as we can, we take our cues from the communities so that they are able to take the lead and are empowered because this is -- when we are working with the communities, you know, once you open that door, they will tell what you the concerns are and working towards having a trusted environment, so that one of the first things that we look at. Where are the communities -- if they are asking is that something that we realistically can provide guidance and support with? And if it's something where we can be a partner with another area of the Department of Health, then that's what we do. Right? Because it's not about what our -- what we feel our needs are for the communities; it's what the communities feels their need is. Yes. So we shouldn't make an assumption based solely on data that this is what they need because this is what the data is telling us. We need to make sure that we are humble with our approach and listen to the communities so what we are doing is going to be realistic and it is going to support health equity and achieve those healthy outcomes.

So there's a lot of moving pieces, as you can imagine, as to how far and how deep we enter. Because we have to take our cues from the community and do what can be realistically accomplished within a certain amount of time, taking our cues from individuals and groups who approach us.

>> PEDRO MONTENEGRO: Great. Thank you, Wilma.

And as a reminder, you should have seen a window with the session evaluation questions. We want to ensure that we are able to provide future webinars and want to know everyone's feedback. So please answer those questions once you see the screen pop up.

The next question is from a group of minority medical students from Oakham University, William Beaumont School of Medicine. The question is really for anyone that can answer

on the speakers. They are interested to know what steps they can take as medical students early in their careers to help support diversifying the healthcare workforce.

>> GODFREY JACOBS: I'll start if you don't mind, Wilma.

>> WILMA ALVARADO-LITTLE: No, not at all.

>> GODFREY JACOBS: I think it's wonderful to hear the medical students asking for tools as to how to address diversity in the workforce and other cultural issues. The first thing is to make sure your voices are heard. Because in medical schools across the country, you often hear that the curriculum is so full that nothing else can be added. But I think that there is room that can be added to different parts of curricula that can improve -- that can include issues of diversity, issues of recruitment, issues of cultural competence, and it needs to start early in medical school so that students, when they reach internships and so forth, are aware of what should be done, what the right procedure should be, what the right behaviors ought to be, how to be culturally aware and competent, and how to take a continuous journey on this wonderful issue of learning about other people and treating them with respect and dignity.

Thank you.

>> WILMA ALVARADO-LITTLE: And I agree. I agree. And one of the things that I would like to add is that a lot of times the term "provider" is used, and the dotted line immediately goes to the physician, the medical student, the resident. And in the communities the provider can range from that person who calls to confirm an appointment or who meets you at the front desk. And so it's important to sometimes do that -- when possible, to do that on-site teaching for that moment to share why somebody might need a little bit of help with scheduling and appointment. You know, as being in the room with an individual, they might share information that they wouldn't give to the front desk. And so how is that information communicated so that it's more of a united front to be able to provide culturally appropriate services? Because it doesn't begin and end only with the relationship with the physician or the nurse or the physical therapist. There's a whole lot of folks that individuals are in touch with before they get to that service and then after. So it is a multidimensional approach to be able to do that. And you can ruin a relationship in a sentence. It doesn't take that much time. However, building that relationship can also be done incrementally and in a way that's going to be a win-win for the individual seeking care and the individual and the organization providing care.

Thank you.

>> PEDRO MONTENEGRO: And I would also like to add that the National Hispanic Medical Association has a program called the Hispanic College Healthcare Scholars, and we are having five conferences around the country to recruit students, to pair them with mentors that are in medical school or in other health professional programs, and for more information, you can go on our website and click on our Programs tab to find out more.

And then we have time for a couple more questions. We understand CLAS standards should be implemented across our departments and among our contracted providers. But what if these standards are not followed? What are the ramifications of not implementing the standards? Can the federal or state government hold county's funding? In other words, how can the federal or state government hold counties accountable?

>> GODFREY JACOBS: Well, the standards themselves are not laws; they are guidelines. And they are not even mandates. Although in the language area, they can, in fact, help you to maintain certain requirements from the Office for Civil Rights in the federal government. But the real accountability for implementing these standards will come from the consumers, patients, and other clients. Because one of the things that happens when CLAS is implemented is that it seems to us, anyway, that there's a greater loyalty to the institution. There's a greater comfort level in returning to the institution. There is a better sense of community and belonging. And therefore, from the institutional point of view, this would be called what we call the business case for CLAS, that the bottom line is that if you treat people with respect, if you pay attention to the principles that are inculcated in the CLAS standards, it will be recognized. People will notice. Word will spread. I have seen that happen. And the institution will do better by implementing these standards rather than not. That's one part of the answer. There are others as well, but I'll stop there. Thank you.

>> WILMA ALVARADO-LITTLE: Well, here in the State of New York, there is an initiative regarding Medicaid redesign which is a Delivery System Reform Incentive Payment program, or a DSRIP for short. Within DSRIP, it is comprised of 25 entities to address Medicaid redesign and to -- how to better serve our constituents here in the State of New York. Those 25 entities are called performing provider systems, or PPSs for short. Within the PPSs, there is a level, if you will, that includes health literacy, language access, and cultural competency. So these three are areas to be addressed as part of the DSRIP initiative so that our communities are better served and that there's a better understanding of -- again, of what resonates

with our providers and our individuals seeking healthcare.

So when we are looking at the CLAS standards and we are looking at cultural competence, again, we have to think about the definition of culture. So there have been really good discussions regarding what is the culture of the rural community?

So then you find the social determinant. Well, you know, transportation is a big issue; right? So we are looking at these other pieces regarding the CLAS standards.

So for the State of New York, the CLAS standards has been an integral part of the redesign of our Medicaid system through the DSRIP program, and so that information is easily found on the website for the New York State Department of Health. This is one way that the CLAS standards have been used. I can't speak for other states. However, here in the State of New York, the CLAS standards have been included as we address health access challenges and health disparities. Thank you.

>> Well, with that, I would like to thank our speakers for the information, presentation, and for you all for participating in today's webinar. A recording of this webinar will be available on the NPA website within a few hours. We hope that you use this webinar as a resource and will share the link with others once it's available.

Thank you, and enjoy the rest of your day.

>> WILMA ALVARADO-LITTLE: Thank you for having us.

>> GODFREY JACOBS: Thanks very much.

(End of session, 4:01 p.m. CT.)

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