

# Community Resources

Goal: Partnerships to meet the needs of families and children

## Change Concepts

## Potential Strategies

**1. Create and sustain meaningful partnerships with key community leaders and representatives to enhance and inform communication between providers, staff, patients, and families and to identify specific community strengths and needs.**

- Assess and update information about community demographics, languages, and epidemiology.
- Encourage and retain participation of community members on organizational governing bodies and advisory committees.
- Establish and maintain forums for meeting with community leaders to identify key community concerns.
- Have community leaders serve as liaisons between providers/staff and community members.
- Meet with community leaders and organizations to improve access and promote preventive care.
- Encourage families to participate in community programs that are effective at improving health and mental health outcomes (e.g., physical activity programs).

**2. Involve community in planning, implementing, and evaluating services and policies.**

- Include community members in process for developing, implementing, and evaluating education and resource materials.
- Identify community representative(s) to engage in quality improvement and patient safety programs (e.g., preventive services).
- Organize focus groups, including community leaders, to aid in planning service changes including those related to the CLAS standards.
- Address identified barriers to community participation in planning, implementing, and evaluating provided services (e.g., childcare, funding, etc.).
- Assess and address community reported barriers and facilitators to care at all levels both quantitatively and qualitatively.
- Establish and utilize relationships with diverse race/ethnic/language news sources to promote preventive screening and positive health behaviors.

“Quality improvement efforts within health systems that serve children of color would reduce disparities in health care, which are essentially disparities in quality.”

**Anne C. Beal, MD, MPH**

*Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care*  
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### Obstacles and Challenges

The pilot study revealed key differences between small private practices on the one hand and larger institutions and community health centers on the other in terms of staffing and resources. Small private practices and solo practices found it difficult to invest staff time in developing community relationships. “Time spent away from my patients cuts into my income,” said one practitioner. In contrast, larger organizations were able to distribute the efforts associated with these strategies among a larger number of staff.

### Successful Strategies

For solo or small practices solutions that were time and resource efficient included having staff and providers make community connections through their personal activities, such as attending church and participating in community organizations. These connections were used to identify sources for ethnic-specific information and materials that could be used as office resources. In addition, some offices reported advertising job openings in small, ethnic-specific newspapers in order to increase the diversity of the office workforce.

Larger organizations are able to distribute the tasks necessary for building community relationships among different departments. For example, Human Resources departments advertised jobs in ethnic-specific media and public relations staff also worked with these media organizations to disseminate information about preventive care and other services. Some organizations reported sending staff and providers to participate in meetings at community centers, schools or other local programs to share and gain knowledge and to build relationships.

One institution created a video called “How to Utilize the Healthcare System.” It was translated into several languages and widely distributed to community organizations, health departments,

local clinics, and other sites. Some segments were even aired on the local Somali television station. It contained information such as how to make appointments and when and how to use the emergency department.

Large organizations also found focus groups and surveys to be useful tools for gathering data on the issues—such as lack of transportation—that are barriers to health care for specific populations. These focus groups were conducted in neighborhoods with large number of residents from a specific racial or ethnic group. Providing child care and refreshments were found to encourage participation in the focus groups.

Effective community outreach was found to improve health and lead to reciprocal relationships. One pilot site reported encouraging community organizations to present at a clinic/hospital health fair or event and encouraged participation by reserving enrollment in certain health programs for individuals and families from that organization.

To learn more about the racial/ethnic groups, large organizations reported asking patients to act as experts and share their experiences and beliefs about health care with staff and providers. Other organizations reported using the local health department to gather population data for catchment areas or to help connect patients to activities and resources in the community. Others asked community support or service organizations to share materials and information that would be useful to the patient populations being served.

## Case Study

### “Care in the Context of Community”

Children’s Hospitals and Clinics of Minnesota is an urban health system with one hospital in Minneapolis and one in St. Paul. The large outpatient pediatric clinic in the Minneapolis hospital serves a diverse patient population. Half of the patients are from minority groups and one quarter have limited English proficiency. When Boris Kalanj, the director of cross-cultural care and interpreter services, came to work at the hospital four years ago, he detected a problem: “We had staff interpreters for Spanish and Hmong languages, but they were not too happy because they felt their role was defined too narrowly,” he says. “They described feeling like ‘voice-boxes’ whose job it was to translate only words. This meant we were ignoring the complexity of conveying the full meaning between different languages or the cultural context in which the communication occurred. We were, in effect, de-contextualizing the essential communication in the process of giving and receiving care.”

As a result, the hospital expanded the role of its interpreters to “interpreter/cultural resources.” These staff members were asked to interpret meaning-for-meaning, rather than word-for-word, picking up on cues for implicit cultural content and the potential for culturally-based miscommunication. “In each situation their task is to assess the urgency and centrality of the issue, and then intervene by sharing cultural information they see as relevant and likely to help improve patient care,” explains Mr. Kalanj, a social worker with expertise in the effects of psychological trauma. “In order to do this, they must interpret cultural models that are expressed by the patient as well as the caregiver.”

Going still further with the support of a one-year startup grant, the hospital added two new positions called “interpreter/cultural mediators” to its staff. These new positions combined the roles of interpreter, cultural competency educator, and community

health worker. In addition to participating in individual clinical visits, these staff members teach a curriculum for limited English proficient patients to help them understand and make use of the healthcare system, and they teach hospital staff about cultural attributes as they relate to care. Their efforts are supported by the full-time educator, whose job is to train staff throughout the organization on various aspects of clinical cultural competency.

Additionally, the hospital has put into place several of the community strategies suggested in the NICHQ Change Package. “We try to create a welcoming environment for newcomers, including several thousand Hmong refugees who came from Thailand in 2004,” says Mr. Kalanj. One innovative project, co-organized with community partners, was a series of mass health screenings for the newlyarrived refugees. “Normally these exams are done individually for each family member, with low rates of completion. We organized them in the format of a ‘village health fair,’ held in one of the area hospitals. A great number of individuals and families completed their health screening during the day and at the same time had a chance to visit numerous health promotion and community resources booths.” His department collaborates on production of patient education materials, including information sheets, booklets, and videotapes. These are distributed at health fairs in the community, through local media and community centers, and at clinics serving diverse immigrant populations.

To promote community partnerships, hospital staff are assigned to collaborate with community organizations, including the Minnesota Department of Health, the Asian Pacific Association, and the Somali-American Friendship Association. These contacts have helped identify several important community leaders. The hospital then organized a series of luncheon meetings with the leaders. “These meetings allowed

for formal exchanges of information and good will,” said Mr. Kalanj. They were also a useful way to gather information from leaders about major healthcare issues and barriers to care in their respective communities. “In order to be effective,” said Mr. Kalanj, “we have to make this kind of contact actively and continuously.”

Another way of connecting with the community is to involve ethnic healers in bridging cultural gaps in service, said Mr. Kalanj, “We have at times called upon local Muslim imams and Hmong shamans to help with patient communication and negotiate treatment and follow-up care. In the future, we plan to formalize these relationships on an on-call basis and reimburse these healers for their time.”

As there is always room for improvement, Mr. Kalanj would like to see the inclusion of racial and ethnic data in the hospital’s on-going quality improvement measures, including safety reports. He would also like a more systematic way to implement health literacy assessments at the time of intake or admission, tracking, for example, not only which languages are spoken in the home, but also which languages are read in the home.

The issues described above are magnified in states such as California and New York

where large populations, 40 and 28% respectively, speak a language other than English at home (ref: Census 2000), and the numbers of different languages spoken and cultures represented are vast. In these states, some organizations prioritize their efforts by identifying threshold groups to focus their efforts. Threshold groups are defined as those populations speaking a particular language (other than English) who meet a numeric threshold of 3000 (reference for definition: <http://www.hhs.gov/ocr/lep/guide.html>). In addition, California has several laws that place additional requirements for written translation of materials on any agency that receives state funding. Threshold guidelines can be useful in guiding the extent and depth of services available. For example, if 20% of families receiving care are Spanish speaking, a large organization will likely want to consider having on-site interpreters or bilingual staff interpreters as well as a range of translated patient education materials. However, when a family presents for care speaking a language that is less common in the community, organizations may find it more appropriate to use contract interpreters or telephone interpreters.

