HERO Forum17 Campfire Chat

Culturally Responsive Engagement: Applying the Evidence

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Date/Time: Wednesday, September 13, 10:45-11:20 a.m.

Abstract

This session explored how employers can work with employees in a culturally responsive manner to achieve equitable outcomes. The session used evidence in the form of de-identified case studies from two large American employers to evaluate smoking rates and depression prevalence of employees stratified based on gender, age, race/ethnicity and spoken language. This evidence framed a discussion about:

- The extent to which outcomes are equitable and the challenges in achieving health equity
- Considerations for workforce health approaches related to the differing outcomes presented in evidence, and;
- Identification of culturally responsive solutions to achieve greater equity.

Discussion Summary

Question 1: What cultural approaches have you tried based on evidence-based data? How well have they worked?

One participant talked about her organization's experience in improving medication adherence by looking at their data (Medicaid vs Medicare). They discovered that African Americans weren't sticking to antidepressants. They hired an African American nurse to communicate with the targeted population, whose voice members can relate to. This helped improve African Americans medication adherence rates.

Another participant talked about issues related to financial barriers to care, with lower wage workers less likely to use benefits. This participant suggested using pay scale data to inform adjustments to copay amounts to encourage employees and improve care access and achieve greater equity.

The group also discussed tools and resources available to reduce stigma around mental health conditions. This included involving stake holders and recognizable people among the community to help others realize they are not alone. Even famous people suffer from depression. A specific resource mentioned was makeitok.org

Question 2: What are the challenges and successes you have had?

During this discussion, it was very insightful for us to learn that many have had similar challenges. Data collection presents challenges: sample size is important to remember and

representation matters. Many agreed that collecting race and ethnicity data was originally controversial, but is now less controversial, because there is more evidence about disparities in health outcomes associated with race and ethnicity.

Finally, the group acknowledged that culture and language are barriers to care. We need to be culturally sensitive in use of language. For example, with flu vaccines some cultural beliefs lead people to think that the shot could make them sick rather than preventing illness.

Conclusion

Participants represented fields of government agencies, academic, and health care providers. A very lively discussion was had on how race/ethnicity data help participants learn about their specific members/employees/customers. In the end, more questions surfaced on needs to learn about cultural perception on wellbeing, for example, Latino wellbeing and health literacy. When discussing tactics to reach populations who need additional help and resources, the group agreed it's important to do needs assessment to gather information and conduct focus groups. Mapping data can also be very helpful to find out resources in communities where employees live. In addition, the power of communication will help people. We need more data on communication and literacy.