AIDS Education and Training Center
National Multicultural Center
HOWARD UNIVERSITY COLLEGE OF MEDICINE

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AETC-NMC NETWORK e-NEWS

Your Connection to Ensuring Cultural Competence in HIV Focused Healthcare

Regional AETC Focus

New York/New Jersey AETC Participates in the AETC NMC's Regional Cultural Competency Emerging Populations Training Needs Assessment and Reveals Their Findings

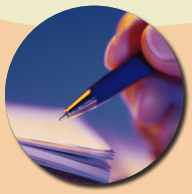
The NY/NJ AETC is an interdisciplinary team that provides training and education to health care providers serving the states of New York and New Jersey, one of the regions in the country most impacted by HIV. Translation of the latest practice guidelines and how to provide culturally competent HIV treatment and prevention interventions to community based providers caring for underserved populations is the core of our work. We partner with the leading academic medical centers and clinical sites in our region to provide approximately 1,800 HIV-related trainings to over 19,000 trainees annually.

The content of the education provided by the NY/NJ AETC is driven by national and state policy and guidelines, clinical and behavioral research findings, professional standards of care, in combination with, local epidemiology, provider identified needs and structural factors of clinical practice. Recognition of patient, provider and institutional factors informs all of our educational interventions.

The NY/NJ AETC MAI Capacity building project draws upon the theory of social capital to build community level capacity for HIV treatment in high-need medically underserved minority populations on both the individual and site level with three core components. Core Component one, the ACCESS (AETC Clinical Community Exchange & Support) program is a coordinated regional effort to provide individualized longitudinal clinical training for minority/minority serving providers. The goal of the program is to increase patients' access to quality HIV care while simultaneously also increasing community providers' access to clinical expertise. Component two, building the capacity of clinical sites located in the highest need and resource poor communities in the region via the establishment and enhancement of longitudinal training relationships. Component three, improving the overall integration of cultural competency principles into all AETC trainings, and improving the delivery of trainings that explicitly focus on improving cultural proficiency. This approach to cultural competency recognizes that both provider and patient come to the clinical encounter with a unique combination of cultural, linguistic, and social influences and good clinical care will recognize how these influences potentially impact the provision of care and health outcomes.

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Please visit our website (**www.aetcnmc.org**) for more information about our work and to register for upcoming Cultural Competency Training in HIV Management.

To better understand the training needs of our providers we partnered with the AETC-National Multicultural Center in their 'Regional AETC Cultural Competency and Emerging Populations Training Needs Assessment'. The assessment included measures of current practice populations and needs for additional resources to aid in providing quality culturally competent clinical care. Some of the key findings from our region follow. The sample consisted of 50 providers, 54 % medical, 21% oral health and 25% other providers. Forty two percent of the total sample served between 1-50 patients living with HIV annually. . A diverse patient population is served by these providers: 90% substance users, 70% incarcerated/newly released, 69% homeless and 46% newly immigrant populations. Overall 7% indicated they did not have adequate resources to treat any of the populations listed, reflecting the ever growing problem of under resourced clinicians serving highly impacted communities. The most frequently cited need for additional resources were with working with the following populations: migrant (48%), newly immigrant (40%) and American Indian populations (40%).

Further analysis was conducted comparing medical and oral health providers. Differences were found in populations served, as well as, perception of need for additional resources. Medical providers were significantly more likely to report having homeless populations among their patient base than oral health providers (77% vs. 30%, $p<.01$) But oral health providers were more likely to serve adolescents (80% vs. 31%, $p<.01$). Nearing significance was the difference in serving incarcerated/newly released individuals living with HIV, with medical providers being more likely to serve these populations than the oral health providers (80% vs. 50%).

As far as the need for additional resources, oral health providers were more likely to report not having adequate resources to treat homeless populations (75% vs. 32%, $p<.05$). While not statistically significant, medical providers were more likely to report not having adequate resources to treat substance users (78% vs. 50%).

These results were presented to the faculty of the NY/NJ AETC at their quarterly meeting in partnership with the NMC leadership and are informing our programs and helping us to target training and support materials to providers.

Daria Boccher-Lattimore, DrPH *is the Director and Co-Investigator for the New York/New Jersey AIDS Education & Training Center. She is also an Assistant Professor of Clinical Sociomedical Sciences in Psychiatry*





VOICES FROM THE FIELD

Mr. Ron Lessard



How long have you worked in the field of cultural competency and HIV?

I have worked in the field of cultural competency and HIV for over 13 years. As an American Indian from the Mohawk tribe I have been deeply involved in what some call "cultural competency" throughout my life as have most American Indian and Alaskan Native people.

What led you to this field?

I became involved in the field of HIV when I was the Executive Director at The Baltimore American Indian Center. In partnership with a local health center, we offered HIV testing to all community members. Due to the stigma attached to HIV we often had to sneak people in the back door or up the fire escape so they could be tested.

Currently, what types of services or programs do you provide?

As the Strategic Advisor for Native American Affairs for the Corporation for National and Community Service (CNCS). CNCS headquartered in Washington, D.C., is an independent federal agency under the Executive Branch of the United States that improves lives, strengthens communities, and fosters civic engagement through service and volunteering. Each year CNCS engages more than four million Americans of all ages and backgrounds in service to meet local needs through its Senior Corps, AmeriCorps State and National, AmeriCorps VISTA, AmeriCorps NCCC and Learn and Serve America programs. The programs of CNCS are committed to supporting the culture of service that has existed in Native American communities for generations. Our programs address issues of concern to Native American communities, including health and wellness, assisting elders, veterans and military families, language and cultural preservation, economic development, youth leadership, educational attainment, traditional language and lands preservation.

What do you think are the most critical areas of cultural competency in HIV care today?

The lack of funding for all HIV/AIDS programs and treatment is always critical. Training and education budgets have been cut creating much difficulty when planning and implementing cultural competency programs. Possibly the most critical area is complacency. Assuming that progress made in the field of prevention and treatment diminishes the need for more funding, training, and education.

When thinking about the future of healthcare, how do you see cultural competency evolving in the next ten or even twenty years?

Cultural competency has to evolve out of a change of consciousness naturally and spiritually. Having compassion for all people while respecting and embracing the differences of cultures and tradition. It is good to require and educate providers to become more culturally aware and in many areas it has been necessary to pass legislation requiring cultural competence training.

Given that about only 8% of the over 850,000 physicians in the U.S. are minority (African American, American Indian/Alaska Native, Hispanic, etc.), which results in the majority of care being provided by someone of a different racial ethnicity as the patient, what are some of the government's efforts to ensure cultural competency is integrated within the realm of health care?

Many government agencies have provided funding and developed programs for the prevention and treatment of HIV/AIDS. Indian Health Service has undertaken several initiatives aimed at building the capacity of providers to offer HIV/AIDS-related prevention and treatment services. IHS has established relationships with tribal community elders, allowing them to come into the local IHS health care facility at the request of tribal members and provide healing services to the patient in the hospital. IHS has provided HIV/AIDS training on sessions focusing on HIV/AIDS behavioral health issues, capacity and partnership building, and related intervention strategies.

One of the overarching goals of the AETC Network is to improve health equity by decreasing the number of persons living with HIV. Can you speak to those targeted or focused approaches to decrease health disparity?

The AETC network has the best professional experts in the field of HIV/AIDS. They have created an abundance of effective education and training tools especially in the area of cultural competency. The use of webinars and social media are all excellent ways to expand outreach and programs, plus more on site training of clinicians.

Do you have any other additional comments, or recommendations regarding the work of the AETC-NMC?

The AETC-NMC has always recognized the importance of incorporating traditional medicine and western medicine for the purpose of creating the best healing programs for the prevention and treatment of HIV/AIDS. Efforts to continue this will help bring awareness to western and traditional health care providers and provide opportunities to bring people of different cultures together.

Mr. Ron Lessard (Mohawk) *is the Strategic Advisor for Native American Affairs for the Corporation for National and Community Service. He is the agency's primary liaison to American Indian, Alaska Native, and Native Hawaiian Tribal communities and the organizations and federal agencies that serve them.*

Tasked to serve as the AETC's leader for the provision of a) training, b) most current information, c) curriculum development, and d) best practices in cross and multicultural HIV/AIDS care, the AIDS Education and Training Center National Multicultural Center (AETC-NMC), in the College of Medicine at Howard University is partnering with Regional AETCs to identify the emerging cultural competency needs of clinicians in each geographic region and provide tools and resources to meet those needs. The objective of this effort is the reduction of HIV/AIDS disparity. *John Blevins, PhD, an Associate Research Professor in the Rollins School of Public Health at Emory University in Atlanta, GA (SEAETC)* shares his work with us in developing a model aimed at providing culturally competent care.

Personal Perspective

I have worked as a mental health provider to men and women with HIV/AIDS in both Chicago and Atlanta. I have also worked in a subsidized counseling program that provided free or reduced cost psychotherapy to consumers without private insurance and without the economic means to pay out-of-pocket. Finally, I have provided clinical consultation to Ryan White programs in rural, suburban, and urban settings across the southeastern United States. In all of those contexts, I approached counseling and the clinical education well aware of the need for self-reflection when working with someone who is from a different race/ethnicity, gender, or social class in order to examine my own social location as a white male. But I mistakenly assumed that such conscious efforts at self-examination were not as important when working with lesbian, gay, bisexual, or transgender clients (LGBT) because I was an out gay man who had experienced institutional and personal discrimination. I was wrong. I do need to be conscious of my own social location with any client. This includes my clinical work with sexual minorities such as LGBT clients; without such reflection, I run the risk of assuming that my experience can be used to understand the experiences of LGBT clients because my experience is the same as theirs (Milton, 2008; Paradis, 2003). Over time, I have found it helpful to reflect on this part of my clinical work using a four-word dictum: ally, ask, assess, act. Each of these words is based on sound clinical practice and has been important in my own self-reflection as a mental health provider.

Ally

Sexual minorities do not always face friendly clinical or service environments but I can take concrete actions to make my own clinical setting and the organizations where I work more welcoming (Arredondo, 1996; Arredondo, et.al., 1996). First, I assess the physical environment (the waiting room, exam rooms, public spaces, and counseling offices). Do the pictures, books, magazines, and other media reflect the diversity of the clients that my co-workers and I see each day? If not, I work to change the physical space. Second, I consider the policies where I work. I am grateful that our patient encounter and clinical forms provide options beyond "male" or "female" when gathering demographic data on gender and allow consumers to specify a same-sex partner. Patient materials include the non-discrimination policy of our organization, which includes sexual orientation and gender identity. Third, I am glad to work in counseling settings that have offered us clinical trainings to increase our competency in working with sexual minorities. Finally, I continue to think about the ways in which I talk with transgender, lesbian, or gay consumers. I work to establish a rapport with these consumers, communicating that they can speak openly about their concerns without encountering judgment and asking them to tell me if they feel uncomfortable at any point (Crisp, 2006).

Ask

Over the past two decades, attitudes toward sexual minorities have shifted sharply toward greater familiarity, comfort, and acceptance. This shift has changed the ways we think and talk about sexuality, culture, and identity. It has also opened up important and long-overdue discussions about the effects of racism and/or sexism in sexual minority communities. The words people use to name themselves are changing and growing as a result of these various shifts. For example, some African-American women and men who feel attraction and affection for someone of the same gender may feel some discomfort with the terms lesbian or gay because of their experiences of racism among the institutions and members of lesbian and gay communities; as a response some may prefer terms such as "same-gender loving" or "in the life." (Johnson, 2005) Similarly, some sexual minorities may proudly call themselves "queer" whereas others may find the word offensive. Transgender clients may use terms such as "MTF" or "FTM," "genderqueer," or "transsexual." In the midst of so many terms, providers may at times find themselves uncertain about language. I know that I have and that I will again. What terms are appropriate? Which ones might cause offense? What do some words mean? If such questions arise, it is perfectly reasonable to ask, particularly if you have allied yourself with the consumer. Our asking allows consumers to provide the terms for their identities rather than our assuming that you have the right to determine those terms for them. Educating myself about the meanings of different terms and the reasons why certain terms should be avoided has been important. Various resources can be found through any internet search. A concise guide is the Transgender Glossary of Terms by the Gay and Lesbian Alliance Against Defamation (GLAAD).

Assess

As a provider I am responsible for completing comprehensive medical, psychological, and psychosocial assessments; in doing so, I need to remember certain issues specific to sexual minorities. For example, when I work with HIV-positive transgender consumers, I might talk with their medical providers about hormone therapies, gender reassignment surgeries, screening for potential interactions between hormone therapies and antiretrovirals, and any history of substance abuse/dependence or mental illness. An overview of these issues can be found at **The Body.com**. Additionally, the World Professional Association for Transgender Health (WPATH) publishes a comprehensive *Standards of Care for Transgender Consumers* and the *Center of Excellence for Transgender Health* offers a variety of resources. Psychosocial assessments should illumine the nature, quality, and effect of consumers' support systems and community. I have regularly found that the support systems that many consumers rely on such as religious communities or biological family systems may be sources of conflict or stress for sexual minorities. And so, I make sure to ask about families of choice as well as families of origin.

Act

Finally, I try to work hand-in-hand with my clients to coordinate a treatment plan. In doing so, I keep three general guidelines in mind, in keeping with sound, client-centered counseling theory: 1) Is the plan clinically sound, reflecting a high standard of care and addressing the specific needs of the consumer? 2) Does the plan align with the consumer's priorities, values, and wishes? If not, how can I bring it into alignment while maintaining its clinical soundness? 3) Is the plan realistic? (Alexander, 1998) If I can answer yes to all three questions, then I feel as I have developed a clinically appropriate, culturally sound treatment plan in my work with sexual minorities.

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Milton, C. (2007). Being Sexual: Existential contributions to psychotherapy with gay male clients. *Journal of Gay and Lesbian Psychotherapy 11*(1-2): 45-59.

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Your Choice: Tune-In or Join-In (HIV and Cultural Competency-Focused Webinars/Webcasts)

FEBRUARY 9, 2012

Upcoming AETC-NMC Training:

Cultural Competence: Strengthening the Clinicians Role in Delivering Quality HIV Care within Hispanic Adolescent MSM Communities

2:00 pm - 3:00 pm EST

- Understand the impact of the epidemic among young Latino MSM
- Identify critical cultural issues and other considerations related to Latino MSM and HIV infection
- Provide an example of a successful HIV prevention intervention with Latino MSM
- Identify important priorities for maintaining the health and wellness of young Latino MSM

http://www.aetcnmc.org

FEBRUARY 15, 2012

HIV Testing and Beyond: Promoting Linkage, Retention and Adherence to HIV Care

12:00 pm - 1:30 pm CST

http://www.adph.org/ALPHTN/assets/021512flyer.pdf

FEBRUARY 21, 2012

Webinar: Implementing a Patient and Family Faculty Program to Strengthen a Patient and Family-Centered Culture

4:00 pm- 5:30 pm EST

http://www.ipfcc.org/events/faculty-program-20120221.pdf

FEBRUARY 23, 2012

Upcoming AETC-NMC Training:

Cultural Competence: Strengthening the Clinicians Role in Delivering Quality HIV Care within AANHPI Transgender Communities

3:00 pm - 4:00 pm EST

- Learning Objectives:Describe the impact of HIV on AANHPI communities, specifically AANHPI Transgender communities
- Understand the history of AANHPI Transgender communities
- Identify at least 3 barriers to accessing and utilizing health services for AANHPI transgenders
- Describe 2 strategies for providing more effective and sensitive services to AANHPI transgenders
- Name at least 1 organization which they can use as a resource

http://www.aetcnmc.org

MARCH 8, 2012

Upcoming AETC-NMC Training:

Cultural Competence: Strengthening the Clinicians Role in Delivering Quality HIV Care within Native American Transgender Communities

2:00 pm - 3:00 pm EST

Learning Objectives:

- To learn and understand Transgender terminologies
- To identify Transgender issues and challenges to services
- To understand the need for Transgender data and research inclusion
- To understand risks and unique challenges for Native Transgenders
- How to become and create Trans-friendly services and sites

http://www.aetcnmc.org

MARCH 14, 2012

Webinar: Moving Towards Culturally Competent Care of the Somali/Somali Bantu Population

8:30 am - 10:30 am PDT

http://www.oregoncenterfornursing.org/documents/20120314CCNFlyer.pdf

MARCH 16, 2012

2011 Caribbean HIV Conference: Strengthening Building Bridges to Cultural Competency

Albany, NY

http://www.cicatelli.org/registration/ai_rtc/ai_rtc.asp

MARCH 20, 2012

The Graying of HIV

Baltimore, MD

http://www.pamaaetc.org/downloads/JHL-113.pdf

MARCH 26 - MARCH 30, 2012

Cultural Competency Training of Trainers Institute

Seattle, WA

http://www.xculture.org/files/cc_tot_flyer_march_2012.pdf

MARCH 27, 2012

Webinar: Culture and Literacy: Their Impact on the Patient Experience

12:00 pm PDT

https://cfhc.webex.com/tc0505ld/trainingcenter/register/registerSession.do?confID=824651336&siteurl=cfhc

MARCH 30, 2012

2012 LGBTQ Meaningful Care Conference

Portland, OR

http://www.cdcnpin.org/scripts/Display/ConfDisplay.asp?ConfNbr=7745

APRIL 18, 2012

Webinar: Moving Towards Culturally Competent Care of the Burmese Population

8:30 am - 10:30 am PDT

http://www.oregoncenterfornursing.org/documents/20120418CCNFlyer.pdf

JULY 22-JULY 27, 2012

AIDS 2012- XIX International AIDS Conference

Washington, DC

HIV/AIDS AWARENESS DAY

- February 7th: National Black HIV/AIDS Awareness Day
- March 10th: National Women and Girls HIV/AIDS Awareness Day
- March 20th: National Native HIV/AIDS Awareness Day
- May 12th: HIV Vaccine Awareness Day May
- May 19th: National Asian & Pacific Islander HIV/AIDS Awareness Day
- June 8th: Caribbean American HIV/AIDS Awareness Day
- June 27th National HIV Testing Day
- September 18th: National HIV/AIDS and Aging Awareness Day
- September 27th: National Gay Men's HIV/AIDS Awareness Day
- October 15th: National Latino AIDS Awareness Day
- December 1st: World AIDS Day

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