HRSA
Health Resources & Services Administration

Enhancing HIV Care: Preconception Counseling, Including Sexual Health, Community of Practice (CoP)

Technical Assistance (TA) on Cultural Competency in Preconception Counseling, Including Sexual Health

July 27, 2023

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

HIV/AIDS Bureau Vision & Mission

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Vision

Optimal HIV/AIDS care and treatment for all to end the HIV epidemic in the U.S.

Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Ryan White HIV/AIDS Program

Agenda

- How Bias Influences Medical Settings
- Key Concepts for Building Structural Competency
- Building Culturally Responsive Services: An Overview of the BESAFE Cultural Competency Model
- Interactive breakout sessions
- Report Back
- Action Steps and Final Poll

Learning Objectives

By the end of this learning session participants will be able to:

- Define implicit bias and medical racism.
- Discuss how provider bias may impact client engagement in Pre-Conception Counseling (PCC) and sexual health services.
- Explain key concepts for building cultural awareness, such as cultural humility, role differentials, and structural competency.
- Explain how the BESAFE Cultural Competency Model to develop culturally responsive counseling and case management in PCC and sexual health services.

Icebreaker Poll

1. What type of **cultural competency** training or learning activities does your organization provide? **(Select all that apply)**
   - Assigned books/reading
   - Quarterly/annual staff training
   - Professional courses
   - Working group on cultural competence
   - Other
   - None

2. Does your cultural competency training **include** a focus on preconception counseling and/or sexual health?
   - Yes, preconception counseling and sexual health
   - Yes, preconception counseling only
   - Yes, sexual health only
   - We do not include preconception counseling or sexual health
   - Not applicable

Building Cultural Awareness, Competency and Responsiveness in Providers Offering PCC and Sexual Health Services

How Bias Influences Medical Settings

POLL: TRUE OR FALSE

Race impacts the biological differences in humans.

- TRUE
- FALSE

Race is a Social Construct

There is no biological basis for race.

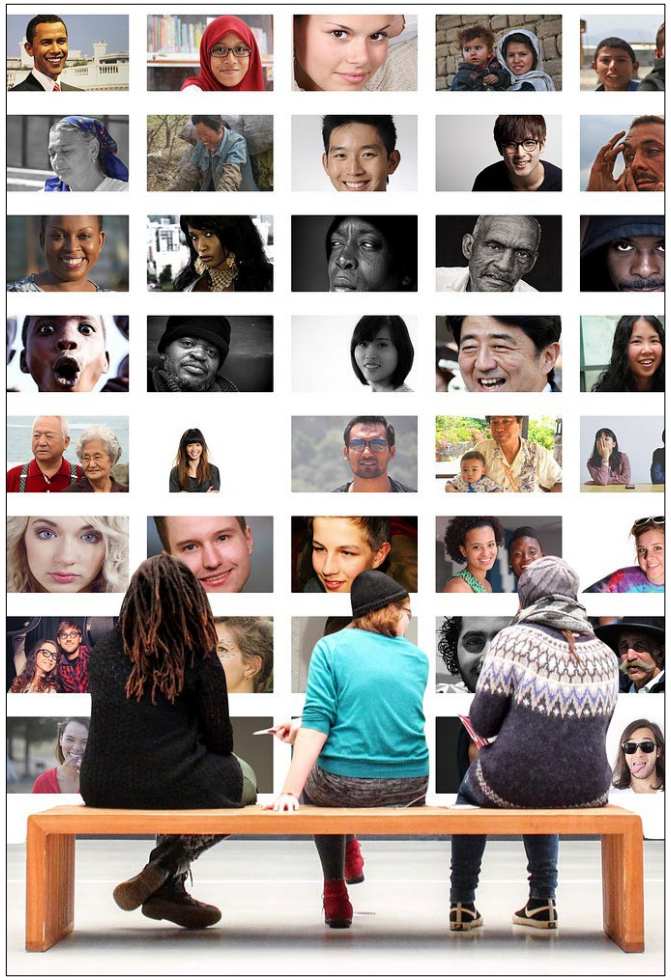
- Race is a **human-invented** classification system used to define physical differences between people.
- This social construct has **real-world** impacts.
- Race is often used as a tool of **oppression** and **violence** towards **marginalized** groups.
- Perceptions of race can create **implicit and explicit biases and racial discrimination.**

What is Implicit Bias?

Implicit bias, also known as **unconscious bias** or **implicit social cognition**, exists when we **unconsciously** hold **attitudes** toward others or associate **stereotypes** with **categories** of people.

(Staten, D. (n.d.). Race & Identity + Lived Experience: Initial Training [Slide show].)

Where Does Implicit Bias Show Up?



01

Implicit bias can translate into a **wide range of behaviors** and range in categories of **race, gender, and sexuality.**

02

Implicit bias can even cause us to **perceive facial expressions differently.**

03

Culture, media, and upbringing can contribute to the development of implicit biases.

Staten, D. (n.d.). *Race & Identity + Lived Experience: Initial Training* [Slide show].

Why Does it Matter?

Explicit Bias

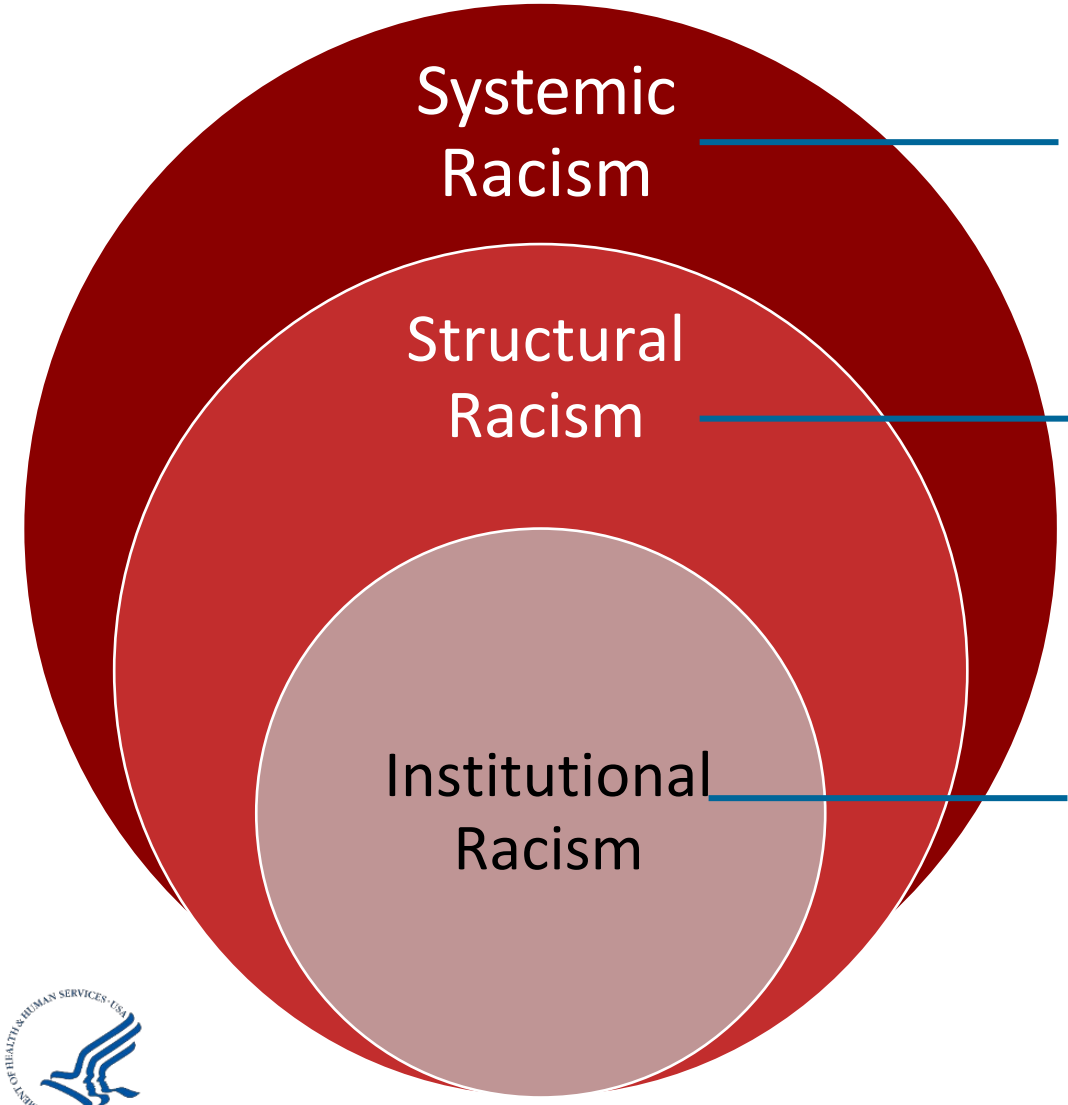
- **Aware of emotions and thoughts about a group**
  - Discrimination
  - Hate speech
  - Prejudice

Implicit Bias

- **Unconscious belief/attitude**
- **Gut reaction**
  - Judgement
  - Feelings
  - Behavior

Can impact healthcare outcomes and patient experience

Levels of Racism



Policies, practices and culture that supports the normalization of racism across all systems.

Policies, economic systems and other institutions that maintain inequality by race and compound across gender, class and sexual orientation.

Unfair policies and biased practices within an organization that reinforce racism.

Positionality

How our identities, shaped by social constructs, determine how we see the world in relation to how we interact with others.

What is Medical Racism?

"Medical racism is prejudice and discrimination in medicine and the medical/healthcare system based upon perceived race."

(*Medical Racism,* n.d.)

Disparities

Maternal Mortality

Overall, Black women face a much higher risk of dying from pregnancy complications than white women, with maternal mortality rates of **41.7 per 100,000 live births** for Black women, compared with **13.4 per 100,000 live births** for white women.

Forced Sterilization

During the 1960s and 1970s, tubal ligation became a popular method of contraception by all women and federally funded family-planning programs subsidized the costs. **These programs targeted people of color excessively and forced sterilization procedures on women of color**. When women of color would go to a health professional for something minor, such as having a cyst removed or a physical examination, doctors would simply perform the sterilization or lie to the patient regarding the procedure.

Infant Feeding

Racial and ethnic minority women continue to have lower breastfeeding rates than white women. For example, Black women continue to have the lowest rates of breastfeeding initiation (60%) and continuation at 6 months (28%) and 12 months (13%) compared with all other racial/ethnic groups in the United States. Minority women report many barriers to breastfeeding.

(Everyone Must Address Anti-Black Racism in Healthcare, 2021; Forced Sterilization in the United States, 2021; Forced Sterilization Policies, 2020; Racial and Ethnic Disparities in Breastfeeding, 2015)

Examples of Provider Bias: Race/Ethnicity

Peripartum Cardiomyopathy

What is peripartum cardiomyopathy?

Peripartum cardiomyopathy (PPCM), also known as postpartum cardiomyopathy, is an uncommon form of heart failure that happens towards the end of pregnancy or in the months following delivery, when no other cause of heart failure can be found. PPCM is most

What are the causes?

The underlying cause is unclear, and likely involves several factors. Research suggests that PPCM may be triggered by prior viral illness, nutritional deficiency, hemodynamic stress during pregnancy or an abnormal immune response. These causes have not been proven.

More recent research suggests that PPCM may be caused by the overactivity of certain hormones that cause damage to the vascular system. These hormone levels have been found to be higher in women with preeclampsia, which could help explain why they are at higher risk of developing PPCM. It is not clear why some women may be more predisposed to the effects of these hormones than others. Genetics or family history may also play a role, although most women who develop PPCM have no family history of cardiomyopathy.

Several risk factors include:

- Maternal age of 35+
- High blood pressure, including preeclampsia or gestational hypertension
- Multiple gestations (e.g., twins)
- PPCM is more common in patients who identify as Black or African-American, though it is not understood how race plays a role in the development of PPCM

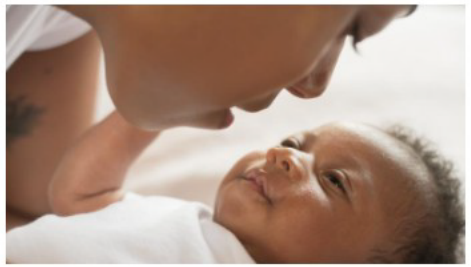
"Race is not a factor for illness and death, but racism, bias, and discrimination definitely are." -**Joia Crear-Perry, M.D**

Examples of Provider Bias: Race/Ethnicity Continued

RESEARCH FEATURE

Systemic racism, a key risk factor for maternal death and illness

April 26, 2021



When Joia Crear-Perry, M.D., an obstetrician and gynecologist, found "African American descent" listed by cardiovascular experts as a risk factor for postpartum heart disease, she realized even advocates like her were doing something wrong, and that the media was amplifying the error. With the U.S. maternal health crisis gripping public attention – and Black, American Indian, and Alaska Native women up to three times more likely to die of pregnancy complications than white women – correctly naming the causes matters, she said.

"Our use of language and our desire to raise awareness about the huge inequities encroaching on the lives of Black women have conflated, even equated, Blackness and disease," said Crear-Perry, founder and president of the National Birth Equity Collaborative, an organization that advocates for better Black maternal and infant health. "Race is not a factor for illness and death, but racism, bias, and discrimination definitely are."

There is no known genetic connection between skin color or melanin concentration and biological causes of maternal illness or death, Crear-Perry said, even if U.S. statistics might suggest so.

Systemic racism, a key risk factor for maternal death and illness | NHLBI, NIH

Dr. Crear-Perry challenged her colleagues claims that race and rejected the notion that race is a risk factor for peripartum cardiomyopathy.

"There is no known genetic connection between skin color or melanin concentration and biological causes of maternal illness or death, even if U.S. statistics might suggest so."

Examples of Provider Bias: Sexual Orientation

When members of sexual minority groups do seek medical care, many experience biased treatment.

In a 2008 study of Health Professionals Advancing LGBT Equality members, 34% of LGBT physicians reported observing discriminatory care of an LGBT patient.

In another study, 26% of HIV-infected patients reported perceptions of provider discrimination. These patients reported discrimination from physicians (54%), nurses and other staff (39%), dentists (32%), and case workers or social workers (8%).

Similarly, many directors of assisted reproductive technology programs reported that they would decline to treat a gay couple (48%) or a lesbian couple (17%) who sought reproductive services.

(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539817/)

Screening practices and beliefs of assisted reproductive technology (ART) programs: Programs' likelihood of turning away hypothetical candidates

Hypothetical candidate	Not at all or slightly likely to turn away (%)	Very or extremely likely to turn away (%)
The man in the couple has been physically abusive to his existing child.	5	81
The woman is HIV +.	26	59
The woman in the couple has severe diabetes, and there is approximately a 10% chance that pregnancy would lead to her death.	25	55
The man does not have a wife/partner.	37	53
A gay couple wants to use surrogacy, with one of the men as the sperm source.	44	48
The woman in the couple is addicted to marijuana.	33	47
The couple is on welfare, and wants to pay for ARTs with social security checks.	47	38
The woman does not have a husband/partner.	77	20
Both members of the couple are 43 years old.	77	18
A lesbian couple wants to use donor insemination.	82	17
The woman in the couple has a history of attempted suicide.	60	16
Both members of the couple have limited intellectual capacity—they cannot do much more than basic reading and math.	68	15
The woman in the couple has bipolar disorder.	66	13
The couple says that they want a child to replace their child who recently died.	77	9
Both members of the couple are blind from an accident.	91	3
Both members of the couple are Jehovah's witnesses.	99	1
The couple is biracial.	99	5

(https://www.fertstert.org/article/S0015-0282(04)02600-7/fulltext)

Provider Bias Impact on Patients

During roundtable and in separate interviews with the authors, Black female participants **recalled times that they did not seek treatment because they knew they would not be believed or be treated**.

They reported being more **mindful of their behavior—even when in pain—in order to avoid being perceived as angry, dangerous, or threatening.** They also recounted the **frustrations of needing to be an informed patient in order to guarantee their care and of being branded as difficult patients when advocating for their needs**.

Other participants spoke about **having to "credential" themselves to get treatment**: One woman said that during one hospital stay, she had to consistently mention her age and Ph.D. to receive help with a bedpan.

(https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/)

Key Concepts for Building Structural Competency

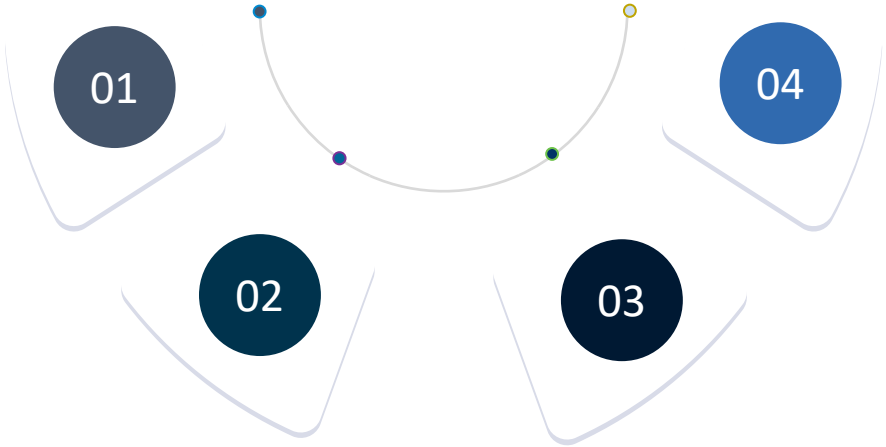
“Without proper context, social determinants lose their meaning and end up presenting disparities, such as Black women’s high rate of maternal mortality, as if they were natural phenomena… We haven’t really addressed the underlying root causes of the problem, so it’s easy for people to still blame and shame communities of color by using the social determinants frame.”

Joia Crear-Perry, M.D., Obstetrician and Gynecologist

From the NIH guidelines: https://www.nhlbi.nih.gov/news/2021/systemic-racism-key-risk-factor-maternal-death-and-illness

Cultural Competency Is Not Enough

As we aim to address a **multiracial population** in our field of work, we **strive** to become **culturally competent.**



We also may treat cultural competency as the **end product** rather than a **process**.

We may assume that
the **more knowledge** we have
of multiculturalism,
the **more competence** we have.

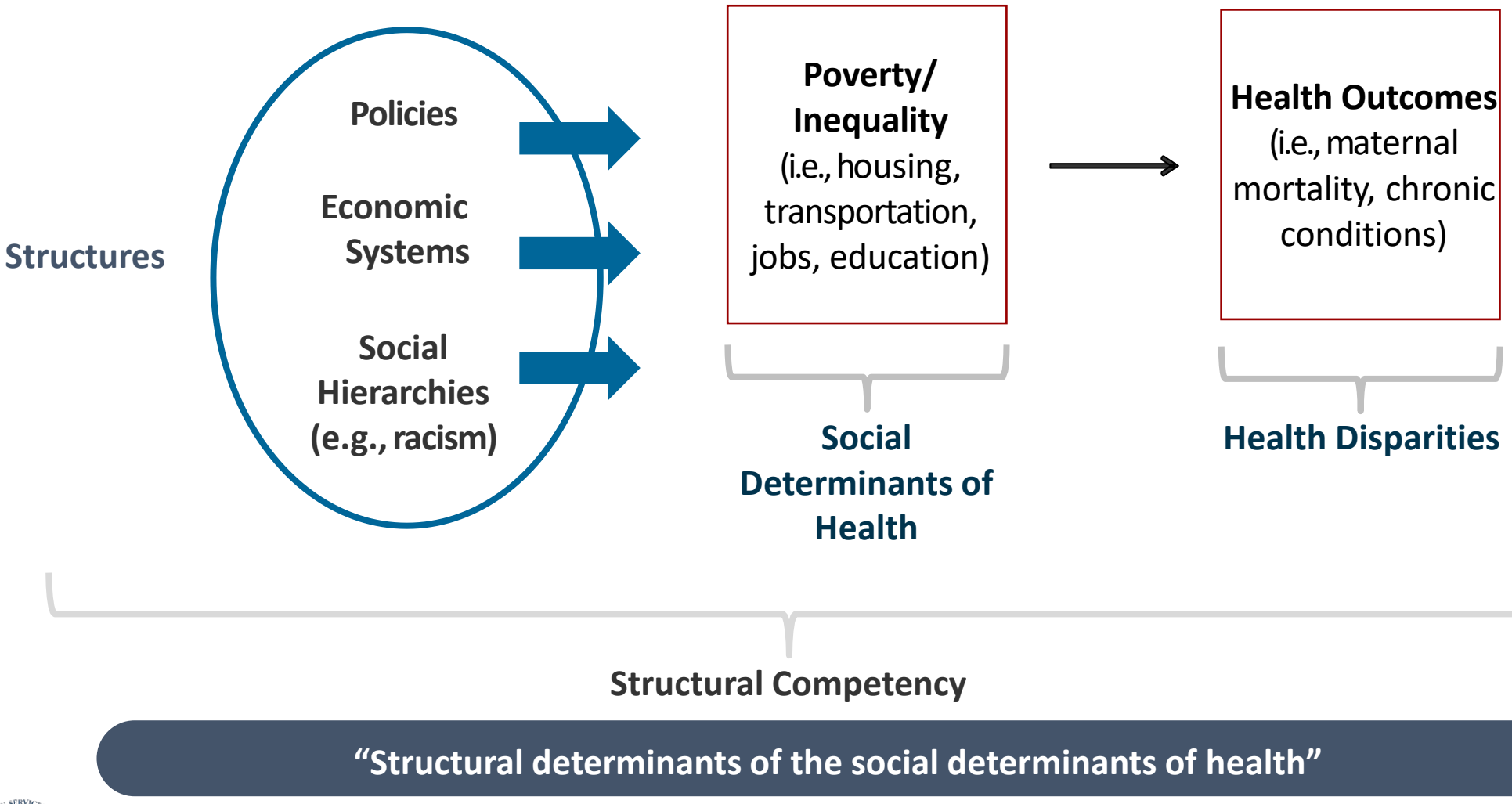
"Cultural competency" can suggest that there is **categorical knowledge** a person could attain about a group of people, which can lead to **stereotyping** and **bias**.

“We tend to conflate race with class and assume all the problems are due to poor women of color lacking access to care, but Black women at all income and educational levels experience bad maternal outcomes… And research is showing detrimental effects of some interactions between women and their health care providers – the way women feel treated due to the assumptions being made about them can hurt.”

Nicole Redmond, M.D., Ph.D., Medical Office, Division of Cardiovascular Sciences, National Heart, Lung, and Blood Institute (NHLBI)

From the NIH : https://www.nhlbi.nih.gov/news/2021/systemic-racism-key-risk-factor-maternal-death-and-illness

Structural Competency



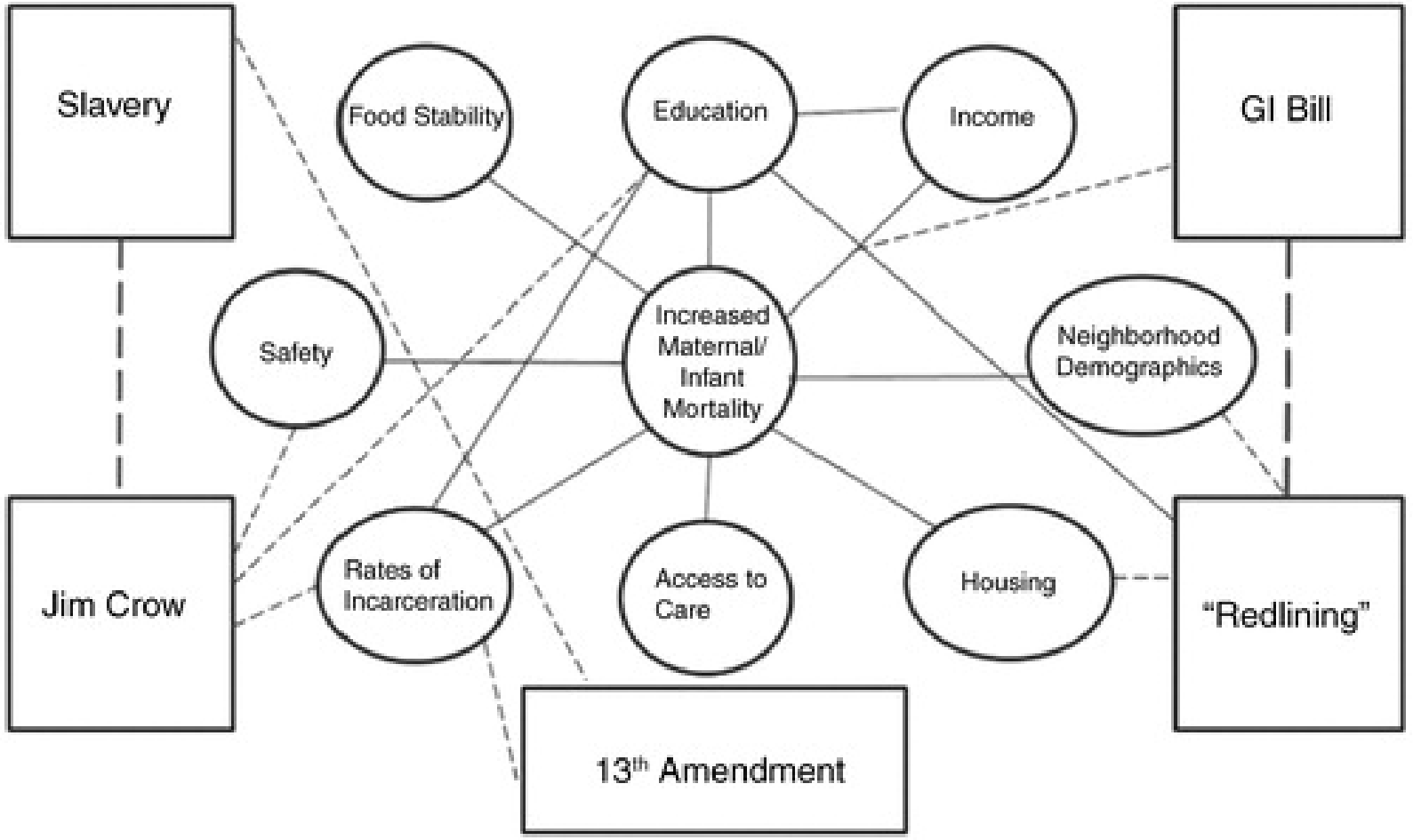
Structural Violence: refers to a form of violence wherein social structures or social institutions harm people by preventing them from meeting their basic needs. Examples of structural violence include health, economic, gender, and racial disparities. (Lee, B.X. (2019)).

Structural Vulnerability: The risk that an individual experiences as a result of structural violence – including their location in multiple socioeconomic hierarchies. Structural vulnerability is not caused by, nor can it be repaired solely by, individual agency or behaviors. (Bourgois et al. (2017)).

(Adapted from Lee, 2019)

WEB OF CAUSATION

STRUCTURAL and SOCIAL DETERMINANTS: IMPACT ON HEALTH



https://www.liebertpub.com/doi/10.1089/jwh.2020.8882

What does the structurally competent provider look like?

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They recognize the social structures that can influence and shape clinical interactions in the questions they ask in the history of present illness, social history, and discharge instructions.

They can see the how a patient's environmental "structure" can limit a patient's ability to make favorable choices that impact their immediate disease state and ultimately their overall health.

They do not attribute a patient's condition to racial or social stereotypes and stigmas; instead, the structurally fluent provider does not blame patients and recognizes the limiters to health maintenance and compliance.

They observe and imagine structural intervention. Structural fluency and competency becomes the spark that motivates the provider to become interested in public health, health policy, advocacy, and community engagement to better serve their patients.

They develop structural humility. They understand the influences of their conscious and unconscious biases, they recognize their limitations, and "deprioritize 'solutions' in favor of productive, active engagement with these issues" and cultivate their self-awareness.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7011415/

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Developing Structural and Cultural Humility

Structural and cultural humility can be viewed as three different factors:

01 Lifelong commitment to self-evaluation and self-critique

02 Institutional accountability and a desire to fix power imbalances (where none should exist)

03 Aspiring to develop partnerships with people and groups who advocate for others

(Tervalon & Murray-García, 1998)

Power and Role Differentials

POWER

Our ability to control events around us.

POWER OVER

Using influence or control over another person to get a desired result.

Recognize power imbalance

You have
- Knowledge
- Skills
- Access to resources

This power can create distance and mistrust

Be comfortable with not knowing

Be open!

Ask questions

Be curious

You are an "expert"

..BUT you are **not** an expert on their life

Source: Culturally Connected. www.culturallyconnected.ca

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Action: Explore a Person's Values and Beliefs

Where were you born?	What does your daily schedule look like?	What do you think makes you sick?	What type of treatment do you think could help?	
Gather information on background	**Learn about environment**	**Explore perspectives on health**	**Ask views and preferences**	**Determine spiritual/ religious practices**
How long have you lived here?	Who helps you when you are sick?	Why do you think the problems started?	Is there anything that has helped in the past?	Do you have religious or spiritual activities that are important to you?
	How many people live in your house?	What do you think keeps you healthy?		

Screening for Social Drivers of Health (SDOH)

Inquire
about physical health, mental health, and social needs.

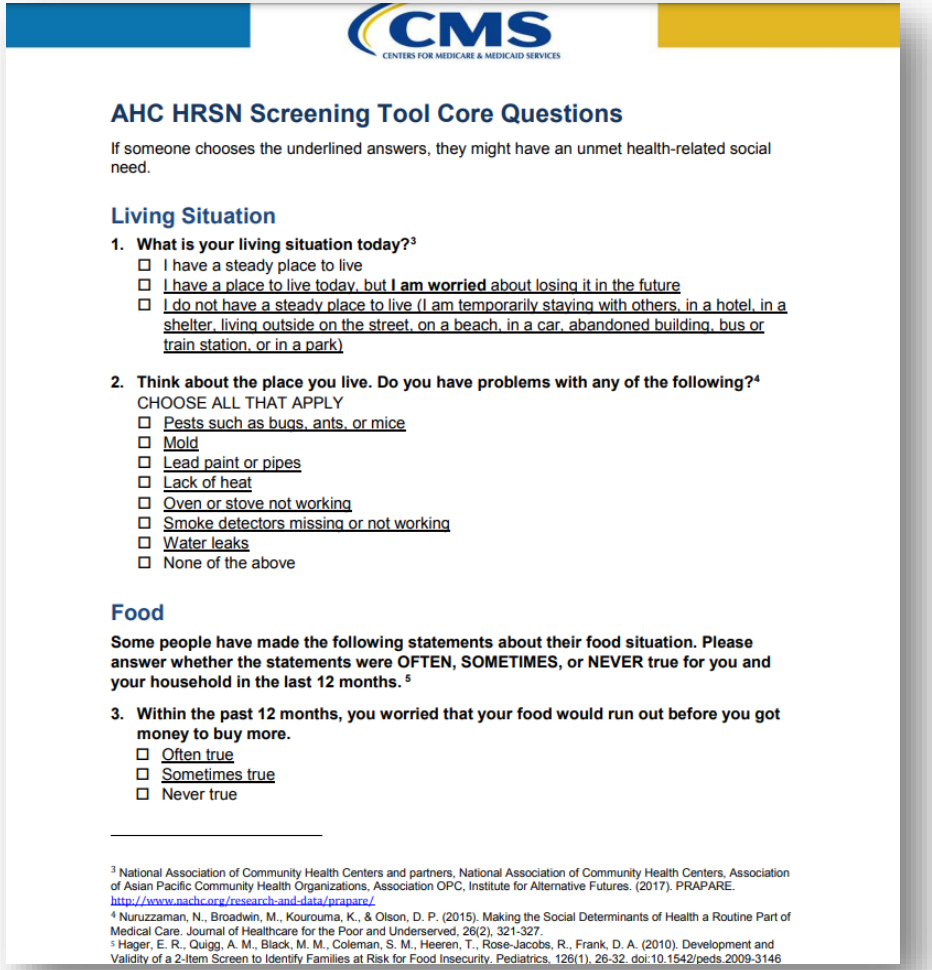
Explore
appointment and treatment adherence *and* troubleshoot related barriers.

Consider
need for support to follow through with or use services and resources.

Understand
readiness for change and use motivational interviewing (MI) techniques.

Examples of SDOH-Related Screening Tools

- The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS)
- Social Determinants Screening Tool (AccessHealth Spartanburg)
- Self-Sufficiency Outcomes Matrix (OneCare Vermont)
- PRAPARE Tool (Redwood Community Health Coalition)
- Community Paramedicine Pilot Health Assessment (ThedaCare)
- Social Needs Assessment (Virginia Commonwealth University Health System)



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

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Collaboration with Community Advisory Boards

Effective implementation of CABs

- Provide a safe space
- Be accommodating
- Time management
- Provide incentives that are relevant to the members
- Include culturally- and developmentally-appropriate activities
- Center and respect the voices of the members

A Community Advisory Board (CAB) is a collective of community members that provides community information and assistance to organization representatives on how to develop best practices that would be effective for the target population.

A CAB charged with discussing needs related to preconception care and sexual health would include clients that are similar to the population (receiving PCC/SH) that is being served by the organization.

A CAB can also be utilized to provide opportunities for clients to develop leadership skills as they are trained and utilized as peer advocates.

Building Relationships with Peer Advocates

- Reinforcing **cultural humility** asks providers to acknowledge that they may not always have the same language or life experiences to relate to the persons they support.
- Incorporating **peer advocates** with common backgrounds can help clients overcome cultural barriers that may exist between them and case managers/providers/nurses.
- Case managers and peer advocates can work very closely to **plan and implement activities** using language and interventions that are culturally relevant and culturally appropriate.

Building Culturally Responsive Services:

An Overview of the BESAFE Cultural Competency Model

Building Culturally Responsive Services

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

- Culture and cultural background in all its diverse representations — including values, traditions, and beliefs — are keys in determining a person's journey and unique pathway to receiving the specific care that they need.
- Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet an individual's unique needs.
- Providers should demonstrate interest in, learn about, and acknowledge cultural identities, values, connections, experiences, and considerations to provide services that align with multiple facets of people's lives and the languages they speak.

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BE SAFE Cultural Competency Model

- **BE SAFE** is a framework that uses culturally pluralistic content and perspectives based on these six core elements:
  - **B**arriers to Care
  - **E**thics
  - **S**ensitivity of the Provider
  - **A**ssessment
  - **F**acts
  - **E**ncounters

BE SAFE Elements

- **Barriers to Care**: Real or perceived gaps to providing quality care that are compounded by the relationship that HIV has to ethnicity.
- **Ethics**: A science of the human condition as it applies to the morality of beliefs, values, and behavior. The sources of ethics include reason, individual experiences, and societal experiences.
- **Sensitivity of the Provider**: Involves examining one's prejudices and biases toward other cultures, as well as an in-depth exploration of one's own cultural background.

BE SAFE Elements

- **Assessment**: The ability of the health care professional to collect relevant data regarding the patient's health history and present problems in the context of the patient's cultural background.
- **Facts**: An understanding of the physiology, behavior, and the patient's perception of his or her illness.
- **Encounters**: Achieving effective encounters with patients from ethnically and culturally diverse backgrounds by considering factors such as language, cultural norms, and concepts of personal space.

BE SAFE Case Study: Providing Care to American Indian and Alaska Native Communities

Ann Drobnik, MPH

HIV/AIDS: Providing Care to American Indian and Alaska Native Communities

"Culturally-specific interventions, developed in partnership with Native communities, have a great potential for success. The HIV/AIDS interventions that address culture and identity nuances are promising practices for AI/AN. Especially since culture and identity are protective factors against high risk behaviors."

BACKGROUND

An understanding of the underlying historical, cultural and structural factors that impact Native populations' communities is necessary in order to implement effective HIV community-level interventions. American Indian and Alaskan Native (AI/AN) tribes and villages are sovereign nations and, as such, have a right to determine HIV programming in their communities.[1] The tribes also have a trust relationship with the U.S. government, established through the U.S. Constitution and numerous treaties, that gives them access to direct services or direct funding for health care from the U.S. government. Despite this, Native people have the lowest per capita spending of any group that receives health care from the U.S. government, including members of the military, veterans and prisoners.[2] Native Americans living in urban areas face distinct challenges. They come from tribes across the U.S., and unlike other minority groups, do not necessarily reside among other Native people. In fact, some may not have any connection to other Native people. They can be invisible in large cities, often mistaken for another race. While some AI/ANs may return to their reservation communities, others remain disconnected from their culture and traditions. Further, the populations living in reservations tend to be geographically isolated, with minimal access to health services, particularly specialty care for HIV/AIDS. They often travel long distances for care, either because services are not available or accessible where they live, or due to concerns about confidentiality. Native people experience historical trauma and intergenerational grief as a result of forced displacement, break up of communities, and the loss of language and culture that have occurred throughout U.S. history. These myriad factors contribute to increased risk for disease, including HIV, among this population.[3] Connection to culture, community and identity has been found to be protective factors against HIV risk behaviors, particularly among AI/AN youth.[4,5,6]

DESCRIPTION OF BEST PRACTICE

American Indian and Alaska Native tribes and communities have a unique culture and history and a unique relationship with the United States government. To develop HIV/AIDS prevention programs and clinical services, understanding the context of history and culture and taking the time required to develop solid relationships with tribal leaders and community members, is vital. Best practices in HIV treatment provided to AI/AN populations must include factors that acknowledge sensitivity to clients' potential mistrust of federal health initiatives delivered to their community.

LEVEL OF INTERVENTION

Community

PROSPECTIVE USERS OF THE PRACTICE

Any agency or individual working with Native communities – Community based organizations, state health departments, universities.

PROBLEM ADDRESSED

Currently, very few culturally-specific, HIV interventions exist for this population. There are several reasons for this, including the lack of accurate data on HIV among AI/ANs, the flow of prevention and treatment dollars, a lack of culturally specific evidence based models, and a lack of understanding of Native culture and history among public health professionals.

PURPOSE OF BEST PRACTICE

To foster community partnerships that will address planning, development, implementation, and evaluation of culturally competent and responsive HIV counseling, testing, referral and prevention programs with Native communities.

CONTEXT

Native communities often face serious challenges to meet the needs of their people in regards to HIV/AIDS services. These include a lack of financial and human resources, including frequent turnover of clinicians many of whom do not have the linguistic experience with clients who have HIV/AIDS; understaffing issues; and lack of capacity to implement and evaluate population-specific interventions. Further, there are very few culturally appropriate prevention interventions available for AI/AN groups. Adapting and implementing existing evidence-based interventions is resource intensive and most tribal health programs do not have the capacity to create or modify existing curricula. HIV/AIDS disease is not the only health concern for AI/ANs. Many Native communities still struggle with disparate rates of co-morbidities such as STDs,[7,8] substance abuse[9], violence,[10, 11] and rampant stigma still surrounds sexually transmitted diseases. Yet, data to support the need for prevention programs and services in Native communities are scarce.

Surveillance data does not accurately reflect the problem of HIV/AIDS in Native communities, as some tribal facilities do not screen routinely for risk, offer testing, or report cases. Racial misclassification is also a factor in the lack of data. Native people often are mistaken and reported as people of other racial and ethnic backgrounds.[12, 13] In developing HIV programming and services in reservation communities, it is crucial that collaboration occurs with the tribal leaders. Due to the long history of broken promises to the tribes, building relationships with leaders like chairmen and council members, tribal health directors and other community stakeholders and a long-term commitment to the community is required.

BE SAFE Assessment Tools

- **BATHE** (Stuart & Lieberman, 1993)
  - Background, Affect, Trouble, Handling, and Empathy
- **ETHNIC** (Like, 1997)
  - Explanation, Treatment, Healers, Negotiate, Intervention, and Collaboration
- **LEARN** (Berlin and Fowkes, 1983)
  - Listen, Explain, Acknowledge, Recommend, and Negotiate

TYPE IN THE CHAT: Have you used any of the following assessment tools with clients?

Interactive Breakout Sessions – 15 minutes

Recipients will enter breakout rooms and must choose **one facilitator** to facilitate discussion and **one reporter** for report backs.

A document with the **case study** and **guided discussion questions** will be made available to facilitate information sharing and discussion.

Context: You are to read the scenario from the perspective of a clinician.

**CoP Teams and HRSA (Health Resources and Services Administration) may be attending breakout rooms to observe.*

CASE STUDY: Alex and Darlene

Alex is a 30-year-old Hispanic man who was diagnosed with HIV in 2001. His HIV risk group is multiple heterosexual partners. Alex and his wife Darlene (HIV-uninfected) have a 4-year-old daughter.

Alex is adherent to his therapy of zidovudine/lamivudine (combined formulation) and nevirapine, and he uses condoms regularly. His initial CD4+ cell count was 170/µL and plasma HIV RNA level was 3,013 copies/mL. On antiretroviral therapy his CD4+ cell count is 377/µL and his HIV RNA level is below 75 copies/mL.

Alex and Darlene have discussed having a second child but have not tried to conceive because of HIV transmission concerns. In 2002, Alex and Darlene began asking his physician questions about reproductive options. They were given several pamphlets on the topic but still had many questions.

Alex and Darlene are interested in pursuing safe reproductive alternatives that will assure mother and child safety, but they have significant financial concerns.

Group Report Backs

Please provide a **60-second summary** of the key points discussed in your group based on the breakout questions.

Action Steps for Providers to Engage in Culturally Responsive Services

- Prioritize openness and curiosity about a person's culture when building a relationship.
- Acknowledge when your personal beliefs conflict with a cultural practice of a person you support.
- Identify cultural strengths and supports that can provide support during preconception counseling and care.
- Adapt treatment goals related to preconception and sexual health counseling/care to reflect the individual's culture (not your personal preferences).

Final Poll: Call to Action

What is one action step you will use to improve your structural and cultural competency to better serve clients (who receive PCC/SH) who have a different cultural experience than you?

A. Explore my own culture, beliefs, and values
B. Develop awareness of my own biases
C. Assess reasons I may feel uncomfortable with people who are different from me
D. Believe that I can help clients who are culturally different than me
E. All of the above

Questions?

PCC Resources and References

- AETC-NCM Case Studies
  - Case studies of provider to patient encounters covering cultural gaps in gender, age, health literacy, trust and other socio-ethnic barriers. Cases also cover intra-ethnic variations among women and the need to avoid stereotyping in one's approach to care and treatment.
- A Guide to Using the Accountable Health Communities Social Needs Screening Tool: Promising Practices and Key Insights
  - This document describes the health-related social needs (HRSN) Screening Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening.
- BESAFE Cultural Competency Model
  - Includes all BE SAFE guides.
- Engaging in Culturally Competent Family Planning Counseling
  - Includes a scenario utilizing the GATHER and PEARLS methodologies to communicate with a patient.
- Patient-Centered Contraceptive Counseling
  - Contraceptive counseling may be subject to undue influence, such as a counselor's personal biases (implicit or explicit), pressure or coercion from a counselor or partner, or even the ideology of the institution at which someone is seeking contraceptive access. This study includes recommendations and conclusions regarding the intentional application of a patient-centered reproductive justice framework and use of a shared decision-making model.

PCC Resources and References

- Provider Bias in Contraceptive Counseling
  - This includes examples of provider bias that may show up in contraceptive counseling.
- Racism and Health
  - An overview of how systemic racism impacts health outcomes in vulnerable and/or marginalized populations.
- Racism and Health: A Reading List
  - A non-exhaustive collection of select research articles and books, both seminal and new, that describes how racism affects health and well-being and offers a starting place for further exploration.
- Structural Competency: What Is It, Why Do We Need It, and What Does the Structurally Competent Emergency Physician Look Like?
  - Salhi et al. introduce the academic emergency medicine (EM) community to the concept of "structural competency" and provide compelling rationale for why there is a need to move "Toward Structural Competency in Emergency Medical Education."

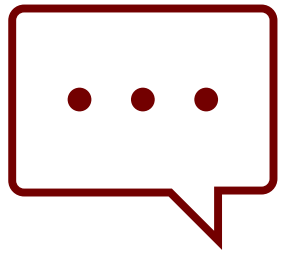
TA Session - Satisfaction Poll

How satisfied were you with the information presented in this TA Session?

- Very Satisfied
- Satisfied
- Somewhat Satisfied
- Dissatisfied
- Very Dissatisfied

I expect to use the information presented during this TA Session to enhance the care provided to women, infants, children, and youth served by our organization.

- Strongly Agree
- Agree
- Somewhat Agree
- Disagree
- Strongly Disagree



Continue the Conversation on MS Teams

- Have you joined the DCHAP CoP MS Teams Channel?
- Look for the 5 discussion threads
  - Key players in the provision of PCC
  - Cultural competency and PCC
  - PCC in a collaborative setting
  - Barriers to providing PCC
  - Electronic health records and PCC
- Share resources, continue the conversation, ask questions!!

FY 2023 DCHAP Chart Review guidelines will be available to Preconception Counseling CoP participants via a HRSA WICY MS Teams Channel site.

Participant Evaluation & Upcoming Events

- Learning Session #3 – September 20, 2023
- Curated TA emails – August 15, November, February
- Targeted TA- Fall 2023

Upcoming Events

CoP Learning Sessions and Action Periods (tentative dates)

- **July through August 2023** – Action Period #1 (PDSA specific activities, data collection and analysis)
- **September 20, 2023** – **Learning Session #3**
- **October through November 2023** – Action Period #2 (PDSA specific activities, data collection and analysis)
- **December 20, 2023** – **Learning Session #4** – Peer-to-Peer report out/combined summary session
- **January 2024** – Action Period #3 (PDSA specific activities, data collection and analysis)
- **February 21, 2024** – **Learning Session #5** - Final Presentations from each CoP Core Team

Leadership Check-in Calls with the Bizzell Team will be scheduled and occur monthly.

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Thank you for attending!