

## **WEBINAR VIDEO TRANSCRIPT**

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# **Addressing Health Disparities through Culturally Informed Research and Evaluation Design**

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INA RAMOS: Good afternoon, everyone. My name is Ina Ramos and I'd like to welcome you to the Minority Fellowship Program webinar, Addressing Health Disparities through Culturally Informed Research and Evaluation Design. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center. Before we get started, I'd like to draw your attention to some important webinar logistics.

Today's webinar is being recorded, and will be made available on the MFPC website in approximately four weeks. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the US Department of Health and Human Services. I now have the pleasure of introducing today's presenter, Dr. Suzanne Randolph Cunningham.

She's chief science officer at the MayaTech Corporation, which is an applied social science and public health research firm located in Silver Spring, Maryland. She directs MayaTech's research and evaluation division and manages federally and foundation funded complex multi-method evaluation studies focused on reducing racial ethnic disparities and promoting health equity. Dr. Randolph is also an associate professor emerita of family science at the University of Maryland, College Park, in the School of Public Health.

Her contributions include research on African-American children and families, as well as community-based and national evaluations of public health issues, health disparities and inequities, and research infrastructure and workforce development for minority health and health care professionals. Dr. Randolph, the floor is yours.

SUZANNE RANDOLPH CUNNINGHAM: Thank you. Good afternoon, everyone. How are you doing? Hope you're all fine. Want you to use the chat to chat with each other, as well as drop your questions in, as we go along, and someone will help me monitor those. The title of this workshop is probably more encompassing than what this presentation will be about.

But I was asked to focus specifically on models for collecting and coding race, ethnicity, and language data, as we do our evaluation designs and address health disparities in minority health research. So I will present two of those models and hope you'll be able to identify those at the end of this presentation. I was also asked to talk about challenges, and so we'll talk about several challenges in obtaining those data, whether you're collecting them yourself or obtaining them from administrative databases or electronic health records.

Hopefully, you'd be able to at least identify or recognize three of those, also explain the impact of cultural humility. We'll be giving you a definition for that and talking about it as a process more than a static concept, as you conduct your research and evaluation. And then we'll also talk about what a collection of skills are that you might want to acquire, in order to manage the cultural adaptations that might be needed to conduct research and evaluation with racially, ethnically, linguistically, or otherwise culturally diverse groups.

So let's start first with the federal government's definitions of minority health and health disparities. The NIH Institute, National Institute for Minority Health and Health Disparities, NIMHD is its acronym, has the lead among federal agencies to support research on these concepts. And so, on its website, you'll find these definitions. And these are important distinctions to have in mind as you're thinking about either applying for grants or developing grants that you have support for already.

So in the design of your research on minority health, for minority health or health disparities research, keep these in mind. Minority health includes the health characteristics and attributes of racial and/or ethnic minority groups-- and importantly, you must use the characteristics and attributes as defined by the Office of Management and Budget. We refer to it as OMB. You've probably heard of it, a lot-- who are socially disadvantaged due in part by being subject to potential discriminatory acts.

The other piece of this definition has to do with the type of research that falls within the category. And it examines singularly, meaning for only one of the racial and ethnic, recognized racial and ethnic minority groups, or in combination any of the following, the attributes, characteristics, behaviors, biology, and other factors, that influence the health outcomes of minority racial and ethnic groups, within group as well as between groups. And within group, we mean with reference to particular ethnic subpopulations, for instance, by country of origin, or by language, or some other designation within the overall main group.

So, to distinguish minority health from health disparities, you'll see that health disparities is not necessarily limited to the notion of racial and ethnic minority group or underrepresented group, or a group that necessarily has been socially disadvantaged. Primarily it may have been discriminatorily disadvantaged, so these groups would be included here. But they refer to health differences that adversely affect defined disadvantaged populations, based on one or more health outcomes.

Could be anything, diabetes, heart disease, or HIV, substance use, et cetera. And it examines contributing factors and underlying causes, to generate knowledge, to mitigate the effects, and improve the population health outcomes. The difference here that isn't explicit, but if you read in definitions of the strategic plans, for instance, for tribal nation, the strategic plan for sexual and gender minorities, you will find that this definition also encompasses other groups, like low-income groups, rural community groups, sexual minority, sexual and gender minority groups, disability, so it has a broader reach in terms of what we're speaking about.

But we're also talking with respect to some disparity, some gap that exist in terms of how these groups have differences in their health outcomes. In minority health, it might not necessarily be a comparison in terms of a disparate health outcome, it just might simply be the influence on that health outcome for a particular group. So the implications for research, as you can see, are important. If you're responding to minority health differences, you need to keep in mind that these do not necessarily equate to health disparities.

Oftentimes people equate even phrases like low-income with minority, so you can understand, probably many of you are of racial and ethnic minority groups, you can understand that, when people conflate those two things, it does not necessarily give us the picture that we need with respect to minority health. It may well be speaking more about health disparities due to what we call social determinants, such as low-income status, or where you reside, or the percentage of people living in poverty in the neighborhood where you live. So it's important to keep that in mind, so that their health disparities are broader than racial and ethnic minorities.

They can include underserved populations such as rural residents, who may not have access to care or insurance or providers, populations with less privileged socioeconomic status, regardless of race and ethnicity, or sexual and gender minorities regardless of race and ethnicity. So it's important to keep that in mind in research and evaluation, as you're looking at minority health and/or health disparities. And there's a lot of literature that NIMHD has led, actually, on this in recent journals, distinguishing minority health research, for instance, from health disparities research.

So to that end, then, what we need are different approaches when we're looking at these. A fundamental step, as outlined here, would be to bring the nature of disparities in the groups at risk for those disparities to light by collecting health care data, quality information, usually, which is stratified by race, ethnicity, and language. Often we might group our populations, we might say white and non-white, or we used to. Or now we say white non-Hispanic, and Hispanic, or Black non-Hispanic and Hispanic. Often language data are neglected, but we'll talk in a minute about how that's being captured as well.

And we need culturally competent researchers who can employ what we refer to distinctively as culturally responsive, which means that you're taking into account the context in which these racial and ethnic groups are located, but also health disparities groups more broadly located. And you're responding to those contextual differences, as well as what we refer to as culturally accountable approaches. And those apply more to what we call system-level outcomes, where we want to change structures. Structural barriers, like you've heard the term structural racism, institutional racism, increasingly in recent days.

The culturally accountable approaches are those where we know that we can distinguish enough to make more informed, data-driven policy decisions or programmatic decisions, based on how we code for race, ethnicity, and language. And we'll show some examples of that later. Before we go on to these models, if you have any questions, just reminding you again, if you do have questions, to go ahead and drop them in the chat. And we'll either take them real time or we'll get back to them at a breaking point.

In this session, I want to talk about those couple of models that we have for collecting and coding race, ethnicity, and language, and I refer to it as REaL data. There was a CMS Center for Medicare, and Medicaid Services had a REaL data project, and it was looking at race, ethnicity, and language, in a pilot way. But I looked for more recent evidence about ways and strategies to collect these data, and that literature doesn't seem to have expanded since when they did this a half a decade ago or so.

So I'm referring now to the national sources of federal agencies that are responsible for collecting data, and the Office of Management and Budget, OMB, has certain requirements about how these data are collected, as we've mentioned. So you use the US Census Bureau, there's the census that was just recently fielded and completed, the American Community Survey, the Behavioral Risk Factor

Surveillance System, or BRFSS, as you might hear it referred to by its acronym, Youth Risk Behavior Survey, the National Health Interview Survey, Centers for Disease Control and Prevention's household pulse survey, which has been being collected every month now amid the COVID pandemic, the National Child Health Survey, which is collected annually, the pregnancy survey which looks at reproductive risk for maternal and child health outcomes, the ACEs, which are the adverse childhood experiences survey, the nHANES, the National Hispanic nutrition survey, and then SAMHSA has some of its own data sets, some examples which we'll use on later slides. National Survey on Drug Use and health is one of those.

Now let's take a little poll here. As I mentioned, the census is one of those data collection instruments where we rely on our race, and ethnicity, and language data for that matter. In what year was the first US census collected? Just select any one of these. When you're done, just click Submit.

And we'll be able to see what your responses are. In what year was the first US Census collected? You probably know that it's typically done in a year that ends in 0, and every 10 years. So I didn't try to put 1992 in here, but in which of these years do you believe the first US Census was collected?

OK, be sure to submit. OK, great. 1790 is the correct answer. So we know that this has been going on for centennials now. And this issue of race and ethnicity has also evolved over those years. And so we're going to talk some about that, and then I'll give you another poll also with respect to race and ethnicity and how it's been captured.

Today, we use a two-part race ethnicity question. As of 1997, the OMB issued standards that said there must be at least five categories, and you must also ask about the respondents, whether the respondent is Hispanic, of Hispanic or Latino origin. So these are usually flipped with the first question being, are you of Hispanic Latino origin?

And I have seen in other places Hispanic Spanish or Latino origin. And you answer yes and no. And then you are also requested to respond to the second part, which is, of these five categories, how do you self-identify yourself. And those are white, Black or African-American, American Indian, or Alaska Native, Asian, native Hawaiian or other Pacific Islander.

So at one point, you may have seen Asian/Native Hawaiian, Asian/Native Hawaiian/Pacific Islander, and some people use that in their research. But the federal agencies require now a separation of Asian from native Hawaiian or other Pacific Islander. Also American Indian or Alaska Native is the language that the federal government uses. Some people use Native American and so forth.

But there is a special strategic plan for collecting data with tribal nations that you can probably Google or go to federal, the dot gov, at NIMHD.gov, and find the resource, and we'll talk in a minute about how limiting that is. Black or African-American, that too has evolved, as you know. It was Negro, colored, Black American, African American, hyphenated African-American. But Black or African-American is not Black American or African-American. It's also thought about to encompass Blacks who might be of Latinx descent or Caribbean descent or came from Europe or Africa, the continent.

And so it includes African immigrant populations who are now citizens and identify as American, and so forth. And then white. There's no designation here, but you'll see when we look at the groups and the classifications and the definitions, there's more that's been added with respect to white as well. And you

can also check for more than one race. So in what year did the OMB-- this out, another poll-- in what year did the OMB recommend removal of the term Negro from the US Census categories?

So here we do have off-years, because of course you have to plan for the upcoming census. So in what year do you believe OMB recommended removal of the term Negro from the US Census categories? You have to phone a friend or something like that? Google, we'll give you a few more seconds. 1867, 1953, 1969, 1997, 2017, or 2020, make sure you submit.

OK, Ina, that's plenty of time. 1969, 48%, OK? And then a few above that, a fifth of you, at 1953. And then most others after 1969. I would imagine 1969, because of the Civil Rights movement and so forth. But the date, Ina, can you reveal for us, and this would be a surprise to you all, can you close that and reveal?

INA RAMOS: Sure.

SUZANNE RANDOLPH CUNNINGHAM: This will be a real surprise to you.

INA RAMOS: The year is 2017.

SUZANNE RANDOLPH CUNNINGHAM: It's 2017. This will be a real surprise to you, I'm sure, because it's so recent and it was just prior to this last census. So it may not have been that the category said Negro, but it may have been in the description of who's in that group that the word Negro still appeared. And so there is documentation at OMB on comments that came in, because the OMB does receive comments, and you may well know about the recent census, there were lots of comments about when it should close and who should be counted or not.

Similarly, you can make comments about how race is being collected, language and ethnicity, or other data for that matter. So 2017, so you know we have a ways to go now, in understanding the research on minority and minority health. And then, similarly, on health disparities also, as we talk about the fact that health disparities can include these broader categories of race and ethnicity, as well as other disadvantaged groups.

Any questions? Are there any questions. So let's talk about the first of these models, and that is the census model. And, as I just pointed out, you have two items. Are you of Hispanic Latino or Spanish origin. And then there are lots of words for you to read and figure out which of those you select, but simply it's yes or no. I believe they also allow you to say refuse to answer.

And then the second question is, what is your race or the person's race. Sometimes this is done with interviewers or interviewees, and interviewees by chat or phone, or in person, for that matter. Amid COVID, a lot more was done in mail surveys and online surveys. So you self-identified. So let's talk about each of the categories.

As I mentioned, it might say white on the form, but there is some specificity about who to include in that group. The category white includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. And then they provide you with some examples, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Caucasian, and Chaldean.

So, yes, there's more information for you to make that determination, in case, and I'm being sarcastic here, in case you might have some confusion about where you fit, but it does create some confusion, if you have the continent of Africa included, and you also have a category Black or African-American, and that category says African immigrant or African descent and so forth. So there are some blurred lines, Black or African-American again, it includes individuals who identify with one or more nationalities, and these again can be groups who originate here in the United States, or it could be in the Caribbean.

It could be anywhere in the world, for that matter, in what we refer to often as the African diaspora. But it's not limited to African-American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, and so forth. And then within these groups, as you know, there would be subgroups and categories. So on the continent of Africa, it might be by country, but it also might be by some tribal affiliation, and so forth.

American Indian or Alaska Native, so yes, thank you, Steve. So we have the category labeled as American Indian or Alaska Native. And it's all individuals who identify with any of the original peoples of North and South America, including Central America, and who maintain tribal affiliation or community attachment. So, again, you might have some blurring of the lines, because now you have people who might have checked that they were of Hispanic, Spanish, or Latino origin, who were also from South America or Central America, and so we don't have clarity on that.

But we'll talk about ways in which people are trying to do that in their research and evaluation projects. It also includes people who identify as American Indian or Alaska Native. And it then names some of the groups, Navajo Nation, the Blackfoot tribe, Mayan, Aztec, Native Village of Barrow Inupiat, traditional government, and Nome Eskimo community. Again, in the strategic plan, NIH strategic plan for tribal health, which goes through fiscal year 2023, you'll find more details about recognized tribes versus unrecognized tribes, and subcategories here as well.

And it might be useful for you, if you are pursuing research on American Indian or Alaska Native populations. Even if you are yourself of one of these categories, it's important to keep educating and informing yourself about these issues, because oftentimes we are making comparisons or we're making judgments or we're, in our discussions, making conclusions based on what people previously found, where those people in previous years may be using other categories of race, other definitions of who's in and who's not in the group. So it's important to stay abreast of those changes historically, as well.

INA RAMOS: Suzanne?

SUZANNE RANDOLPH CUNNINGHAM: Yes, question?

INA RAMOS: One question did come in, pertaining to the white category.

SUZANNE RANDOLPH CUNNINGHAM: Sure.

INA RAMOS: Can you expound on why Egyptian is included?

SUZANNE RANDOLPH CUNNINGHAM: Sure, so you also, I believe, saw in the white category that North Africa is included. And so, as I said, I believe that people may have made some judgments or provided some rationales, and we do get, we the federal government, collectively does get comments about how people are being classified, and so forth. I would imagine that there has probably been some comment

for Middle East and North Africa about being classified in the Black or African-American group, for instance.

Such that these groups self-identify in the white category, so that's not unusual. So again, when you're doing your own research and evaluation, it may be important for you to try to understand, if you have that luxury, and aren't using secondary data or administrative data, more about country of origin and more about how people self-identify. Many people are of multiple races as well.

So you might also look to see, are they identifying white and. But you'll see in many people's descriptions about how they treat these data, for instance, with Hispanic, Latino origin, many people revert back to using Latino and Latinx now as the category, by lumping anybody who checked that they were of Hispanic origin, but then you may nullify those who might be Afro-Latino, for instance, or Euro-Latino, and so forth.

So this is real tricky but also real critical, when I talk about culturally accountable, like how confident are you that you're telling the true picture, by lumping everybody into these five categories. Another question I think was, can you expound on why Egyptian is included, and that relates to the North African content. But interestingly, I think you'll find, and one of our staff members is on the line, we have other North African countries in that region, but they aren't lumped into the white category.

But I'll show you a different model. This is just one model. So when I'll show you the next model, you'll see how the federal agencies and researchers at large are trying to broaden how we collect these data. So for instance with Asian, the groups I just showed you, you don't have the luxury of checking these additional subgroups, as you do with Asian. So the category Asian includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent.

So some people will, of Indian origin, East Indian origin, will identify as white. Others will check Asian. There's been more, I guess, willingness, maybe, a social desirability, and less stigma attached to how one self-identifies, perhaps. And so we are getting a clearer picture, because we now also ask, if you check Asian, we don't ask to check Asian. We ask, check one of these boxes, basically.

And I'll show you in a minute how it's actually printed out on the census. But it includes Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, et cetera. But these are the choices you get to make. And if you don't fall in one of these, then you pick other Asian. And these are the words from the census. I didn't make these up.

So someone commented, that it sounds power and financially based, based on time when the census was created, or fielded, yes, indeed. And so that's where accountability comes in. But that's also where these notions of structural racism and institutional racism come in, that we have systems that align with certain groups, being able to have more people self-identify as white, let's say, than Black or these other groups, or be afraid to identify as Hispanic, Latino because of immigration issues and so forth.

So there are lots of issues that we probably will never know about, unless we also do some of that deeper work, qualitatively or even quantitatively, with the specific groups. Native Hawaiian and Pacific Islander, as I mentioned, has been pulled out. This is one group, and it's still not unusual that people just lump it back together with Asian. But in a recent project that I'm completing with other racial ethnic

minority affinity groups, the Asian-American Association of Asian and Pacific Islander psychologists, keep reminding us, when we do our reporting, when we do our analysis, our tabulating, they want Asian and they want native Hawaiian or Pacific Islander, as two distinct groups, though native Hawaiian and other Pacific Islanders are still grouped together.

And they give you examples here, native Hawaiian, Samoan, Chamorro, Tongan, Fijian and Marshallese. So the territories of the US, where we have populations that want to sub-identify, because it might be important that the Marshall Islands keep track of their census data, because these things are also attached, as one of the Fellows has commented, or alumni, has commented that these things are attached to money. And that's why there was so much comment about the most recent census.

So it attaches to what percentage of the population lives in a certain district or area, political district. It attaches to what kinds of moneys are needed and what kinds of programs are needed, if you have a certain percentage of different ethnic groups dispersed in different areas of the country, and so forth, by census area. OK, so if you do check, then the individual Pacific Islanders also have checkboxes, for people who so identify, and can check native Hawaiian, Samoan, Chamorro, and then the other box.

INA RAMOS: Suzanne?

SUZANNE RANDOLPH CUNNINGHAM: Yes.

INA RAMOS: Just wanted to highlight a comment that came in: "As a Pacific Islander myself, Pacific Islanders are often considered as Australo-Asian."

SUZANNE RANDOLPH CUNNINGHAM: OK, so again pointing out that this connection to a part of the world that is not necessarily Eastern Asian, Southeast Asian, China, and so forth. But there are other connections that people can make. And I believe you might have the opportunity on census to actually write in now what the other is, and that those data help census in this next decennial make decisions, too, about the granularity they would like to have. Thank you for the comment.

So, in terms of this method, census data are often used in those surveys that I pointed out to you, the federal agency surveys, often the only types of racial, ethnic, and language data that are collected, and we'll talk about language later. And so in these test data, the treatment episodes data set from SAMHSA, I have circled in red race and how it's captured in that data set, white, Black or African-American, with a hyphen, American Indian or Alaska Native, Asian, or native Hawaiian, or other Pacific Islander. So there's a place where we know census captured it as Asian is one group, Native Hawaiian or other Pacific Islander as its own group, but they were lumped together.

Why? Because there's low episodes or low incidence of substance use, 1% there or so. So probably to report it out differently, perhaps the researchers or contractors who work with SAMHSA said, that would not be any more meaningful than just saying 1%. But that's what their position is. But in a culturally accountable way, it may well be that the Asian sub-group and the native Hawaiian/Other Pacific Islanders sub-group, look very different within that whole constellation.

And then there's this group of other. And we don't know what that is, but 7.2% of them means that they have a higher incidence of using substances after white or Black. So we need to know who those people



are. What are their races? So it would be, is that some combination with Asian, with Black, with white? Is that the Hispanic group that didn't identify as one of these other groups. So but that's an unknown.

And then there is something called unknown, because people either skip the item or they chose not to report it. With respect to ethnicity, then, it's pulled out here. And as I mentioned, some might say white non-Hispanic, white Hispanic, and give you all the subgroups. Here it's just been pulled out, and we have Hispanic or Latino, not Hispanic or Latino, and again, these are census data.

Many people are using the x on the end, like Latinx. But Hispanic or Latino or non-Hispanic or Latino, and this is really capturing everybody, including, I should say, everybody above as well. So it's suggesting that groups who, or anybody within those groups, who designated Hispanic or Latino, might actually have lower substance use, 13.5%, as compared to all the others. And again still we have a 4.2% who prefer not to answer or didn't answer at all.

This is important just so that when you're reading data and you're trying to compare what you found and do your discussions, or you're doing your literature review to do the statement of the problem for your research and evaluation, that you're relying on data like these, data that may be limited with respect to what you want to be, what I refer to as culturally responsive to. So but the way our federal government collects these data may not permit you to make certain statements that you believe or hypothesize, because you know your group more intimately. You may have to do some additional data collection to get at that, either directly with your populations, or with people who are well-versed and well-known or gatekeepers, as they like to refer to, or other stakeholders in the population.

So in the census Household Pulse survey, which I mentioned, has been going out monthly, amid COVID, trying to get at mental health, anxiety, depression, coping strategies like using drugs or exercising, attitudes toward vaccinations, and so forth, you'll find a lot of literature using the Household Pulse survey. Or you have Hispanic, Latino, or Spanish origin, census, what is your race? So this is the two question, two item, my model.

And you'll see here it's not just yes or no. It's no, not a Hispanic, Latino, or Spanish origin. But if you said yes, there's a forced choice of yes, Mexican, Mexican-American, Puerto Rican, Cuban, and then there's a yes, another Hispanic, Latino, or Spanish origin. The census does allow for some of that as well. And we'll show you that in a minute.

And then, what is your race? And you can see it's taken the five main categories that census spoke about as well as the way that it was approved for census data, with Asian having its subcategories, the green circles. Other should be included there as well. And then native Hawaiian and other Pacific Islander having its own subgroupings. So that's fielded by CDC using census data. And here's, I don't know if you're familiar with CDC's Wonder data query system, but you can get a lot of data from [Wonder.CDC.gov](https://wonder.cdc.gov).

You can go in there and query. But here's an issue. What do you see as a takeaway here, looking at the left text box, circled in purple versus the data query on the right. So on the left is how OMB recommends at a minimum you collect data. And on the right is how you can query in CDC Wonder. What do you see as a takeaway? Just put a few responses.

Humor me. Put a few responses in the chat box for me. What do you see as the takeaway here? If you wanted to go query data in CDC Wonder. Are we getting any chats? I don't see anything. OK.

OK, well, what I see was that Asian is separated from, OK, thank you, Erica. Thank you. Thank you. OK, so we have a couple of different things here. One is that, looking at the Asian separation from native Hawaiian or other Pacific Islander, we can see census recommends some minimum data collection. But the query has locked this as Asian or Pacific Islander. It's even thrown out native Hawaiian, for that matter.

So that is an important distinction, that if you want to use this Wonder database, maybe you won't be able to do that. You can, with the Wonder database, though, tell or ask whether you want all ethnicities, Hispanic, or Latino. Yes, some people mentioned that, again, it might be a structural problem. Who are the personnel that came up with the formulae for the data queries, and so forth?

These inconsistencies can lead to difficulties in interpretation, if you don't have these distinctions. So for lots of reasons, just knowing that the information you're looking at was based on census data race, language, and ethnicity categories, does not ensure that you will have the data you need to make decisions about exploratory questions or hypothetical statements about what you expect to find, based on race in minority health research, or if you're using race and ethnicity in health disparities research. These are some of the sources where you might go for data.

We do know, amid the COVID pandemic, for instance, that vital statistics, like the reports of cause of death or hospital records on admissions, and so forth, were not maintained uniformly across states or localities in terms of reporting by race and ethnicity, and I doubt by language, for that matter. And so we do have that problem. The federal government, because it's a structural problem that requires culturally accountable approaches, the federal government and some states have tried to address it by mandating or requiring that people also report some statistics about race and ethnicity.

So, yeah, maybe marriage licenses get reported by race and ethnicity. But do they report by sexual and gender minority status? Do they report by rural and urban locations, these other measures of disparities, that NIMHD says it's important. Erica says it also shows that the government isn't prioritizing respecting differences in identity. And I can't read the other, the rest of that, but, yeah, these are the issues. Anything else you see, issues in using these types of data?

You have electronic health records that many of you enter data into or rely on for your decision-making. Information management systems, administrative data are things like the reports we have to make to the federal government for child welfare or substance use treatment, housing status, HIV status, and so forth. The intake forms that we use at these agencies, and perhaps some people are still using manual forms, paper forms, but some of that is on electronic records and other electronic databases, how are data captured about race, ethnicity, and language there, and do they resemble or align with some of the definitions the federal government has used?

Oftentimes they're dictated by that, especially if you're receiving federal government moneys, either through block grant or special set-asides, or a grant specifically for some reason. And then your client surveys, satisfaction and evaluation surveys, and then there are multiple uses for these. The way we do our reporting, and increasingly so, people are doing diversity, equity, and inclusion audits, not just on the service population, but also on the workforce, so and to track that diversity.

And so HR and the board and the executive director and the medical officer or the clinical officer in charge of psychological services, all have to be on the same page with respect to how we collect these data, if we're going to use these data to drive decision-making and be culturally accountable. And again, that's different than the responsive notion, because often with the responsive notion, we're relying on context, and having worked with the community, understanding it, and so forth.

Doris says there can also be language variation in college accreditation data, so very important as well. Often people only speak to English as a second language, but what does that mean about what the primary language is, right? Everybody gets categorized as ESL, but what does that mean when we're looking for ways to improve or be more equitable with respect to all people?

OK, thank you. Any questions in the chat? I see nine comments. Some people use the National Center for Analysis and Statistics, along with the Department of Veterans Affairs, to collect data on veterans populations. Thank you, April.

Here's the second model, a little more detailed, a little more involved, still a federal model. And then we'll talk about its advantages over just the census two item solution. But you can go and include the link, so that you can go and investigate more on this. Probably the more of a research and evaluation geek you are, like I am, then maybe the more interested you might be in this, but also, as a clinic administrator, as a professor, as a policymaker, as a university administrator, or a mental health or substance abuse behavioral health administrator, you might want to know about more nuanced ways of understanding who's getting services, or to whom you need to deliver services, or who you need to include in your evaluation and research protocols, in order to give us a more equitable picture about what's going on, and therefore remove some of these barriers to health equity and racial equity.

So this is called, I'm calling it the OMOP, Observational Medical Outcomes Partnership. That's the acronym that you will see in the literature. And it's referred to as a common data model. And the idea here was that we have so many different electronic health records, of vendors, and we have other ways, REDCap and other databases, that we use to collect data. It was trying to provide a platform when the federal government is handing out grants to multiple communities and multiple institutions, to collect data that it then wants to leverage and use to make a difference.

And so, in order to do that, all of us, if you're familiar with it, is collecting tens of thousands of pieces of data or data on tens of thousands of individuals, that then gets rolled up and used so that we'll have a common data set, and have what we call harmonized data. And the idea here is that we need standard ways of talking about these data. We need vocabularies and we need definitions and coding strategies, in order to get these data harmonized.

So this is an attempt at doing that. And this will then enable people, who are using different epistemologies, ontologies, theories, and theoretical frameworks, to guide your study, people who are drawing from different data sets, a study-specific one, or one that you're pulling from census of BRFSS or household survey or the VA, or wherever you're getting it, to think about how can I make my race, ethnicity, and language data in more harmony, if you will, more consistent and aligned with what others are doing. It's a relational database.

So what that allows you to do is to pull data from different sources and also look at relationships among data within different data sets and provides different ways for you to access it, so you can then curate

your own data set. It tries to do, as I mentioned, standard vocabularies for you, in how to capture the data, especially with electronic health records. And then they try to also have domains.

So you all have heard social determinants of health. So one of these models we'll talk about, the social determinants of health, that's a big domain. But within that domain, race and ethnicity and language often fall. And so there's some guidance about how to capture race and ethnicity. So if you do want to compare your data to others, or you do want to use it as a basis for understanding your data, once collected, in terms of extant literature, you can. And so we will have domains.

And then you have definitions and descriptions of what those are and what's all included in there. And then there is all this stuff behind the scenes in terms of the metadata, and ways that your programmers and others might want to use, so that you can go in and retrieve the data. There is another platform called Athena, that you can click on, and it will give you some of that standardized vocabulary. Even if you don't use the OMOP, you can at least get some ideas about how others are thinking about this.

And then I went to a site called GitHub Wiki and they give you even more details and specificity with respect to this OMOP. So let's look at a couple of things that rely on this kind of harmonized common data set model. And one is the health disparities pulse at NIMHD. And you can click again on [HDPulse.NIMHD.NIH.gov](https://HDPulse.NIMHD.NIH.gov).

And you can see it's fairly recent, June 7, 2021. And there you can go in and you'll find maps and a data portal, as well as intervention portals, that might have data about the types of populations that you're interested in. Again, it would be important to understand, though, first, how to query on the racial categories and subgroups, so that you can use systems like these.

And OMOP can help you with some of that, by understanding that Asian may have lumped Asian, native Hawaiian and Pacific Islander, for instance. Or that Egyptian is going to be found in white categories, and so forth. And then there's what's called the PhenX toolkit. And this toolkit was designed because NIH has a lot of clinical trial data, and it's trying to harmonize data across some of these randomized controlled trials. And so it was launched, and then there are lots of different domains in there.

But within the domain, within the domain collection, NIMHD launched the social determinants of health assessment, which I referred to earlier. And so there you'll find how to measure food security, housing stability, economic stability. These are factors that, in and of themselves, could be protective or risk factors, typically risk factors in health disparities or minority health research, especially with socially disadvantaged groups. You can go in and see how other people are measuring this. And they will also have the protocols there for you.

So if you're thinking about, if there are some researchers here who are thinking about applying for federal grants, or even if you are a program or service delivery person, and your agency is trying to get a grant, you might want to see how other people are measuring these things, because they might resonate with an NIH or a SAMHSA or a CDC or HRSA. So the toolkit provides you with these resources, defining the variables for you, defining and giving you lots of detailed description about how to use it and how they have been used, and even some original sources for the protocols. And so it's a way, again, to get just a common data set.

So in the project I mentioned, where we're doing this National Assessment of the Impact of COVID-19 on Mental Health with the National Psychological Associations, we use those social determinants of health protocols across our studies, so that, for instance, we might all have the same measure of food security, for instance. And so that's one way to use it, but there are others as well. Are there other sources of real data, any more, that you would like to offer?

Does anybody use PhenX tool kit or HD Pulse? You can feel free to go in there now and skip around and see. Just give you a screenshot here, and then I'll go in and just click on a few buttons. So in HDPulse, this is the NIMHD newly launched site, you can see, you can query on all races. And when you do, it comes up as all races, including Hispanic. You get white, including Hispanic, and within white you get white Hispanic or white non-Hispanic.

In Black you get not Hispanic/Latino, and you get, I mean, and you get Hispanic/Latino. In Hispanic/Latino you get any race. And in American Indian, Alaska Native, you can also get Hispanic, non-Hispanic Asian. Pacific Islander is combined in this data set, as opposed to native Hawaiian and other Pacific Islander. So you have to make choices when you go in, or you're going to have to do some combining and so forth when you're looking at this one.

You can see that you can select Asian only, or you can select native Hawaiian, or other Pacific Islander, if your topic area is American Indian, I mean is Asian/Pacific Islander. OK? Next, please. Steve, can you go in and click on the HDPulse link for me? Keep clicking. OK.

OK, so you can see it expands and defines all these terms that we've been talking about, under the definition slide. Why don't you go up to the data portal and just click on Explore. OK, and you see, you can click any where here, any state you're in, and find out the data that you want in terms of outcomes. The outcomes might be more limited than what you're looking for. But if you're trying to do your literature review and say there's a gap I want to fill, this might be a good place for you.

Which state was this, Colorado? Yes, OK, and so you can get trends, and you can also get race trend comparisons. And so feel free to skip around in a site like this, and it'll give you lots of information. Again, there will be limitations for sites like these, because you might want to compare multi-race people to single race people, and things like that. And you might not be able to, but it will at least give you a start of what's happening.

Thanks, Steve. We can go on to PhenX, interest of time. But I encourage you to go, and we've dropped it in the chat. Skip around and look at some of these things. It will help you in designing your research. But, again, if you want to, it'll be informed largely by race and ethnicity and how it's been captured or collected. But then you'll have to bring your own sense of cultural awareness and knowledge to your design, as well as your data collection procedures, because you probably better understand that than maybe some of the groups that collected these data.

OK, now we're in the PhenX toolkit. Why don't you go back just a minute to the slide 26, maybe, the one that had HDPulse and PhenX. So in the PhenX, I mentioned you can get the protocols, for instance. And so, again, this allows us to compare across studies.

So there might be some items that all studies used. And when you go and pull those studies, you want to look for that item. Let's say anxiety and depression, which can be requested in any number of ways,

right? You could ask about the past two weeks. You could ask about the past month, or 30 days, the past year.

Amid COVID we were asking about the past two weeks. And we were asking about symptoms, how often have you experienced any of these symptoms? But we used the four item patient health questionnaire. Others use a nine item questionnaire. Some use 24 items, and so forth.

But you would want to be sure you have at least some confidence, again, in the quality of the data. So you want to make sure that you select a study that did the past two weeks, and perhaps use the patient PHQ-4, Patient Health Questionnaire Four, and not compare it to one that used annual, in the last year, how anxious did you feel, and they use the full 24-item scale. So and it also will give you information about how it's scored as well.

So with the anxiety and depression, you could score it as the two items for anxiety, you could sum them and say I'm just taking total symptoms. Or you could use the clinical approximation of clinical cutoff, which is scores three and above are considered enough concern to warrant more detailed assessment. So depending on what clinical care setting you're in, or research setting you're in, you need to understand all those.

And rather than spend lots of time going through the data doing literature searches and so forth, web science searches and so forth, you can come to a tool kit like this and get some of that information. With respect to race and ethnicity, you can do the same thing. So for both, you can find out whether anxiety and depression was collected on different racial ethnic groups, and whether there are data available. So you can go click on that source, Steve, that's fine.

So here they give you the rationale. And then click on Protocol. And go down, and you can see it'll tell you, basically, they're using the census version that I showed earlier. And go back up and click on publications, underneath protocol. They have none for this protocol. It probably came sourced, maybe source says American Community Survey or something, yes.

So it shows you it was the same thing we showed for the census. You already know some of the limitations of that. But then they give you references that you can consult about that. There's one in there some might be interested in, understanding the quality of alternative citizenship data sources, for instance. OK, let's move. Any questions?

But there are loads of data and domains in the PhenX. So you, again, can get almost anything in there, if it's been collected in a clinical trial or in an NIH supported research grant in the last five years or so. I'm giving you lots of resources, don't have time to go through them all. We did have to go through these.

We had a rapid turnaround time on our COVID-19 assessment. We had to get data collected in six months, with five affinity groups. And it was quite monumental, but we were able to do it. So in the OMOPs, this approach, we call it culturally accountable, because you will be able to get levels of specificity with respect to ethnicity, in particular, not just whether you're of Hispanic/Latinx or Spanish origin, but other countries of origin.

And so it allows you to expand the codes for race concept if you're so interested. So I hope you can see it on this next slide. We've laid out the four pages of terms that are in the OMOP. I don't know if you can

make that any larger. But basically, on four pages they lay out for you the countries of origin that a person might also select from, or that are captured in their standard vocabularies and protocols and ways they're recommending to harmonize the data.

So with African, with Black or African-American, or with other groups for that matter, you might have African, then you have African-American, Alaska Native, American Indian, American Indian Alaska Native, Arab, Asian, Asian Indian, Bahamian, to Tobagoan, Trinidadian, Jamaican, OK? So this is a way that you can get more of that specificity within the Black or African-American group, for instance, that maybe you might not have captured elsewhere.

And I think it also allows for multiple races. But there are four pages of all these terms and concepts, that are available there for you. OK, also in the OMOP you can see now how that can get used, right? So by asking for more of the specificity, such as the country of origin that Blacks come through, you might be able to make more informed policy and practice recommendations. So that perhaps you're learning that populations that have inter-generational ancestry in the Caribbean, even more specifically, Jamaica, for instance, you can find out what their percentage of substance use is or not, what their other health outcomes might be, educational outcomes, percent poverty, and so forth.

That's not to say that it's always available, but this is that attempt to move toward this harmonized data collection, so that we can get more culturally accountable, if you will, particularly around policymaking. So you had census data collection is one way to frame your race and ethnicity questions, and then you have the OMOP or PhenX and HDPulse tools that you can use to find other ways. Haven't gotten to language yet. So I'm going to go quickly through the challenges in trying to collect the real data in health care settings, which is one of our objectives I was charged with.

I'll talk really high level, and then you can read for yourselves on the slide. But one, and many of you mentioned it earlier, in your comments in the chat, one challenge is minimizing the inconsistencies across the data sources, particularly in terms of how data are captured or collected in the first place. And we've talked about that. But also in terms of how they're recorded.

So some clinics have people still self-identifying the client or the patient's race and ethnicity. Others have the client self-reported, but they have them write it out and it might be illegible, so you can't read what they wrote. Some audio record it, and some have Zoom, as we're doing now, with Telehealth and so forth. So there are lots of variables that figure in when you're trying to collect quality data in this arena.

Then how you code it, so you can decide that, OK, only 1% or 5% for that matter, of my population is non-Black, and so I'm just going to code everybody as non-Black. Or do you still want to try to capture those non-Black groups, so that, if one of your goals strategically in your agency's plan is to increase racial equity, or the numbers of people across racial categories, you would have that fine detail, so that you can track across time whether or not you're increasing people in certain categories. How are the data managed?

Some people take it, and, as you saw earlier, they just recode it and collapse it into groups anyway, even though you took the time to collect it specifically. And then how are data analyzed, of course, many of what we call the decolonized methodologies, or suggesting that you do non-comparative work. Even though we have five affinity groups in this COVID-19 study, we report in dis-aggregated ways, and we

also don't try to line our data up alongside each other by race or ethnicity, so someone isn't visually inspecting and saying, oh, the Asians are doing much better and so forth.

Sometimes it's unavoidable, but when you have control and power, or are empowered, with respect to conceptualization, design, data collection procedures, sampling, and the analytic strategy, interpretation, justifying the conclusions, all along, and reporting, and disseminating, all along the research and evaluation spectrum, you want to make choices that will help you inform the people, the beneficiaries, of the work, the people who really you want to have benefit in practice or policy from this. So keep that in mind as you go through all these stages of the research. The second big, oh, this is just an example we've already pointed out, many of these.

Let's take a minute to kind of look at this and give me your sense in the chat. If you look at A and compared it to B, just all look at what they're studying. But if you just look at the racial ethnic categories, since we're talking about the challenge of inconsistencies, tell me what inconsistencies you might see between A and B, or A and C or B or C, for that matter. Just pick one and give me your ideas. This was pulled from one of the national data sets, and it's for the state of Louisiana, my home state.

And it's talking about premature death in A, not feeling so good physically in B, and then just overall demographics of the Louisiana population by race, ethnicity, in C. OK, so one main inconsistency, again, with respect to race and ethnicity, April says B does not include American Indians/native Alaskans, but C does. So is it because there was less than 1% of the population in that American Indian/Alaska Native category, that the state chose not to report them?

But that might be an important population. Louisiana is a state where there is a sizable population, of American Indians, anyway. So that's 6/10 of a percent of 100,000 people, of a million people? Might be meaningful, you know, it might be practically meaningful. And so, again, you want to make choices that are informed by your understanding of the context, and the culture as well. Anybody else?

It's hard to know where Louisiana Cajun are reported. Where did census say to report it? Census said that Cajun was white. But would Cajuns self-report white? I don't know. But, because this might rely, probably did rely, on census data, it probably got reported in white, which also includes the Hispanic/Latino in B, and in A.

OK, so Shana says, does it double count people and/or only count some Hispanic people of different races separately? I'm not even entirely sure how to ask that, but it's always bothered me. So some people will report both ways. If you remember, in one of the earlier slides, it had white, including Hispanic/Latino, as it does here. And then others that said white non-Hispanic, and then, at the bottom, it said ethnicity, Hispanic or Latino, any race.

And so, again, it's an important question. You're asking the right question in the right way. What you want to look for are the footnotes or the methods for these types of reports. Often we get the two page summaries, and you want to look in the methods. For instance, in one of the slides I'll show you, it said that it was asking about children. But the child's race is based on the mother's race.

So that excludes any children who might be multiple race, biracial, or multiple race, if the mother is singular race. So you can see the problems that could proliferate if we don't take care in one, understanding the populations that we want to do our work on anyway, and then going into the



literature or these kind of databases and understanding how these categories are defined, or how they were collapsed, and so forth. So here we also in B get foreign-born, OK?

So that's 4.2%. Now would that make a difference to you now, that we have 4% of the population, certainly not 0.6, but we don't have that in B, saying, during the past 30 days, when an adult's physical health was not good. We don't know how many, maybe immigrant populations. And this is foreign-born in the last four years, meaning people who came in, in 2013 to 2017. Danielle, you're unmuted. You want to say something? OK. You had a question, Danielle?

No, OK. Thanks.

DANIELLE: No, I'm sorry.

SUZANNE RANDOLPH CUNNINGHAM: Oh, no problem. OK, but if you look in A, you have white, Black, regarding a double count, you have white, Black, American Indian, Alaska Native, Asian Pacific Islander, all include Hispanic/Latino, and then you also have Hispanic/Latino, any race. That seems like a double count.

OK, again, don't look at what's in the dots. Just know there's a pink dot or coral colored dot and a blue dot. Probably you can discern that, whatever the blue group is, has got more of whatever it is we're measuring than the pink group has, for most groups. Right? And so that's true for white and non-Hispanic whites, and for Blacks and for two or, and Blacks, and for Asian and Native Hawaiian and other Pacific Islanders.

You can see for Blacks, the pink has even less than anybody. Pink is women, blue is men. Wonder how they came up with that concept. And then you also see that, for the Asian groups, it was important to distinguish Asian from native Hawaiian and other Pacific Islander. Says please move this window away from the shared application. Don't know what's happening.

But, anyway, that circle group up at the top, in the middle there, those are two different groups that otherwise might have been collapsed by another researcher. And you can see here that, by taking the native Hawaiian and other Pacific Islanders out, this is marriage rates by men and women, the women in the native Hawaiian and other Pacific Islander group, the lower pink group, don't get married as frequently as the women in the other Asian group.

But men seem to be about on par with each other in those two groups. And then, for the other groups, some other race, two or more races, you can see there's parity for some other race, not any of these five main categories. And for two or more races, even though blue is doing better than pink for most groups, blue does worse, men do worse, or men, or not, I shouldn't say worse. Men are less likely to be married than are women, if they report that they are biracial or multiracial.

So it can be important to have these distinctions, depending on your research question. OK, you can chat away if you saw anything else, also. I did want to point out that that slide, the slide, when you get the slide that, the slide we just saw, that's the slide where it's on infant mortality, but the race of the infant is based on the race of the mother. And these are federal data.

So again, you have to look at the fine detail, that little stuff way down at the bottom that you really can't read in the slide on the right, is going to give you that information. Another challenge is, we've been talking about this, addressing racial, ethnic, linguistic, and cultural nuances. Again, you can have more than one race, come from different countries of origin. Ethnicity has to do with more than country of origin. It has to do with what region of that country, your heritage, your tribal affiliations, your religious beliefs.

There's also inter-generational ethnicity. So I am of Caribbean descent, but I was born in the US. But my parents were born in Jamaica. I might want to know that about my Black population, or my grandparents were. The immigration status has become tricky because of all the problems with immigration in recent times and currently.

And then preferred language, language is often skipped and, as it is now, we're going to have little time to address it. But I'll do as good a job as I can, in the minutes that remain, and still give you five minutes. Preferred language is very important. Even in the COVID-19 assessment that we just did, I led the Association of Black Psychologists portion, which was focused, of course, on Black and what we call Africaners, anybody in the African diaspora. All the other organizations asked about preferred language in the home, at work, in school, and so forth and so on.

And the Asian subgroup had nine languages, actually. And so but we didn't ask that question in the Black subgroup, even though we have people of Caribbean descent, of African immigration status, and so forth. It was just a cultural context thing, an assumption we made that, if you're going to take this 30 minute online survey, which is only in English, then we had to do an inclusion criteria for our B approval, that said, it was people who self-identified as able to speak, read, and write in English.

But that was a choice we made in our research design. And then, finally, the reason that it's important to know whether it's not just the preferred language, but whether they have more than one language, even though I speak Spanish and English, both fluently, I might want to tell you my story in Spanish, because I can just express some of the symptoms better. I can use some of the idioms and metaphors and storytelling that my grandmother passed on, about an ache or pain. So there's a book called, *What Language Does your Patient Hurt In?* by Salimbene, and it's more than a decade old, but it's got some great strategies for how do you address this language thing.

Oh, this is just an example of how people can write, and if they want, if they're white, whether they're German, Irish, English, Black or African-American, what country they come from, and so forth. This is census data. This is one of our affinity groups. The Indigenous Wellness Research Institute had to collect information on tribal affiliation. And, in addition to that, they also asked for whether you were indigenous from Mexico, Central America, or South America.

So even though census asks, and groups and lumps those groups, for this purpose of the needs assessment, the Indigenous Wellness Research Institute also specifically asks the participant to self-identify. So in barriers for language, you probably know these if you are working with multilingual groups, or are yourself bilingual or multilingual, people often want to use interpreters or translators. But those have some cultural nuances that you need to pay attention to. In *What Language Does your Patient Hurt In*, there's a good overview of that.

But, for instance, don't try to use Google's online Spanish interpreter necessarily, or your voice recorder on your phone necessarily. Yeah, and don't try to use the patient's child or the patient's mother or father, or adolescent's mother or father, necessarily. So we do need to pay attention and understand the cultural context in which these interpreters, and/or translators, I say and/or because oftentimes you can capture it in their language and yours, and then you have other people then translate it. And that relates to the methods.

Some people simply take the language, if it's not English, and translate it to English, but they don't back translate it to the person's preferred language, or vice versa. Also think about the original sources, of ways you're going to collect the data. Is it self-report? Are they online? Paper, pencil, Zooming, you know, what makes the most sense in terms of being able to accurately capture quality data?

And then, again, your purpose, and where you are. You might not want to capture that in a non-private setting. Maybe in a private setting you could, and understand fully that any context influences what's going on. And another thing I learned from one of my organizational development friends is that you have to understand culture, whatever context you're in.

And that culture always wins. We can have as much research rigor, and pay as much attention to cultural adaptations, but it's probably the culture, the cultural adaptations part of that, that's going to win. We do use census data some time, because census instructions come in 13 languages. However, you should, 59 languages, are use to collect data, so there's only 13 instructional packages, 13 different languages, for the instructions, but there are 59 languages.

So that means somebody is being left out in terms of the guidance they're getting. Also think about doing a glossary of terms of the English or the other, or the primary language, and educating staff and front desk staff, clinicians, providers, researchers, research assistants, and your community gatekeepers or promotores, and navigators can help you with some of that, community health workers. And CDC has what's called a language template or guidebook.

If you just Google that, that will help you have a way to organize all those terms. And then, finally, the class standards. These are the federal culturally and linguistically appropriate service standards. You've probably heard us talk about these in other cultural competency workshops in this series. I'll go through it quickly, just so that, when you Google that, the class standards at, I think it's at, [thinkculturalhealth.gov](http://thinkculturalhealth.gov), when you do Google the class standards, there's a link.

It'll be in the slides for you. Look for standards 5 through 8, which are about communication and language assistance. Some of it is related to who to use as individuals and their competence and who to avoid as interpreters or translators, and both for print material, oral presentations, as well as any electronic formats. And then this notion of cultural humility.

There's a lot on this slide, but I put it all there for you, so that you understand that cultural humility is not a simple static concept, that I'm going to be humble or listen more. It's not just that. It's also a measure of self-reflection and self-assessment. You have to understand what you know and what you don't know.

And then try to understand who can you go to or where can you go to get the information that you need, so that you can be better prepared to collect data, conceptualize your research designs, code

data, interpret data, use data, even, to make decisions about what treatments to use or what evidence-based practices to select, and so forth. So it's very important that you understand more about this notion of cultural humility being a process, and that it is an ongoing process. There is no end.

And it does relate to these notions we use in IRBs of beneficence, and justice, do no harm, and the equitable treatment of all people. Finally, I leave you with a set of skills to help you manage through this whole process. In addition to all that you've heard so far, I mention that, throughout the research project from conceptualization to analysis and dissemination, you need to apply your best cultural competency skills and often become very proficient at these things.

But there are other things you need to do, too, just in managing people, conflict resolutions, the power imbalances that can result, the use of technology, and how limiting that can be. But in a world that we're in, that's likely to face us and continue to be a mode of interacting with people. And so I encourage you to review this list with all of those things in mind, and self-assess the extent to which you are competent or not, along these.

I leave you too with, when you go to the class standards, don't just look at the communication and language ones, but also look at the accountability ones. The fact that this is a continuous improvement process, you have to keep doing this. Almost daily you have to get up and prepare yourself to go in and face whatever you're going to face, if not personally, at least even technologically. And so the class standards give you some guidance on how to do that and [thinkculturalhealth.gov](http://thinkculturalhealth.gov) also gives you many of the evidence-based strategies for doing so.

I apologize that we have so much to get through. There's a couple of minutes here. I do, I will answer any questions that I can in that two minutes. But if you do have them, pose them in the chat and I will work with Ina and the MFPC to get you a response or a resource where you can look for yourselves. Thank you all.

INA RAMOS: Thank you so much, Dr. Randolph. So we'll just do this one question here. Besides presenting the results, how can researchers truly give back to the communities directly that provided study subjects, that is, give back in a tangible way, that is as enduring as possible, publication life.

SUZANNE RANDOLPH CUNNINGHAM: Yeah, so I'll give you two examples. One with a substance abuse prevention project, substance use prevention project, we do community briefs. We just do infographics or graphs, simple language, and you can go to CDC for the plain language. And it gives you many examples of how to translate your research findings into community usable, community friendly tools.

We call ours the community brief. The other is for the COVID-19 assessment, what we're doing is we have different briefings for different types of audiences. And we use what's called a dissemination matrix. So for the people who funded us, the foundation execs, we do one type of briefing, all virtual right now. For the Urban League and Congressional Black Caucus and Congressional Latinx Caucus, we do a different type of policy briefing.

And for the community we're doing Zooms, and we're inviting all the participating organizations to invite whomever they want, up to 1,000 people per Zoom, and we're going to do breakout rooms by community and state to share our findings, for each state. We had six states. And then they can ask all the questions they want.

And then we will put links on our website where they can follow up with us. Sorry it had to be brief, but I'm happy to follow up with you more, if you have a specific project in mind that you want to do that translation for. Thank you.

INA RAMOS: Thank you so much. So, again, thank you so much, Dr. Randolph. And we want to thank all the participants for joining us today on the webinar. We hope that you'll be able to utilize the information presented to strengthen your work. In closing, we would like your feedback on this webinar. Before disconnecting, please select the link found in your Zoom group chat, to complete a brief feedback survey.

SUZANNE RANDOLPH CUNNINGHAM: Thank you.

INA RAMOS: And this will conclude our webinar for today. Thank you so much again.