Live webinar recorded March 13, 2019

Developing a Culturally Competent Workforce for a Culturally Diverse Population

Transcript

Jenny Inker: Good afternoon and welcome to today's live event. We're so pleased you could join us. I am Jenny Inker, Gerontologist and Joint Program Director of the Assisted Living Administration Specialty Area at Virginia Commonwealth University Department of Gerontology and also your host and moderator for the webinar today. Our webinar today is part of our seven series in the mental health and aging training initiative, which brings together the geriatric mental health planning partnership in collaboration with the VCU Department of Gerontology and the Riverside Center for Excellence in Aging and Lifelong Health.

The series has been funded by a great from the Virginia Center on Aging and we are most grateful for their continued support. This initiative has produced a library of 20 webinars which have attracted close to 5,000 attendees. As a reminder, all of our webinars are archived and all resources and materials are available for review and download for free. A couple of housekeeping items before we begin. We kindly ask that you help us out in continuing this free offering by taking five minutes to complete the demographic survey which we shall send by email.

Certificates of attendance will be made available one week after the event. To receive your certificate, you will have to complete the exit survey which should popup following your exit from the webinar and which will also repeat by email. Today's interactive webinar titled Developing a Culturally Competent Workforce for a Culturally Diverse Population will address a timely topic and will feature Karla Almendarez-Ramos and Dr. Susan Elmore.

Karla Almendarez-Ramos is the manager of the City of Richmond's Office of Multicultural Affairs. Her job is to oversee the city's language, access, plan, implementation, ensuring city services are accessible to diverse cultural communities and others with limited English proficiency. The plan includes development and implementation of outreach and employee trainings. She supervises a team of five which includes two interpreter or translators, a multicultural outreach specialist, and administrative liaison and a language access coordinator. She graduated from University of Phoenix with a degree in business and marketing and has taken Hispanic marketing communication courses at Florida State University. She is bilingual and bicultural, Spanish and English and a trained interpreter.

Dr. Susan Elmore's career in health care includes a breadth and depth of diverse experiences. 40 years of caregiving with persons with disabilities in older adults. Over a decade as a medical facilities inspector for the Centers for Medicare and Medicaid Services. At the Virginia Department of Health and many years working with persons of all ages with intellectual and developmental disabilities and/or physical disabilities. She has a PhD and master's in business administration and health care management, is a qualified intellectual disabilities professional, and a therapeutic recreation specialist. She is an advocate for quality of life, care, and supports for the person and person-centered health care. Many years of lived experiences have formulated her advocacy.

Our webinar today will begin with two presentations which will be followed by a question and answer period. To submit your questions, please use the questions tab on the control panel on your screen. Feel free to submit your questions throughout the presentations. Following the presentations, I will share your questions with our panelist and we will address as many as possible in the time remaining. Also, please note that our webinar today is highly interactive and we will be issuing several polls throughout the presentations which will require your attention and fast input. Please mark your answers directly on the screen when you are prompted to do so. Without further ado then, I'll ask Karla to begin her presentation. Karla, the microphone is yours.

Karla A. Ramos: Thank you, Jenny. It is a pleasure being here and I'm honored to share this time with you and all of our participants. I am going to be switching right now to my screen.

Jenny Inker: Excellent. Karla, we may have a little problem with your audio. Let's see how it goes and if we're still having the problem, then we might be able to ask you to switch. Let's give it a go and let's see how it is.

Karla A. Ramos: Okay. Thank you very much. Welcome again and, first, this is Developing a Culturally Competent Workforce for a Culturally Diverse Population. It sounds like a lot and it maybe for many of you. We would like to know a little bit more of who is participating in this webinar to cater a little bit of the information and some of your needs. Jenny will take over from here and walk you through our first poll question.

Jenny Inker: There we go, great. We would like to know what type of setting you work in. Do you work in the government or education or university sector? If you work in any of those, go ahead and select that option. Do you work in long-term care, perhaps you work in an assisted living community or in a skilled nursing facility? If you work in any kind of long-term care setting, go ahead and select that option. Perhaps you work in acute care. Do you work in a hospital or perhaps an urgent care setting? I think if you work in a primary care setting I know that you're not necessarily be acute care but you might select that option or do you work in a community health or social services setting? That could be a wide range of different settings or perhaps our poll doesn't explain your setting. In which case, go ahead and choose other.

Our two presenters today are interested in knowing what type of setting you work in. We'll give you just a minute or so to make your selections and as soon as most people have voted, then we'll go ahead and share the results with you. Choose your sector. Here we go. All right. Almost half of your work in a community health or social services setting, 43% of you. Then, just under a third at 32% worked in the government or education or university sector. 19% of you work in long-term care either for an assisted living community or a skilled nursing facility for example, and 6% of you worked in another setting that we didn't list. We don't have any participants today working in an acute care setting. Karla, back up over to you.

Karla A. Ramos: Thank you, Jenny. I don't know why.

Jenny Inker: All right. Do we want to run another poll on occupation of our participants? Again, bear with us and let us just briefly gather a little more information about you so that Karla and Susan can gear their presentation to your needs. Are you an MD? Are you a physician or a registered nurse, perhaps a nurse practitioner or a licensed practice nurse? If you're a physician or a nurse, go ahead and select that first option. Perhaps you work in administration or policy development or training, that second option would be for you. Is your occupation based in the long-term care facility? If that's the case, then you'll select

that third option. Perhaps you are in one of those ancillary services. You're an occupational therapist perhaps, a physical therapist, a language therapist, therapeutic recreation or activities professional. Go ahead and let us know if that is your occupation. Then, if you don't see your occupation listed there, go ahead and select others so we can just get a sense of the range of occupations that the audience is coming from.

We'll just give people a moment there. All right, what we have here. Wow! Okay, so 44%, just under half of you have selected others. You may want to use the chat box to tell us who you are, but we see that just over a third at 35% are in administration or policy development or training. 12% of you are licensed health care professionals either physicians or nurses of some type. 5% of you are occupational therapist, physical therapist, speech and language therapist, therapeutic recreation specialist or an activities professional. 5% of you are attached to long-term care facilities. Thanks for sharing that. Karla, back over to you.

Karla A. Ramos: Thank you, Jenny. Now, I'm going to make sure that we ... Our objectives are here and I'm going to cover the first two objectives and Susan will cover the last two. The first one is learn the difference between cultural awareness and cultural competency. It is important that we all speak the same language when it comes to this terminology and for that purpose, we're going to have an activity that because cultural competency is such a vast topic, I want to make sure that you are able to experience in some way what it is to be from a different culture. We have a case study based on a YouTube video and we will implement this way in a set of poll questions because we wanted to work with you and some other workplaces may have different settings for accessing content online especially YouTube. I'm going to set up the case study and you can put yourself in that position.

Imagine a young woman entering the emergency room. She is holding a crying baby. Her expression shows anguished, stressed, desperation, and she seems in a hurry. She reaches out the reception desk and starts speaking really fast that her baby has a high fever, that she can't stop the fever. The baby is continuously crying and she needs help immediately. She speaks English, so nobody around her nor does anyone understand her as they each point to forms or address each other in an unintelligible language that she doesn't know. The receptionist starts speaking louder and asked other people in the waiting room if any of them speak English, nobody steps up. The frustration escalates. The baby continued crying and the scene becomes chaotic to the point the mother runs through the doors, screaming, and looking for help. Now, remember this scenario and now Jenny will help us with a few questions to gauge what you know and what you consider will be the best way to act, Jenny.

Jenny Inker: Thank you, Karla. You've just had the scenario of the mother appearing with a sick baby, frantic, not easily making herself understood. What would you do if you were this mother of the sick child? Would you do the same thing as the mother did in the case study that Karla just read to us? Would you wait in the room until help arrived? Would you leave and find another hospital? Would you demand help from the receptionist or are you not sure what you would do? In which case, you would select I don't know. Bearing in mind that you're imagining yourself in the shoes of that mother with a sick baby and no one speaks English but you do and cannot make yourself understood, which of these options do you think you would do? We'll give everybody a chance to vote here and as soon as everybody has had a chance to do that, we'll publish those results and share them with you.

Again, picturing yourself in the scenario of this case study, which of these options would you choose? We'll just give people just a minute more to make their selections. All right. Thank you very much for voting. We see that the majority of units splits fairly evenly across the number of different options. 28% of you would leave and find another hospital

whereas 24% of you would demand help from the receptionist. Between those two, that's almost half of the audience. A fifth of the audience at 20% says they would do the same as the mother in this case study did. You'll see it says video but it's in the case study that we just read through. 15% don't know what they would do and 13% would wait in the waiting room until help arrived. Back to you Karla.

Karla A. Ramos: Thank you, Jenny. I also wanted to invite Susan to share what will be her selection and also you, Susan, what would you be selecting?

Susan Elmore: I think I'd probably leave and find another hospital if there is one available.

Karla A. Ramos: Okay. What about you, Jenny?

Jenny Inker: It's such a tough scenario. It just wrings my heart to even think about it. I think I'd probably be tempted to leave but I think I'd still be frightened about it.

Karla A. Ramos: Well, I can tell you that my choice will be to wait in the room until help arrived. One of the reasons because that's my culture. I think in an Hispanic culture, we are raised to do not go against authority in some way. The receptionist will know better and people from the hospital will know better. My initial tendency will be to wait in the room until help arrive. The reason I say that and probably we have a higher percentage of people leaving and being more action oriented or demanding a better service that can be a characteristic of a different culture, more American culture and action, demanding in some way. We can move to the next question.

Jenny Inker: Okay. Here, we'd like to hear your views on. If you were the hospital staff in this scenario, what would you do if this happens? What would you do if presented with a very distressed woman with a sick baby? Would you call security? Would you try to calm her down? Would you call your supervisor or are you not sure what you would in this scenario? Again, if you were a hospital staff in this scenario and somebody presents it, you could not understand them, they could not understand you. They were increasingly distraught and distressed. The baby is distressed. Would you call security? Would you calm them down? Would you call for a supervisor or are you not sure what you would do? We'll give people just a moment to cast their vote for which option you think you'd be most likely to take if you were on the staff when this situation occurred.

All right. So, 59% of you say that you would try to calm this woman down. 34% of you would call for a supervisor and I wouldn't mind betting that some of you probably were thinking I would do more than one of these things possibly. 5% don't know what they would do and 2% would call security. Karla, back to you.

Karla A. Ramos: Thank you. I think the majority speaks about or empathic way of being specially working in a health care environment, but at the same time many of you in positions of administration, policy development. You may see the need to have a coverage of a policy establishment of what would be the right procedure to implement and that's when you will need the supervisor to make a decision in some way. We will move to the next poll.

Jenny Inker: All right. We have a third poll on this scenario. If you were a bystander in the same scenario, this is a very distraught woman with a sick baby. She could not make herself understood. Others cannot understand her. What would you do if you were a bystander in this scenario? Would you do nothing believing that this woman should speak your language if she lives here? Would you try to calm her down and offer her a sit or would you help her if you could speak English which is the language that she is able to speak but

nobody else around her is able to speak? What would you do if you were a bystander in this situation? You happen to be in that waiting room and you noticed this is happening.

Your choices are you would do nothing because she should speak your language if she lives here. Would you try to calm her down and offer her a sit? Would you help her if you were able to speak her language which is English in this case? Let us know by casting your vote which of these options you think you'd be most likely to take in this scenario if you had witnessed this occurring. We'll just give you folks a moment. Okay, 78% of you would help this woman if you spoke her language, 20% would try to calm her down and offer her a sit, and 2% would do nothing because she should speak my language if she lives her. Karla, back to you.

Karla A. Ramos: Thank you. I just want to remind everybody this is not a right or wrong answer. We all have different backgrounds like a remix in song come from different environments or maybe in a different position in the administration or as a service provider. What makes us react different are compounds of all of these circumstances in positions. After this activity, I would like for you to use this exercise as a conversation started at work or what you prefer. This is to create awareness of the different needs that a person can have in a health care setting. Probably, we have been very helpful for the staff person to have some standard operating procedures instead of making the decision themselves in a situation like this. Keep this in mind and take notes some of the answers for these will be later throughout the presentation.

Now that we are going to cover our first objective and that is learn the differences between cultural awareness and cultural competency. What does culture means to you? We have another poll. Remember this is a very interactive webinar. Jenny?

Jenny Inker: Thanks Karla. All right. We'd like to know what you think of when you say or hear the word culture. To you, does that mean diversity or does lifestyle come to mind? Perhaps you associate culture with music and the arts or do you associate the word culture with other languages? Perhaps you associate the word culture with all of the above with diversity, lifestyle, music and arts, and other languages. We'd like you at this point just to cast your vote for what comes to your mind when you say or hear the word culture. Which of these others matches that word culture in your view? We'll just give you a moment to cast your votes and then once the majority of people have voted, here we go. 91% of you say all of the above, 4% say music and the arts, and 2% each say lifestyle and other languages. Karla, back to you.

Karla A. Ramos: Thank you, Jenny. With these results, I want to show you the next graphic. This is known as the cultural iceberg. There are different versions of this slide graphic and different trainings but please take a moment and read some of the characteristics composing what we call a culture. You may notice there are only a few cultural traits that are visible at the top of the iceberg. These are like language, food preferences, holidays and festivals. The way we look and all of these information is mostly external. We can see it even without us sometimes expressing it verbally.

The other information, 9 out of 10 characteristics of the culture are not visible. Some of them and the most important in making who we are are at the core of who we are. Those are some of them are work ethics, beliefs and assumptions, sales concept, humor, gestures, child rearing practices. What is our pride? Our concept of justice. Just mean we can save the whole but you can take a look at all of them. This graph is a powerful learning tool that you can take whenever you think we know a specific group or we want to generalize. You have to think about this iceberg. There are things that we don't see that matter and influenced who we are.

According to Cristina De Rossi who is an anthropologist at Barnet and Southgate College in London, culture encompasses religion, food, what we wear, how we wear it, our language, marriage, music, what we believe is right or wrong, how we sit at the table, how we greet visitors, how we behave with loved ones and a million other things. We're going to go over these definitions because it's recommended that we are all in the same page when we're talking about cultural awareness and cultural competency. Cultural awareness is being able to recognize what is my own culture, what do I believe in, how do I interact with people. In some cases, for example, in the medical field, what type of medicine practice do I prefer receiving?

The more you emphasize those cultural traits, the better, not just you will be aware of your culture but it will be easier for you to see differences with others and that takes us to the cultural sensitivity which the value and learning from diversity. Being able to identify those different culture, traits and others, who you interact and be able to respond quickly and adequately to these differences. Then, the next step is cultural competency, which is the ability to work respectfully and effectively with people from different backgrounds. As you see, the cultural competency is a journey. We may sometimes need more time depending on who we are on different stages of this process. I recommend that it's a continuing conversation and training process. Sometimes we may not be aware fully of our culture or may not be aware of different cultures to be able to see in how we can work together. It' important that we remember that this is a journey and it's a constant conversation.

What is our ultimate goal with being cultural competent? It provide equitable service. Becoming cultural competent requires some work, I will say a lot of work and many of you are in the position that need to make it happen. You need to understand that culture is representing in different areas of our lives and remember from what we eat. If you're in a facility that will influence the meal planning process, part of our culture is who do we pray to so that will influence us, programs, festivities, holidays, hours of praying. The way we dress, it will define if I as a patient or customer need my head to be covered, covering the arms, covering certain parts of the body in order for me to interact with people from other genders, ages, or backgrounds.

The purpose here is not to solve differences but to being aware of them and they are simple and valuable points to keep in mind when you had to work or provide services to people with different backgrounds. Take a minute and these are simple steps to keep in mind but the most important thing is to take the time to listen and ask the people that we're serving or somebody from their same either family or social groups, churches, organizations to help us understand and cater better to their needs.

Language access and service providers, it's our next objective. Why is language access is so important? The information provided by the US Census is at your hands and this slide does not represent a language proposition at your city, county, or state. Many of you are from different parts of the country. It is vital that you and your organization are aware and knowledgeable of the languages spoken in your geographic area. This information may determine your customer composition and the language needs you may experiment at work. For example, I can tell you this year Richmond's top service languages are in the following order: Spanish, France, Arabic, Vietnamese, Korean, and Mandarin. This information is not just based on the demographics of the city but on the data collections from our customer service lines. We need to be aware of the different populations we are serving and how they will be changing yearly. For that case, the census is a great source at the mid picture and in general but you also need to use probably internal information or data that will help you make better decisions.

When it comes to languages, it's imperative that we do not omit the late deafened, deaf, and hard of hearing community. We are living longer and due to better medical care and that means that with age we may experience hearing loss and is more common as we age even though there are hearing appliances available. However, a high percentage of people never uses them. As a service provider, you may need to ensure that your message is heard completely and understood either with implementation of hearing or speaking slower techniques, printing bigger fonts, or having assisting interpreters in the case of American sign language. It's important also to remind you that the sign language is not a universal language. There are many varieties or versions of the sign language as there are spoken languages. I've learned a few years ago that even here in the states, American sign language have different regionalism, terms, and signs that they use based on their region where they live, the East Coast, even people living in countryside so that you may be aware. You need to be aware when hiring interpreters for the community use in American sign language.

To provide accurate language access is key that we all know the difference between these two terms: translation and interpretation. The first one is the conversion of the message on paper and one language to the same message in another language. When translating information, you have to remember that you're ensuring that with the words, the conversion, the message, the intention of the message is conveyed. It may take different words or phrases to explain the same concept in a different language. The second one is the conveying which is in this case is interpretation. Is the conveying of the message verbally or sign? From one language to another? Interpretation is a difficult skill. It requires building up vocabularies about different subjects and the knowledge of ethics and different techniques. There are different types of interpretation: consecutive and simultaneous, and there are different types of formats. It's in person, video related interpretation or over the phone interpretation. We wanted to give you very clear best practices for experiences that something that you can implement on a very basic level.

Since language services are provided by translation and interpretation, it's important that you remember these do's and don'ts when it comes to these two areas. For translations, I do in myself even native speaker Spanish. We test the word received by a translator with some of our customers or partners to ensure that dialects and regionalisms are being considered. To save money, if you're in a small organization, you can translate forms that need to be signed and have them laminated as a guide next to the form in English that needs to be signed. The next do's that we recommend is you can translate vital forms or keep a laminated guide that you can make copies if requested, if the customer or patient request that.

After evaluating the demographic composition of clientele or patients, I think it's important that we design appropriate translator signage throughout your facility. For that, I will recommend you are always aware who are your customers. You are not going to be needing to translate signs in French if your basic clientele is from Latin America. You also need to be aware that different countries in the world, African or Middle East and Asia speak French. You need to be aware of where your customers are original from. The last one is to make sure that you are thinking on people or patients with different visual needs. Make sure that the proper colors are used and the size of the font.

What we should not do? I know technology has differently improved a lot and the use of the softwares and applications for translations but we do not recommend the use of these softwares and automated software and apps for official or legal documents. Never assume that a person who speaks the language can write in a proficient way. How many of you when you were in school, English and writing and grammar, what's your favorite subject? Writing for massive consumption in public is not the same at writing a letter or

writing between friends or an email. It requires a different skill. It's important that when you translate documents, you use a person who has been tested or it is writing proficiently in their language.

Never ignore the origin of the customers. We were talking about these before about different countries that speak Arabic for example, and they can be from Africa or Middle East. The last one is very common at companies make pre-made materials with different topics and they make them available to organizations, in general, public education awareness. I will not deter you from doing these. The only thing I want to do is recommend you that you test these materials before you purchase them because if the material was done in a different islet, then they won't be effective with your customers.

This is also some information we wanted to share about the right position of interpreters in medical settings. You can see from the three pictures in your slide. The top left is showing a video relay interpretation which is a screen and there is an interpreter doing sign language. The screen is positioned in front of the patient and the provider is on the side. On the other picture on the top right, you can see how the interpreter is positioned behind the patient so their communication channel is not interrupted between the service provider and the patient. The service provider just want to point that it's looking directly to the patient, not to the interpreter. You can see the same in the bottom picture, the provider is addressing the patient directly and not the interpreter. These are very simple but very commonly missed, points that are missed and what the message that we get as patients or customers is that we are disregarded as the patient or customer when the service provider is not addressing the patients or customers.

In the next slide, we're going to talk about the do's and don'ts of interpretation. Always, always use a medical certified interpreter. You either use it over the phone through a vendor or contractor or in person. You need to ensure that you use a certified interpreter and Susan will explain in more details the laws about the use of interpreters in this area. I want to encourage you that besides thinking on possible legal consequences, a use of a trained interpreter ensures that their objective on providing equitable services is met and is the right thing to do and the don'ts.

We do not recommend or never to use children, minors to interpret for family members or any adults. Imagine if you had a child and their responsibility was of accompanying you to a medical doctor and you receiving a bad diagnosis. Treatments, financial information, all of that information will put a burden into that child and feeling responsible of being the bad news provider to the parent or adult, and the children may not be aware of the terminology and they probably will change the words and the message will be lost. Also, it's not fair. We want to protect children and the best way to do it is finding a professional interpreter. The use of apps and online software for communication may be appropriate during leisure time. If we're going vacation, we want to learn a language, but it's not appropriate in a professional setting especially in the medical field. Now, I'm going to pass it over to Susan who is going to present the other learning objectives, Susan.

Susan Elmore: Thank you, Karla. Thanks for sharing the great information with us. Now, we're going to go over to and make sure ... Nico, do you have me? Okay, pardon a minute here.

Nico: Yeah, perfect.

Susan Elmore: There we go.

Nico: Thank you.

Susan Elmore: Little technology swap there folks. Now, we're going to go to objective three and what I'm going to try to do is explain some examples of how the information Karla shared with you will interface with the business rules and regulations. A lot of what we're going to talk about are healthcare businesses, however, it's also transferable to other types of businesses and applies across the board to many. Understand too that the laws and requirements for healthcare business operations are related to culture and communication in the workplace. We know that every business regardless of the type has rules and regulations.

The first rate rules and regulations you have are operational or corporate rules from your owner or whoever the structure is underneath. The second is that there are federal state and local laws for every business type. If you're in healthcare, then there are also rules and regulations which affect the business depending on the type of insurance coverage or an organization accepts for healthcare services. Whoever your payer is, you will also have rules and regulations for them. Rules and regulations are generally made due to negative outcomes. We know for example all of us drive in the United States, there have been on a road way. There are speed limits on the roads in the United States. The amount of speed is based on the scientific characteristics and quantitative data of the roadway to determine what is the safe speed to prevent accident. Generally, speed limits are made due to a negative outcome or death. A lot of times our laws are made due to a negative outcome.

In healthcare, there's also other organizations which in order to be associated with the organization, the healthcare facility agrees to their rules and regulations surveys and one such organization is The Joint Commission. The Joint Commission also has cultural awareness and communication similar to the Centers for Medicaid and Medicare Services. Listen close, what do you hear?

Jenny Inker: All right everybody. Susan asked us to listen closely just now and we'd like to know what you heard when she asked you to listen closely. Did you hear nothing? Did you hear unintelligible noise? Did you hear music or did you hear conversation in the distance? Go ahead and answer this poll for us please. Tell us what you heard when Susan asked you to listen intently for a moment. As soon as everybody has had a chance to make their selection, we'll publish those poll results. Did you hear nothing, unintelligible noise, music, or conversation in the distance? We learned that 75% of our audience heard nothing, 13% heard unintelligible noise, 13% heard conversation in the distance and no one heard music. Susan, over to you.

Susan Elmore: Very good. Thank you, Jenny. The answer is you heard what a person who is deaf or severely hearing impaired hears. For the 75% that heard nothing, it could be a person who has no appliance. For those who heard unintelligible sounds in the background, a rattling of paper or something, it could be that you have a hearing appliance but your appliance is not working well, so you never heard a thing that I was saying. It just got muffled. I want you to think about putting yourself in the place of a person that you're in a setting whether it be a care plan meeting or be a meeting in your office where someone is explaining to you your medical condition or report a fact about that meeting or decision that needs to be made. Could you converse with them? Could you understand and make an informed decision if you heard nothing or all you heard was an unintelligible sound? I doubt it. I doubt you could make an informed decision without hearing and understanding the discussion.

I'd like you to remember this the next time you are working with a person who is hearing impaired or who uses an appliance and keep in mind today appliances are very, very small so you may not be able to look around the ear to see it, an ear appliance. It may be in the

ear and you not even see it. Remember if somebody doesn't respond appropriately to you, to make sure that you are communicating with them in their language. If they cannot hear, you need to ask, "How you prefer to receive communication? Is it American sign language? Is it written? Is it pictures or do you lip read?" Some people may even deny that they have a hearing impairment so then you have to kind of walk that fine line with them to get them to understand they really didn't hear what you just said. We don't have time to go into detail on each of the different regulations, so I just want to mention some which will affect communication and culture.

For the purposes of this presentation, I'm going to talk about some of the long-term care federal requirements or what we'll use for nursing facilities. The code of federal regulations are what's known as the CFR section 483.10 requires the facility to incorporate the resident's personal and cultural preferences in developing goals of care. 483.10 item F talks about self-determination and choice making. As per my previous example, without understanding the conversation, you can't make self-determination and choice making. We have to be sure that a person understands communication so that they can make appropriate choices to their life.

483.10 G, which is also known as F572 or F574 if you're in the nursing facility industry, it says that communication is in a language that the resident understands means verbally and writing and in a language that's clear and understandable to the residents and/or his or her representative. This could include but not limited to larger text, Braille, translation, American sign language, or have an interpreter for either American sign language or a foreign language. There are many multiple ways to communicate effectively. The obligation is on the provider to ensure they provide effective communication. Please remember to adhere the specific regulations for your type of facility of your organization. For you all that are in the government or policy making, there could be other avenues which also apply to what you're doing or to the areas that are underneath you. There's an additional handout that will be with the slide deck when the slides are presented to you. They give a lot of different resources for communication.

Another area is the CMS Emergency Preparedness Requirements. The CMS Emergency Preparedness regulations apply to 17 different types of providers. First and foremost, remember, your facility or the facility communication plan must start with how you're going to communicate with your resident which includes those who speak languages other than the spoken word or English. This would include explaining relocating to another area of the facility or another facility and how you're going to let their family members know where they are and what [inaudible 00:51:01] going to be taking care of them.

For example, the person who has a brain injury due to stroke might understand spoken word but may not be able to speak so others can understand them. How would you communicate and ensure the resident understood and could share any thoughts with you? Think. If your residents have been a victim of trauma or is a Jewish Holocaust survivor and all of a sudden they're being rushed into moving and cannot hear what is being said because they're hearing impaired or you do not speak the language being understood or cannot hear the audio messages or you didn't take time to communicate, how would you feel? What would you want to happen if you were in their shoes?

Some awareness and preparation tips to help you be in compliance with different laws. Printed material should be a minimum of 12-point font, larger is better or have a large print available upon request. Blue and light gray font are hard for persons with macular degeneration or other eye disorders to see. There's also section 508 compliance which there's a handout for which talks about websites and communication and signage, et cetera. Audio messaging. We have TVs and electronics. They come across with an audio

message. You may have them in your building. You also want to remember to have the close caption or turn the close caption feature on. It does no good to have somebody giving an audio message and someone who is deaf or hard of hearing and doesn't get the message.

For graphics, you want to explain or label the pictures. Screen readers or blind or visually impaired will read what the picture is to the person. This has to be included in our electronic media. If you think back to the pictures that Karla did a few minutes ago, she explained each one of the pictures to you. If you were blind or visually impaired and could not see those pictures, she gave you the description of what those pictures were and why. Service dog is another area that's been a big topic lately and there are three basic rules. One, they are allowed in all facilities. Two, do not pet a dog without asking the handler and, three, the handler is responsible for the care of their animal.

On another note, remember that there can be electrical interference to some hearing appliances or assisted hearing equipment. The person may hear this interference through their device that you may not hear. If they're complaining about their device, it could be that they're picking something up. Even the buzz of light can come through on some appliances. You want signage to be both visual and auditory. You want translations for signage to be in various languages and [inaudible 00:53:56] had become widely used. We used to label restrooms in the United States with men and women but if you don't understand which language you don't know the difference. Now, we're using pictures more widely now.

In the area of civil rights and we did another handout that would help you explain some of this. Civil rights is under the jurisdiction in the United States Department of Justice which includes Title VI or what's known as 42 United States code section 2000D, also known as the Civil Rights Act of 1964. This act which any organization would accept federal funds either directly or indirectly must ensure compliance with. It prohibits discrimination on the basis of race, color, and national origin in programs with activities receiving federal fundings old system.

These are a few of the other laws which affect our businesses. More importantly, more information is given for each one of these on the handout [inaudible 00:55:05]. Don't just look at the Civil Rights Law or what you think of the regulations for your facility or for your organization. Be sure you look a little bit deeper. Another critical area for our businesses is what's known as the cultural and linguistic appropriate services or class standards. These are important standards for you and your organization to do an assessment of where your organization is today to develop a plan and to implement that plan to improve on each one of the standards.

As you heard Karla explained this slide a little bit earlier and as you will see, health is the unseen area. It stand about midway of the bottom part here. There are many things that apply but our health, our family values are kind of unseen. They put away and people just don't really recognize it. We tend to forget that we have to communicate both our health needs, our medical needs, our psychosocial integration. Remember, there are multiple areas of the culture in each person's life regardless of what language they speak.

Reflect for a minute on a personal question. What makes you feel included? When you're invited to participate. When others involve you in their activities. When others understand your personal interest, religion, belief. When personal matters such as health concerns or child concerns or acknowledged and strong positive communication. What makes you feel excluded? Not being invited to the party on the unit or not being able to go to a neighbor's house because your family member use a wheelchair or have a cognitive disability and the

neighbors don't want that particular issue or you can't get up the step. Not being able to go to a restaurant to eat because you're on welfare or public assistant. How would you feel if you were one in those situation? You want to ensure and remember this when you are working with others whether it's in a healthcare setting, whether it's in a government agency writing policy or wherever you are in church or in social situation. Now, let's do another poll if you would, Jenny.

Jenny Inker: All right, Susan, thanks and this is our final poll for the presentation today. Susan is interested in knowing if you have a choice, what is a comfortable talking distance between you and the customer? Would you say the less distance the better? Would you prefer to be across the desk from your customer or perhaps you'd prefer to be at arm's length distance or would you like to be at the distance that makes both parties comfortable? Just take a moment and answer our final poll please. Tell us which choice is most comfortable for you when you are talking with a customer.

Once everyone has had a chance to vote, we'll publish those results. You see our four options there on the screen and we'll shortly have the results of the poll for you. You can see the four choices for the distance you would prefer to have between you and a customer when you're chatting. What we hear from our audience is that 60% of you would like to be the distance apart that makes both parties most comfortable. 26% of you say arm's length distance feels pretty comfortable. 11% would prefer to be across the desk, that sort of distance and 3% says the less distance the better. Susan, back to you.

Susan Elmore: Thank you Jenny and thank you everyone for participating. Yes, the appropriate answer is it depends on your and the customer that you are working with. Most of the time, yes, you want to be able to allow them to see you, watch that where you need to be. What's comfortable for you, what's comfortable for them, and you can always ask. This leads us into a couple pointers on the Americans with Disabilities Act which applies to most if not all attending this webinar. A few pointers. When speaking or conversing with a person who uses a wheelchair for mobility, it is correct to sit to converse versus standing as if towering over one first. Do not lead on the person's wheelchair. It's considered part of the person's body.

It is also quite important not to move a person's wheelchair to an area the person cannot reach the chair, not only is it part of their body you're moving, it is essential for them to be able to access in case on an emergency. For some person too or in a nursing facility or in a hospital, removing the wheelchair, walker or crutches to the hallway or across the room can be evaluate as retraining the person to the bed or an area where the person is and when I cannot reach the mobility device. Be aware too the ADA applies to employee, employers, and all persons, residents or customers. Study the areas appropriate to your business and be sure you're in compliance with this particular cultural feature.

How to create an inclusive environment? First of all, be friendly to everyone. Second, remember ask, "How can I help you? May I help you? What can I do to make things better for you? Tell me about your culture so I can learn more." And the universal language for everyone is a smile. Regardless of what language you speak, everybody understand a smile to be friendly. Behavioral health is also covered by the ADA as well as it affects all classes, gender, race, race, nationality, and ethnicity. It affects all person. Behavioral health, mental illness, and substance use disorders. Not all behaviors are mental illness or psychiatric issues. In healthcare, one has to determine the difference in behaviors and communication versus behaviors due to a psychiatric illness. The environment can cause behaviors or can make a psychiatric episodes escalates and there are many free resources on this that are on the end of our slide deck for you.

The environment as a causal origin or cultural issues can cause behaviors. If you cannot understand the healthcare professional, what would you do? Would you refuse? Would you push back? Would you be noncompliant? Would you scream, yell, run or all of the above? If you wanted to tell staff something but do not speak the language, how would you? Remember the case study that Karla mentioned. If it was you as the mother, how would you make them understand that your child was really sick? How can you handle better that situation in your organization if you were the staff member and a person who spoke the different language or could not communicate verbally to understand them? If staff do not face you to speak to you directly or you have lost your ability to speak, how would you get assistance? Would you reach out for staff to get them to turn around? Would that be assault if in the act of reaching you accidentally hit a private area or someone's breast? No, the act is communication.

Causal factors due to medical factors, for example, brain injury, strokes, or falls. Many times the environmental sound cause sensitivities and reaction. Sounds where we have lack of materials on the walls to absorb sounds or lack of private space or loud TV. Does the facility accommodate so that people can have appropriate work areas or appropriate living areas if they are resident in the facility? Hearing and light issues cause pain reactions. We have LED lights now. They're extremely bright. They can actually cause pain. If someone cannot communicate to you, that's the reason why they have a headache. How are you going to pick that up and ensure that you understand and communicate?

Temperature sensitivity. If we toss the covers, does that mean I'm being noncompliant or does that mean I'm hot? What would you do if you were in a semi-private room and a roommate was doing anyone or more of the above that negatively affected you? How can you as a staff member help this situation? Now, I'd like to share with you an approach from one of our geriatric mental health partnership colleague, Dr. Andrew Heck on assessing behavioral issues. The HEAR slogan sums up what the previous slide has been talking about. H for evaluate health and medical causes. Is there a medical reason for the behavior? E, evaluate environmental causes. Environment is a causal factor to behaviors. Approach factors. [inaudible 01:05:18] another person approached the person or due to perhaps ignite the behavior where they [inaudible 01:05:24] the person's face and R, the resident factors. Is it a resident factor due to the above? Is it the medical or nonpharmacological intervention needed? If you would like to learn more about HEAR or any other topics, please be sure to put it on your exit survey.

How would you work on culture in your organization? It's up to leadership to lead and change the culture in organization. Leadership begins with leadership at the top. Top management has to buy-in and culture change has to begin from top down. Leaders have to support diversity, not just race but also culture, disability, gender, age, all areas include diversity, diversity at all levels. Leadership has to walk the walk, not just read the script. Leadership has to allow training and time for staff and residents to engage in learning each other. When we learn each other and learn where we have more commonalities than differences, we learn to respect each other.

Here are few best practice training ideas and we're sure you can think of others for your organization that you can do to engage interaction between your staff so they can learn other. You can have an international covered dish with staff because it always brings people to the table. You could celebrate birthdays if it's culturally appropriate, but keep in mind there's some religions that don't approve of celebrating and having parties or birthdays or holiday. Be sensitive to that. You could reach out to the chamber of commerce or guest speakers to engage more conversation and there are many, many more things you could do.

Earlier, we talked about the Americans with Disabilities Act and we have talked about communication in your facility. The question is, now, is your facility or your organization accessible? Language accessible? Culturally accessible? Physically accessible? If you answered no to anyone of those, what are you going to do after this webinar? The 2011 United States Census Bureau reported the following with persons with disability. There were over 19 million with mobility issues, 6 million with vision, 10 million with hearing and 14 million with cognitive issues. There are many more people with disabilities, some that aren't seen, some that are seen that you need to ensure you're providing services for in your organization. Get to know them and get to know what they need.

Here are some things to think about to use for training. Most of us have seen an anatomical chart in a physician's office or, if nothing else, on the Internet. Maybe similar to the one here, maybe a full one. If you've noticed, the anatomical chart, yes, they're gender specific. They have a male and a female anatomical chart. What they are not, they're not by culture, they're not by race, they're not by natural origin, religion or disability. We're all the same as one anatomical chart. We all bleed the same color of blood, last I looked it's still read. All humans have the same organs regardless of race, ethnicity, or culture. If we are so similar, why do we sometimes think we are so different? That's what we call bias when we were talking about bias earlier.

Hopefully, after this webinar, you will be able to address your biases and realized that we are more similar than we are dissimilar. If you take nothing else from this webinar and every interactions with every person you meet regardless of race, creed, nationality, disability, remember the word respect. Respect for every person regardless of where they came from, regardless of their skin color, what they look like male, how they act or whether they have scars from a severe burn event, their nationality or their religion.

Our fourth objective is the toolbox. It can give you some resources and tip and the first resource and tip is that we are people first. Before we become a label of students or clients or patients or nurses or physicians, employees and employers and doctors and children or parents and spouses, we are all people first. You want to recognize the person first. We've included in this webinar some handouts on person first language tips to help you as you are working with your staff or developing your policy. In this best practices toolkit, we've included some [inaudible 01:11:06]. These are free. You can get them off the internet. On the far left, talks about food issues, gluten free, sugar free, vegan. In the middle, it's different languages for welcome. On the right, it's different religions and practices. If nothing else, you can have a picture and people can point to it.

As Karla talked about before, you want to be sure you provide documents and forms that are translated and to make sure that your resident rights or rights posters or visions are translated. Anything that you have posted are translated and that print electronic materials in the multiple languages or you have a way on your website for things to be translated. For here, there's one. You could put up a sign language is spoken in this office or Spanish is spoken in this office. In this particular tool, it's an online tool. They're free. There are many of them that you can use for either training or the one on the left has multiple languages on it. You can point to it. You can explain to the person, "I'm getting ready to take you on a gurney to have a test done." That way they know what's going on, it reduces their anxiety.

At this point in time, I want to stop and see if we have any questions before I go on. There are some other resources on the rest of the deck but I'll forward over to Jenny and tell us if we have any questions.

Jenny Inker: Thank you so much, Susan. I think we probably got time for just one quick question so that we can finish on time today. Both of your presentations have provided such a wealth of information. I think this is tied to your last few slides. Given the huge amount of resources that both you and Karla have presented, where would you recommend our audience, members start? Where would be a good place to dive into this topic or dive into these resources?

Susan Elmore: Okay, I'll start it off. The first thing I would do is open the door and tart the question and the dialogue. If we start with people and who the persons are and learning what the persons are, that would be the first to start. The second would be to start with a class standards and evaluating where you as an organization are and what do you need to do. Until we start having conversations with each other and learning each other, we're going to make assumptions about people and everybody knows what the word really means. We're going to make assumptions about people, that could be incorrect. When we start learning, Karla and I are talking by telling you about your country. Is she going to ask me something about the United States? That starts the conversation and we've got to be open and start discussing that. Karla, do you have any extra thoughts?

Karla A. Ramos: No. I agree with Susan. The initial starting is going in both way establish that conversation and then the policymakers or leaderships can start researching about developing your own standard procedures and starting what are your guidelines in the law.

Jenny Inker: Thank you both so much. That's really very helpful. I'm going to go ahead and bring this presentation to the close today and I would like to thank once again our wonderful presenters, Karla and Susan, for a very interesting and informative presentation today and for sharing your wealth of knowledge and your experience with us. I'd also like to thank our audience for participating so actively in today's webinar. I think we may have set a record for polls today. This webinar has been recorded. If you missed any portion of our presentation today or you would like to re-watch it or share it with a colleague, please visit the webinar page on our website. As a reminder, information alongside the survey links will be emailed to all registrants and you'll be able to access Karla and Susan's wonderful wealth of resources you'll find at the end of their slide deck too. I don't want you to miss that. Thank you once again for joining us today. We hope you enjoy the rest of your day. We appreciate you.