

The Lewin Group
Culturally Competent Direct Care: Meeting the LTSS Needs of Diverse Dually
Eligible Beneficiaries
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Alana Nur: Thank you. My name is Alana Nur. I'm with the Lewin Group. Welcome to the webinar, Culturally Competent Direct Care -- Meeting the LTSS Needs of Diverse Dually Eligible Beneficiaries.

Today's session will include a presenter-led discussion, a panel discussion, and a Q&A discussion among the presenters and participants. This session will be recorded and a video replay and a copy of today's slides will be available at <https://www.resourcesforintegratedcare.com/>. The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access the number, click the black phone widget at the bottom of your screen.

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You'll see on this slide that we've laid out the various Continuing Education Credit Options. For both social workers and nurses, you can obtain Continuing Education Credit if you complete the pre-test at the beginning of the webinar and the post-test.

CMS is also offering CEUs for other individuals looking to obtain credits for attending this webinar. In order to obtain these credits, you must complete the post-test through CMS' Learning Management System. Additional guidance about obtaining credits and accessing the links to the pre- and post-tests can be found within the Continuing Education Credit Guide in the resource list on the left-hand side of your screen or at the Resources for Integrated Care website.

This website is supported through the Medicare and Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless high-quality health care that includes the full range of covered services in both programs. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time, I'd like to introduce our moderator. Renee Markus Hodinis the Deputy Director at the Community Catalyst Center for Consumer Engagement in Health

Innovation. For the past 20 years, Renee has worked to bring the consumer perspective to the forefront of health and health innovation. Renee?

Renee Markus Hodin: Thank you so much, Alana. And welcome to everyone participating in today's webinar. I'm really thrilled to be here today.

As Alana mentioned, I'm the Deputy Director of the Center for Consumer Engagement in Health Innovation. Among our priorities is to promote health equity for underserved populations in all efforts to transform the health system. So I'm really thrilled to be working with the Lewin Group again and the Medicare-Medicaid Coordination Office again to bring this webinar to everyone.

Some of you may have participated in last year's webinar on Culturally Competent Long-Term Services and Supports which is available on the Resources for Integrated Care website that Alana mentioned before, and today's program will be a wonderful companion piece to that one.

So before we hear from our great lineup of public speakers today, I'm going to first take a few moments to introduce them and also offer our participants a roadmap for our time together today.

We'll begin with MariaElena Del Valle. MariaElena is a Workforce Innovations Consultant with the Paraprofessional Healthcare Institute or PHI which is based in New York City. In that role, she works closely with employers who are implementing innovative strategies to recruit, train, mentor, and supervise Direct Care staff. She also works with Direct Care staff to develop leadership advocacy and mentorship skills. With her expertise in organizational development, participatory management practices, and leadership skills building for managers and workers, she's really a perfect person to start our conversation today.

MariaElena is going to give us an overview of the population needing long-term services and supports today, the Direct Care Workforce, and then share information from the Cultural Competence Training Programs that PHI has developed.

We'll then jump all the way across the country to hear from our next speaker, Andrew Adams. Andrew is the Chief of Staff at Homebridge, a home care agency located in San Francisco. As Chief of Staff, Andrew serves as a key strategist to the Executive Director and provide senior leadership and capacity building to support and further the mission of Homebridge. He holds responsibility for organization-wide communications, marketing, grant development, and fundraising, legal, policy development, administrative staff, and board relations.

During his presentation, Andrew will introduce us to Homebridge's client population and to the population of Direct Care workers who they refer to as caregivers. He'll also share more information about the Cultural Competence Training Homebridge offers and the types of strategies they employ to recruit and retain a diverse workforce.

I'm particularly excited to share that Andrew's joined today by Melanie Morehead, who is a caregiver at Homebridge. Melanie has been a caregiver for over 31 years, working with clients to help them thrive in their communities. Melanie has been with Homebridge since 1999, first as a caregiver, then as a support and retention coordinator providing peer mentorship and currently as a specialized training coordinator. In that role, Melanie utilizes her caregiving skills to work with clients transitioning home from long-term care facilities. She coordinates with the client's medical team to develop a discharge plan, acquire the necessary equipment and train fellow caregivers on a specialized care that her clients and their clients require to successfully return home. We'll be hearing directly from Melanie a bit later in the program.

So first, I wanted to thank you all for being with us today, great speakers. And then next slide, please. Let's talk about our learning objectives.

So here are the learning objectives for the session. By the end of today's webinar, participants should be able to recognize the diverse needs and preferences of dually eligible beneficiaries for culturally sensitive direct care services, such as communication, food and physical touch. They should also be able to identify strategies direct care workers can use to meet the cultural and linguistic needs, values and preferences of diverse beneficiaries. And finally, they should be able to identify the key elements of training that direct care workers get in cultural competence.

So let's go to the next slide. This is our agenda for today's program which should track what I mentioned earlier when I was introducing our speakers. So we'll start as we typically do with some polls, get a sense of who is in the audience. We'll then have presentations from MariaElena and from Andrew and then we'll bring Melanie in to join the conversation and a panel discussion and to hear about her own experiences working with diverse clients.

Following that discussion as we always do, we'll leave plenty of time for questions and answers from all of you. And then finally, we always like to make sure to ask you to stay on to complete a brief evaluation of the webinar. Next slide, please.

Okay, let's get started with our polls to understand who's with us today. Again, these are the polls that we typically take, so anybody who's been on one of these webinars before will find this familiar. So the first poll is in what setting do you work? And you can choose the one that is most appropriate for you, whether that's health plan, ambulatory care setting, long term care facility, home care agency, community-based organization, consumer organization, academic or research setting or something completely different.

So I'll give everyone just a few seconds to fill that out. Again, pick to one that's most appropriate for your setting. Okay, let's go take a look and see who's with us today, and what settings they work in. Next slide.

Okay. So by far the majority of our participants work in some capacity in the health plan, followed by another, which we will actually do a little more digging to find out and then we have a bit of representation from community-based organizations as well.

Let's find out a little bit more about -- now that we know what setting you're in -- what your professional area is. So again, which of the following best describes your professional area? And you can choose one, and again these may not be precise, but choose the one that best describes it, whether you're a health plan case manager or coordinator, health plan customer service, administration or management in a health plan, health care administration of some sort, if you're a provider of one sort or another, a direct care worker, the topic of today's webinar, if you're in pharmacy, social work, advocacy, policy research or something else. And again, I'll give everyone a chance to weigh in.

Okay. Let's take a look and see who's out there. Okay. So again, because we had most of our participants from the health plan sector, it looks not surprising that most people are in health plans, but specifically, care coordinators or case managers, nearly 40%; 17% in health plan administration or management, and a good chunk from social work. Okay, terrific. We're very excited to have such a diversity of folks with us today.

So now, I'm going to turn things over to our first speaker, MariaElena Del Valle from PHI. MariaElena, take it away.

MariaElena Del Valle: Thank you, Renee. And thank you everyone for choosing to participate in this webinar this afternoon. Let's begin by looking at the diversity of the population using long-term services and support.

Today, more than 15 million Americans rely on long-term services and support. The need for long-term services and support is particularly important to the dually eligible population, with nearly half of the 12 million beneficiaries relying on long-term services and support. Working age adults, those between ages 18 or 64, with personal assistant needs currently outnumber older adults aged 65 and above at 7.7 million versus 7.2 million people. However, the balance will shift as the population grows older in the coming decades.

About 60% of long-term services and support users are women. Due to the longer life expectancy for women, this gap can be expected to widen as the older population adds more women than men over the decades ahead. The need for long-term services and support varies among ratio and ethnic groups.

So like for example, among the older adult population needing long-term services and support, 78% are White, 9% are Black and 8% are Latino, 6% are of another race, including Asian-Pacific Islanders. The diversity of long-term services and support population is expected to grow. Only a small subset, approximately 677,000, of the 15 million living at home, the long-term services and support needs reside in rural areas. Next slide, please.

This continued to now look at the direct care workforce. There are about 4.4 million workers including over 2 million homecare workers; 600,000 nursing assistants employed in nursing homes and 1.6 million workers employed in other settings including residential care facilities, assisted living facilities, continuing care retirement communities and hospitals. The direct care workforce is projected to grow by 30%, from 4.4 million to 5.8 million, within the decade. Next slide please.

Let's look at some key figures about this workforce. 87% women, the medium age is 41. 50% are people of color and 25% are immigrants. Next slide please.

Let's take a closer look at two words that we will be hearing throughout the webinar presentation that haven't been already stated, culture, cultural competence. But let's look at what is the definition, let's look a little bit more closely at what is the definition of cultural competence in healthcare. Cultural competence in healthcare is the ability to provide high-quality person-centered care for and with those who may be different from you.

So as the growing diversity within the population using long-term services and support grow, as well as the direct care workforce grows, it increases the opportunities for cross-cultural interactions in these settings. And these interactions often involve a variety of factors including race and ethnicity, language, religion, gender, and sexual orientation.

So as these cross-cultural interactions increase, how do we do this? How do we strengthen these interactions in communication? I want to offer you these thoughts, awareness and respect for client's uniqueness, beliefs and preferences is an important tool in delivering person-centered care and navigating the territory of cultural competency.

So when we think of awareness, we look at what is the personal inner dialogue that we're having when we meet someone that's different from us? What are all the assumptions and biases? This is very key to improving your interpersonal skills.

Once you become aware of these inner dialogues and you get stronger at communicating with other people, the self-knowledge will support you to develop more and have more respectful communication. Without this self-knowledge, it can be harder. This applies across the board. Next slide please.

In order to provide cultural competent care, direct care workers need to be able to meet individuals' needs and preferences related to these concerns such as communication, verbal and nonverbal. For example, in some cultures, looking at someone in their eyes is a sign of respect and in other cultures, it could be considered disrespectful.

Let's look at food. One might think, what could get complicated in serving cereal for breakfast? Well, in some cultures, people eat cereal with cold milk and in another cultures, people only eat cereal with hot milk. Imagine if you're used to having a bowl of cereal with hot milk and someone served you a bowl of cereal with cold milk, this can

create a very distasteful breakfast experience. Some serving cultures consider serving cold food insulting. One might ask, what would be insulting? Why is that insulting? Well, because warm food symbolizes intentionality and care that goes into preparing food.

Physical touch, some orthodox Jews are not allowed to shake hands with any women except their wives. There is no formula for how to work with a client from any given culture because every person is unique and that person's relationship to the culture is unique. Next slide please.

I want to share with you a little bit about PHI's vision, mission, and commitment. PHI is a not-for-profit organization based in Bronx, New York. For the past 25 years, PHI has been working closely with direct care workers and their clients in cities, suburbs and small towns across America. PHI offers tools necessary to create quality jobs and quality care.

Let's look at the trainings. PHI offers specialty training to direct care workers on topics such as Alzheimer's and dementia, congested heart failure, diabetes, enhance, observe, record, and report. PHI's trainers and researchers and policy experts work together to learn what works and what doesn't work in meeting the needs of the direct care workers and their clients in a variety of long-term settings and support policy makers and advocates in crafting evidence-based policies to advance quality care.

Advocacy; PHI has lead advocacy efforts to extend wage and overtime protections to homecare workers nationwide and to create an advanced home healthcare role in New York. In our curriculum design, we have a core curriculum for entry-level personal care aides and home health aides. We also create curricula that support the advanced roles in long-term care and promote continuous learning and curricula on leadership development and team building.

Next slide, please.

I like to highlight two training programs that PHI designed for individuals and organizations to use. The first is the specialty training associated with the Homecare Aide Workforce Initiative, HAWI. This training consists of four modules.

We begin by exploring our relationship to culture. We ask the participants to share examples through personal stories about cultural components from their own culture.

Then we look at respecting an individual's unique perspective and these include the following topics. Identify differences from someone in the same culture, explain how generalizations about a culture do not always apply to individuals from that culture, and we explain how we will share some common needs which are similarities for how we want these needs met can be different which is our uniqueness. Some key skills to demonstrate respecting differences include communication, looking at sender and receiver, nonverbal communication which is so important, to be aware of your own body language.

We all know that often, our body language arrives before our words. People can hear our body language before they hear our words. Be aware of your client's body language. What is that client's expression saying when I'm looking at them? We explain and then we go to the module on applying our learning, which is a lot of practice and application on how to use communication skills, how to pay attention to nonverbal cues, practicing paraphrasing, asking open-ended questions, and pulling back to build trust with a client who is different from them.

We look at and explain how to show respect, gain understanding, resolve misunderstandings, and more effectively, how do we manage these challenging and confusing situations that involve a client who is different from us. We also provide additional tips about nonverbal communication in different cultures.

These four modules are particularly important for the direct care workers to meet the diverse needs and preferences of their clients.

Next slide, please.

The second training program, which is generally known as PHI's Signature Program, is Coaching Approach to Communication. Here are some core skills that are covered in this curriculum.

Active listening. This requires listening from the speaker's perspective. Then we also look at the verbal and nonverbal. So for example, a direct care worker from a Caribbean Island was participating in a training and she said that she entered a client's home with dementia and says -- good night. The client goes to bed and the direct care worker wonders why her client always goes to sleep when she arrives. Well, when she shared this example in the class, the other direct care workers asked her, why do you say good night when it's only 6 PM? And she said -- in my country, when the sun goes down, we say, good night.

Listening from the speaker's perspective, as I mentioned, is very important. And one of the tips that we offer in the classes, how do you know when you stop listening to someone? Well, when you are talking with someone and someone is speaking with you and you start to have a conversation with yourself about what the person is saying to you, you have stopped listening.

Another skill is paraphrase. Paraphrasing for fact and paraphrasing for feeling. When you do this, it affirms to the speaker that you are listening. It demonstrates interest and it helps often to identify a client's need, concern, or issue. An example, a client says to a direct care worker -- I'm not feeling like myself today. This time of year reminds me of the smell of crayons, pencils, and notebooks.

During the session, we ask the participants, if you paraphrase the fact, what would that sound like? If you're paraphrasing for feeling, let's hear what that sounds like. And the

important thing is if you don't paraphrase and you don't catch important information like the smell of crayons, pencils, and notebooks, you may have missed an opportunity to engage in a conversation and learn more information about the client that you're serving and you may have missed a very important meaningful connection.

Because if you paraphrase and you say, Mrs. Gonzales, you're saying that you're not sounding like yourself today and you're also saying that this time of year reminds you of crayons, pencils, and notebooks. Mrs. Gonzales might respond, yes, it reminds me of when I was a school teacher. I miss teaching children. Which will lead to conversation. More for future conversations.

Let's look at pull back. This is what I call pause for the cause. Often in interactions, even with people we know, we say or someone does something or we may do something that will trigger someone. And the challenge here is to gain emotional control, right, because when we get triggered, we know we cannot control other people. We can only control ourselves. But when you gain emotional control, you're able to pull your attention back on the client.

A client is going to a salsa dancing activity and a direct care worker put sneakers on him. He got upset and he yelled -- what are you doing? I need my brown special dancing shoes. Well, the direct care worker could be triggered by the gentleman yelling at her saying -- what are you doing? And she would have to pause for the cause and say -- I'm here to serve the client. What is it about these special shoes? What is it about the brown shoes? So she would put the focus back on the client and it will lead to maybe paraphrasing or another skill that I'm going to now talk about a little bit is asking an open question. Why do you need these brown shoes to salsa? And that will most likely lead into a conversation about what is so critical about these shoes when you're going to participate in a salsa activity.

Effective questions are always important, some are closed because we need to get facts and the open questions open conversations. They also cultivate effective working relationship. Next slide, please.

I'd like to invite everyone to participate in this activity. There will be an opinion poll. We're going to do a poll question. I would like to read a scenario and ask you to select the response that makes the most sense, or that describes what you think is happening.

Scenario one, a client says to her direct care worker -- Carmen, when you're at the drug store can you buy hair conditioner for me? Carmen, the direct care worker responds -- you'll need a deep conditioner. You have what my mom would call bad hair. What's happening in this scenario? Please check the one you feel best describes the situation.

Let's look at the responses. So I see that D, Carmen isn't really thinking about what she is saying, her mind is elsewhere was a popular choice. And --

Renee Markus Hodin: So MariaElena, this is Renee and --

MariaElena Del Valle: -- to stand.

Renee Markus Hodin: This is Renee. It looks like the top choice actually is A, that she's unconsciously being insensitive to her client's feelings. And then down at the very bottom, Carmen's unaware that she's expressing a racial stereotype and bias. Those seem to be the highest percentages, maybe you can comment on that.

MariaElena Del Valle: Yes. Thank you, Renee.

So a little bit about this backstory and this, by the way is a real true scenario. Two women of different cultures with similar hair texture, different culture responses to managing their hair and assumption that all people with thick, coarse, curly hair understands that the term bad hair is intended as an endearing and playful way to say curly hair requires extra care. This difference led to misunderstanding and confusion.

As I just mentioned a few seconds ago, this a real scenario and the client filed a grievance stating the following -- I don't want Carmen to take care of me anymore. She was rude, disrespectful and discriminated against me. The worker stated -- I didn't mean to offend her. I have thick, curly hair, too. In my family, we call it bad hair. It's a playful way of saying it's going to require extra care. I hope she gives me an opportunity to explain. Carmen's desire to resolve the confusion led her to what I describe as the learning path to cultural competency. Next slide.

Let's look at the second scenario. Jessica, a home care worker, is going to meet a new client, Mrs. Singh for the first time. When Jessica comes to Mrs. Singh's home, she opens the door, she introduces herself and she smiles, she steps in. Suddenly Mrs. Singh starts yelling -- you are so rude. Get out. What's happening in this scenario? Please check the one you feel best describes the situation.

Renee Markus Hodin: So again, this is Renee. It looks like we have a few choices, is she being insensitive to her client's home environment? Is she not really thinking about what she's doing, because her mind is elsewhere? Is she unaware that Mrs. Singh's religion prohibits wearing shoes in the house? Is she just being friendly in doing her job? Or is she unaware that entering the client's home without permission is disrespectful? So if people can make their choice and then we'll go to see what the results were, the next slide.

Okay, why don't we look at the results and then we'll turn back to MariaElena to tell us what was really going on here. Okay, I'm not seeing the results. I'm not sure if we can get those up.

Alana Nur: Renee, looks like on our end, I can see that about two-thirds of folks thought that Jessica's unaware of entering a client's home without permission is disrespectful, or that Jessica was unaware that Mrs. Singh's religion prohibits wearing shoes in the house. So it looks like to be the most common responses.

Now if I can turn it back it to you, MariaElena, comment a little bit about that and about the scenario?

MariaElena Del Valle: Yes, and those two responses are on point. And to share a little bit more about this backstory is that, it is against Mrs. Singh's religion to wear shoes in her house. She has told the agency that all aides must take off their shoes before entering the house, that they should bring slippers or shoes that have never been worn outside, and to leave them at Mrs. Singh's house. So this is such a small scenario but it's so important, right? Because here is someone who's very well intentioned and maybe had some assumptions about when you go to someone's home, you smile, you say hello and you just walk in. And what this points to is that home care workers should be aware that acting on any assumptions they may have about clients can result in a negative consequence. There's usually a deeper story that what is revealed in the care plans and even in the first visit. So we definitely encourage in our trainings that is important as a first step to become aware of your assumptions, and for the second step to explore the assumptions by asking the client questions or to explore a little bit about their story, his or her story.

Thank you for participating in those two scenarios. Next slide.

When I started to talk about -- when I explained and offered the two scenarios for us to do little practice, I mentioned Learning Path to Cultural Competence. The Learning Path to Cultural Competence begins with awareness. Having an awareness of your client's unique personal needs including general knowledge about their culture is an important tool and the first step in providing individualized person-centered care. Once you become aware it leads down to the path of responsiveness, showing respect will help you gain understanding, resolve misunderstandings and more effectively manage challenging or confusing situations. Carmen demonstrated respect by asking to meet with the client, and to try to resolve the misunderstanding that resulted in her feelings. The client met with Carmen and agreed to reestablish a working relationship.

In competency, competence begins when you realize that differences can show up in any area of caregiving such as verbal and non-verbal communication, health-related beliefs, food choices, housekeeping preferences, family relations and systems. Next slide.

Renee Markus Hodin: MariaElena?

MariaElena Del Valle: Yes?

Renee Markus Hodin: This is Renee. We need to move on to Andrew and what I think we'd love to have you come back later on and talk a little bit more about how we apply that learning path to cultural competence to those two scenarios with Carmen and with Jessica.

So if it's okay with you, I'm going to have Andrew pick it up from here. And like I said, we'll come back during the question and answer period to hear a little bit about the application.

Thank you so much. Let's move on to Andrew.

MariaElena Del Valle: Absolutely. Thank you. Thank you everyone.

Renee Markus Hodin: Thanks.

Andrew Adams: Thanks, MariaElena. Hi, everyone, this is Andrew. As Renee mentioned, I have an organization called Homebridge. We're based in San Francisco. Homebridge began in 1985 as a non-profit advocacy organization focused on ensuring that underserved populations receive in-home support and services in a culturally competent manner. And since 1994, we've been providing direct in-home care to some of the most vulnerable residents of the San Francisco, and the Bay Area. Next slide please.

Our client population's very interesting, we annually provide care to about 1,500 clients, about 75% of whom are dual eligible. Homebridge's client population is 30% under 60 and we're increasingly seeing that our client population is skewing younger as our services are being utilized as in a vision prevention measure to help keep younger in-home supportive services recipients housed primarily in single resident occupant dwellings. Next slide, and one more slide please.

As you can see from this slide, Homebridge's clients are predominantly female, about half are racially ethnically diverse. While we note that our client population is 2% transgender, we believe that this is really under reporting and that our transgender population is significantly higher here in San Francisco. Next slide.

Our caregivers -- as Renee mentioned, we refer to our caregivers as -- we refer to our direct care workers as caregivers and Homebridge employs about 350 caregivers; 83% are female and over 90% are racially and ethnically diverse.

In the past five years or so, we've seen a significant shift in our workforce with the doubling of the number of new caregivers who are 25 or younger, termed as transitional age youths. What we've observed with this is that generally, this transitional age youth population has little to no work experience and as a result, requires a lot more direct cultural competency training than the older population of caregivers. Next slide.

Because we serve such a diverse client population, we also require a diverse caregiver staff to meet the client's needs, and so recruiting and retaining a diverse workforce is challenging. And on this slide, you'll see some of the tactics we use to assist in this endeavor. It starts with accessibility.

We make sure that our marketing materials, our applications, the job descriptions are all available in multiple languages. We're really proud that our supervisors and team

members speak over 25 languages and it's also important that we honor lived experiences. You'll see on the slide there, we do target populations with barriers to employment, which means we also need to employ a workforce development team.

We're a fair chance employer. One of the most effective recruiting forces is by advertising ourselves as a fair chance employer. This means that we are actively recruiting people who are previously incarcerated and even recruit in jails and prisons with people who are shortly being released.

Because we work with vulnerable clients, some convictions do prevent us from hiring people but overall, we found that this population is incredible reliable, hardworking, very compassionate, and appreciative of the opportunity to work. Also note there that honoring lived experiences includes hiring caregivers who are reflective of our client population and communities and we make sure to use preferred names and pronouns.

Next slide.

We found providing barrier removal support, that workforce development that I talked about, and job coaching, to be very effective. One of the things that I wanted to call out on this slide is that we provide prepaid transit cards to our caregivers. Transportation in San Francisco as it is around the country is very expensive and we know that the majority of our caregivers commute by public transit to come to work.

And so we went to ensure that just getting to work is not an additional barrier for our caregivers and so we do provide prepaid transit for them. Staff development is another important area for us for retention. As you can see on the slide, we have an employee referral program where we found that the majority of our new caregivers actually find Homebridge through other employees.

We offer peer mentorship, and potential employees are also offered an opportunity to attend a 4-hour professional development workshop. Homebridge understands the importance of supporting the employees and in the workforce by providing them the foundation of exploring key elements to long term success as a caregiver. The goal of the workshop is to offer a voluntary, pre-employment opportunity to learn more about Homebridge, learn more about their role in our organization, and to learn to different types of communication styles, discovering various career options that exist at Homebridge.

Ongoing professional development workshops also are provided to our caregivers who are already our employees. Lastly, we offer continuous training opportunities and this is one of our most important points when we recruit staff. In addition to CPR and first aid, our most popular training classes that our caregivers take are what we call specialized trainings. These are classes such as dealing with bed bugs, how to handle clients who hoard, handling challenging situations, how and when to report abuse, how to deal with substance abuse that consumers and clients are doing, and understanding mental illness. Importantly, we offer this training in English, Spanish, and Cantonese.

So next slide please. I want to talk you through around the challenges we've had of recruiting culturally competent caregivers. In San Francisco like around the country, the cost of living is very, very high and unfortunately most direct care workers are low-wage workers. About 18 months ago, Homebridge developed the STEPs program.

It's an acronym for Skills Training and Employment Pathways. We did this to create three levels of caregivers in Homebridge, where each successive level indicates having gained new important skills and also earning more money. It also indicates working with more challenging clients who have more complex care needs.

In the past 18 months, over half of our 350 caregiver workforce has progressed at least one step, if not more. And today we've had over 12 caregivers in the past 18 months be promoted to higher roles within the organization. So they've advanced through the three caregiver steps we've created into peer mentorship roles, and importantly, over 25% of our care supervisors, these are people who supervise caregivers and do client management for our clients. Over 25% of our care supervisors are former caregivers.

This is a huge shift for Homebridge. Before we redesigned this program, the care supervisor type role was made up primarily of people who saw themselves as case managers and who had MSWs. This has also resulted in higher retention, better client care, being able to provide a career growth pathway both inside and outside of our organization. Next slide.

Importantly, as I mentioned before, we do a lot of our own training and this training is done on-site. Homebridge over the years has really designed and privileged the concept of adult-centered learning. And adult-centered learning for us is really using and honoring the adult learning cycle.

What this means is four things. One is that we focus on having direct experiences. So we structure the learning experience by even small groups, offering case scenarios as we just did in this webinar, and doing role plays. Secondly, we make sure that we're reflecting on the experience.

So we help learners to focus on key points, and sharing ideas, and reactions with others. Third, we generalize about the experience. We help guide the learner to new insights based on their experiences and discussions. And lastly we apply what's being learned.

We can try to coach the learner by providing feedback, advice, and encouragement. You'll see there that we talked about the modules to develop the soft skills necessary for cultural competence, including reflecting differences, conflict resolution, and communication.

Homebridge employs a philosophy of care not only in our trainings but in interactions with our clients, and with each other in the office, called Motivational Care Management or MCM. MCM is a competency-based community support practice model that promotes

consumers' standard of care, culturally responsive care, a strength-based approach, and a results-driven approach. Next slide.

In our training modules, we talk about what culture is and we define culture as unique behavioral patterns and lifestyles that differentiate one group from another. So for example, set of values, beliefs, or views that are transferred from generation to generation. Often times they are manifested in daily life, in routines and activities, or they're reflected in legends, or drama, art, religion. We also importantly discuss ethnocentrism which is, as MariaElena was talking about, the evaluation of other cultures based on the values and customs of our own culture.

It's important that we, in our training, talk about diversity and cultural competence, really having an ability to interact effectively with people in different cultures. So what we teach is that, first, you have to have an awareness of one's own cultural worldview. What is my culture? What's my worldview that I'm bringing to the situation?

Second, an attitude towards cultural differences, being open to learning, and being respectful to differences. Third is, knowledge of different cultural practices and worldviews and cross-cultural skills, and lastly is developing cultural competence results in an ability to understand, communicate with, and effectively interacting people across culture. Next slide.

So Homebridge caregivers are trained to care for diverse clients in a variety of ways. And on this slide I have given three examples. So the first one is we, in San Francisco, we do have a good number of transgender clients. These clients are not -- sometimes have not gone through the process of legally changing their name. And so when we first receive them as a client from the Medicaid system, their name maybe different from what they would prefer to be called, and so we have developed a system internally where we can update the care plan to reflect their preference.

The second example we have is as I mentioned, all of our clients are Medicaid, or here in California, Medi-Cal recipients, which effectively means they are poor, but that has not necessarily been their experience for their entire life and nor does being low income means the same thing for everyone. And so we teach we shouldn't make assumptions about socio-economic status.

Third, we take confidentiality and our adherence to it very seriously. At the same time, we know that in some cultures, it is common to involve family when making health decisions. So we want to make sure we teach that seeking the client's consent and permission before including family is important, but at the same time, including family for some clients is really important and if we don't do that, we can come across as being rude or insensitive. Next slide.

So when we talk about client outcomes, there are couple of ways in which Homebridge assesses this. We do assess clients every 1 to 4 months, depending on the complexity of that client's need. And we're really proud of the results that we've had. We know that

from the point at which our client is first referred to Homebridge, to 4 months out, that for instance, we have 46% reduction in 911 calls. We see a 44% reduction in emergency room visits, and a 51% reduction in missed doctor's appointments. These are all important health metrics that we measure. And I think, going back to the cultural competence piece that feeds into that, one of our clients said -- Homebridge really understands me. Before Homebridge, I had providers who didn't speak my language, didn't respect my decisions, and didn't try to know me. My caregiver is absolutely wonderful and has saved me from having to move from my home.

Renee Markus Hodin: Andrew, thank you for that. That was a wonderful place to end. And I want to go back and thank you both, MariaElena and Andrew for giving us some real solid background about the people who need long-term services and support, the professionals that care for them in their homes, and also the essential elements of cultural competence training that you both do.

So as promised, we're now going to bring Melanie Morehead into the conversation in order to dig a little bit further into what this looks like on the ground, so to speak, or in the homes, and dig into her experience providing direct care services with cultural sensitivity. So Melanie, welcome, and I think I'm going to start with you. We'll bring everybody into the conversation, but let's start with you, Melanie.

So during his presentation, as you just heard, Andrew talked about the cultural competence training at Homebridge. And you took that training. So if you could just say a few words about what stood out for you about that training and what you learned that perhaps you didn't know beforehand?

Melanie Morehead: Good afternoon on your end. Just basically, the client's cultural needs, their preferences in how to treat all clients with respect. We learned by asking questions in effective way to learn more about our clients. Also Homebridge also helped me understand how to set personal and professional boundaries. Instead of asking the clients -- why -- they need certain or preference in that. I asked more about religion, cultural background to learn more about them. Ultimately this provides better care for my client in a professional and respectful manner while maintaining professional boundaries.

Renee Markus Hodin: Thanks, that's really helpful.

Andrew, if it's okay, I want to turn to you in this point and just pull the lens back a little bit. Is there anything else that you wanted to add to what Melanie share, maybe around the professional boundaries, personal and professional boundaries that she mentioned?

Andrew Adams: Yeah, I'm glad now they brought up professional boundaries because that's what important part of our training. And we try to provide guidelines from maintaining healthy relationships with the clients. There's a fine balance to be had where caregivers need to be really intrinsically curious about their clients, but also respectful and cognizant of not digging too far into their personal lives. So our training curriculum helps define and explain cultural diversity, ethno-centrism, and discusses how to

recognize the assumptions we make in our daily life, and how to see when folks are exhibiting behavior that indicates they may not be comfortable with the conversation, where it's going.

Renee Markus Hodin: Thank you for that. I appreciate the explanation of that fine balance.

So MariaElena, I wanted to bring you into the conversation as well as we just talk a little bit more about training, and ask if you might be able to share some information on what training on cultural competence in other long-term services and support settings looks like so we're talking about assisted living or a long-term care facility. Could you share a little bit about that what that might look like?

MariaElena Del Valle: Sure, so the most part of the concepts we cover in cultural competency training are nearly identical, right? But the difference is really about ongoing support. In homecare settings, they may have less on-site support for direct care workers because other staffs are usually not with them in the homes.

On the other hand, in the institutional settings, they may have more organizational support available for direct workers and so that gives them the opportunity to hard wire cultural competency training throughout the larger organization. And if something that homecare agencies do and others may consider doing is to offer an evening support group for direct care workers to do a peer exchange, to share common experiences about their challenges and to provide support for them.

Renee Markus Hodin: That's a really helpful distinction. And then actually your comment about organizational support reminded me of the webinar that I mentioned at the start of our program today, the one we did last year on culturally competent care. And we featured an example of an assisted living facility for first-generation Japanese, American, older adults. And I recall that in that training, or in that webinar, they described the training that they provide the staff, but the director also talked about their ability to provide a kind of on-the-spot in-services. So she mentioned, when they noticed a staff member who might have missed a cultural cue. So actually, I think that that's a really good example of the kind of on-site organizational support that you were talking about, MariaElena. So thank you for that.

I'm going to shift gears now to talking about how we get to know and understand client needs and preferences.

So, Melanie, I'm going to turn back to you and ask you about that. So when you're assigned a new client, how do you get to know them? And maybe you get information ahead of time and then you gather information yourself with starting up with the client. If you can talk a little bit about that, that might be helpful.

Melanie Morehead: It usually starts with the supervisor who gives us basic information, including name, address, and preferred pronouns. When meeting my client for the first

time, I always greet with a smile, explain who I am and why I'm here, and ask permission to enter their home.

Once I enter, I observe, look around, might be different types of paintings, artifacts, and I notice something and I will like to ask them can they explain this piece of art to me and usually, they'll explain it. It might be passed from generation to generation. And I always want to learn. Learn about your client, learn about their culture, their history.

Some of the artifacts might be related to a specific religion. I will ask them could they explain their preferences related to their religion.

Alan Nur: Yeah. That's a great example and it really does also highlight what you mentioned earlier about those boundaries you sort of asking a kind of open-ended question to get them to talk and show curiosity without crossing the line into something too personal. So thank you for that.

Let's actually go to some concrete examples. So, Melanie, if you can share some of the experiences that you've had in caring for diverse clients and some of the strategies that you used in those situations to make sure that you were being respectful of that person's needs and preferences and values. So can you tell us about one of your clients?

Melanie Morehead: Yes. My supervisors gave me an assignment to go to. When I went to the client's home, his wife answered the door. I introduced myself to her and told her my reasoning to be there.

She explained to me that her husband's English language, his skills wasn't that good, but she would interpret it for him. Diagnosis of the client, he had fallen and he suffered traumatic brain injury. Client and wife explained that they were Muslim and they kept a Halal household. They explained to me which stores to go to and what type of meat to purchase. I asked them -- once she gave me the directions and what she wanted me to purchase, I asked her, I reflected back and said, this is what you would like for me to purchase and this is where you would like for me to go. She told me -- yes. Once I made, did my shopping for them, I was finished for that shift. I reached out to shake her husband's hand and she explained to me that in their tradition, no physical touching by opposite gender.

And that was a learning experience for me because I didn't know that much about the Muslim community.

Alana Nur: That's a great example and I think it reflects a little bit on some of the concepts you talked about earlier.

Andrew, if I could actually bring you in at this point and just ask you to, again, pull the lens back on that example and talk about how those strategies come from some of the Homebridge training?

Andrew Adams: Certainly. I should mention that we're really proud that MariaElena came to Homebridge several years ago and trained us on the culture part that she talked about and Melanie demonstrated how we implement that culture part perfectly, because she talked about using open-ended questions to learn more about the client's preferences and importantly, doing that paraphrasing, and mirroring back the client's request back to them to ensure that she understood the request completely.

Alana Nur: Thank you. Thanks for drawing all those connections.

Melanie, I'm going to come back to you again and ask you to share another story about one of your clients and how you met their cultural competency needs.

Melanie Morehead: My supervisor gave me a client. The client was male-born, but she was transgender. So when I met her, knocked on the door, she asked who it was. I told her my name was Melanie from Homebridge and she said -- come in.

When I arrived she wore a wig and she had on women's lingerie. I asked her at that point -- what would you like for me to call you? And she said -- Miss Stephanie. She said -- that's what everybody calls me. And from there on, that's what I called her, until this day whenever I see her I say -- hi, Miss Stephanie.

Renee Markus Hodin: Oh, that's great. And again, I'm going to ask Andrew to sort of pull back that lens and talk about the context of that situation. I think you've mentioned a little something about this earlier but can you talk about preferred name versus what's on the forms?

Andrew Adams: Certainly. Yeah, I did mention before, and here in California we have Medi-Cal, or state Medicaid system. And often the name, and that's how we get our clients, that information is shared through that system. And so often in these situations, the name that's present in that state database may not match how the client presents and how that client would like to be called. So interactions between the caregiver and the clients are important to identify and document any changes to preferred names and pronouns.

And so we both teach our caregivers to be cognizant of that and respectful of that and then also, so that it's not just a one-time thing to either change that in our case management system or to report that back to the supervisors so that they can do that. And we've actually created an alias field in our database so that any new staff member interacting with that client can see that while their legal name may be something else, they prefer to be called by this name.

Renee Markus Hodin: Great. So it sounds like you've got both training and infrastructure in place to support your clients that maybe have gender or sexual orientation differences however they prefer. So that's very respectful and again, it's borne out of the infrastructure you've put in place including the training.

So I'm going to actually turn it back to MariaElena. We started our session today with you providing us with an overview of cultural competence training. And you've just heard Melanie describe some of her experiences as a direct care worker. And just hoping that maybe you can bring us home by reflecting a little bit about what you heard and how it connects to what you talked about earlier.

MariaElena Del Valle: Yes. First of all I want to say thank you to Melanie, thank you, Melanie for those incredible two examples, and also to Andrew for representing all the hard work and commitment that has to go into doing this work well, both on an organizational level, and then supporting the direct care workers the way that you all do in Homebridge.

But in Melanie's example, it really highlights the qualities that direct care workers need to serve diverse populations. It also helps to track back to the learning path to cultural competency I talked about earlier. The awareness, the honesty and responsiveness are very important guiding principles in providing quality, when we're doing person-centric care. It's the need to be aware of one's self and also of the client at the same time is really what allows us to navigate these unknown moments and these unpredictable moments.

So to be honest and to ask about your client's preferences, where you're ensured the way that Melanie did when she really, that was yet a great example with the Muslim family and finding out what was necessary and just as a way you could tell Melanie that you were so present in doing the nonverbal listening or paying attention to facial expressions and paying attention to important information on how to serve that client. And to be so responsive in the second example that you gave with the transgender and I can tell like the sincerity and like, if this what you prefer to be called, this is what I will do. So this really supports a lot of what PHI's vision and mission is, that quality jobs lead to quality care.

And I'm sure that those clients of Melanie, they must be so appreciative of your commitment to provide person-centric care the way that you do. So training direct care workers to pay attention and respond to their clients' unique needs and preferences, leads to moments where client show your appreciation of care they have received like the examples we just heard. This helps to build trust between direct care workers and clients in a very meaningful way.

Renee Markus Hodin: That's great. It really sort of emphasizes, you've underscored this issue of relationships and when you're talking about being in someone's home, it really is, very intimate relationship that I think requires a kind of training that we've talked about today and the kind of attention to issues that we talked about today.

So I want to take a moment to thank you all for the conversation. It was really terrific to hear from you Melanie, from your grounded experience.

And we're going to shift gears now. And instead of me asking the questions, we're going to take questions from our participants. So I'm going to turn the program back over to Alana, who's going to moderate the Q&A section.

Alana Nur: Great. Thank you so much, Renee and thank you so much MariaElena, Andrew and Melanie for your insight into cultural competence and direct care.

So we now have a few minutes for questions from the audience. Thank you, all, who have submitted your questions already. Please keep submitting them. If you have any questions, you can submit them using the Q&A feature on the lower-left of the presentation. If you type your comment at the bottom of the Q&A box, you can press Submit to send it.

So I will start with a question, okay, I'll start with you Andrew, but I'll turn to the others as well. How do you train Homebridge caregivers on how to meet their preferences around client holidays?

Andrew Adams: Actually a really interesting question because at Homebridge, we do -- three years ago, we started a program called Homebridge for the Holidays. And it is a program that -- where we identify our most isolated clients and provide a meaningful gift for them during the holidays.

One of the things we were really cognizant of and then we realize we needed to train on is that when we do this during the holidays, many clients have many different cultural practices during that time. You know there's Hanukkah, there's Kwanzaa, there's Christmas, and then there's clients who don't celebrate anything during that time. And so, for our caregivers, they would lead often times with a Merry Christmas because that's what they're celebrating. And so, we needed to reinforce these principles that we've been talking about and to make sure that when we go out and give those gifts to our clients during the holiday time, that we're saying the appropriate holiday greeting for that client and what they celebrate or don't celebrate. And sometimes, that means we're just giving you a gift during kind of a dreary winter time because we're thinking about you. And that's a nice thing to do too.

Alana Nur: Thank you, Andrew. And MariaElena, anything to add on your end about the type of training that you provide direct care workers in general on holidays of clients?

MariaElena Del Valle: We don't provide a specific training like on holidays, but I definitely agree and support what Homebridge is doing around this and what I have seen by way of activities to help cultivate awareness and I've seen this in some of the assisted living. They do an incredible calendar giving like background on holidays and suggesting language on how to greet one another. So I think like those visual cues also helped to do that in the moment education of what do people prefer? What do people like? What do we need to be aware of?

Alana Nur: Thank you. Melanie, I'll turn to you. Do you have any examples of ways in which you've understood or been able to respect your clients' holidays and celebrations around holidays?

Melanie Morehead: Yes, here at Homebridge we have a few clients that are Jehovah Witnesses. And Jehovah Witnesses they don't practice, they don't celebrate any type of religion, I mean holiday or birthdays. So usually, when you go into a client's home, you may see that they have their literature around and you basically, being raised in a Christian background, your parents will tell you about Jehovah Witnesses. And sometimes I asked if -- how long have they've been Jehovah Witnesses and they tell me. And I say, and I understand about their background and I don't push. And sometimes they ask me about my religion and I tell them and they don't push on my end either, so we respect each other on both ends.

Alana Nur: Thank you, Melanie. And Andrew, I'll direct this one to you. Do you -- when you're hiring caregivers, is there anything that you look for to ensure that you're hiring caregivers who are open to serving clients from diverse cultures and may come in with cultural competence already or open to learning more about serving clients with diverse needs?

Andrew Adams: Yeah, certainly one of the most important attributes we look for is having a potential caregiver who has that sense of compassion and curiosity about other people, and so we actually have very few job requirements. Sometimes, we hire people who haven't been in the workforce at all, especially with the (inaudible) population. Other times, we hire people who've been care giving for 30 years, but are looking for different environment and across those populations, we make sure that the kind of one job requirement, that we really do follow up on is that ability to empathize and bring compassion to the job. We find that those things, if one is exhibiting those, then they are really receptive to their cultural competency trainings that we do in our new hire trainings.

Alana Nur: Thank you Andrew. And Melanie, we have a question just asking to talk a little bit more about some of those professional boundaries that you learned about in your training. It sounds like that was very helpful for you in your role in going into clients' homes. Can you say a little about what are some of those things that you learned that were most helpful for you?

Melanie Morehead: Just being respectful of -- asking open-ended questions or reflecting back on what was said from the client just to make sure we have a clear -- that I have a clear understanding of what they were trying to say to me and also in what I would -- just being just respectful. Respect is the number one thing, being respectful, having patience.

Alana Nur: Thank you Melanie. MariaElena, I wanted to turn to you to reflect a little bit about the example with Carmen that a direct care worker, who was one of the scenarios that you shared. Can you talk a little bit about how Carmen moved along that learning path to cultural competence that you mentioned? So from her initial awareness that her bad hair comment was offensive to her client to then taking action to become responsive

and competent, can you share a little bit about that process along her path of learning to be culturally competent?

MariaElena Del Valle: Yes. I think that example also is about intent and impact. I happened to be working directly also with that organization as a consultant and that process, the way that that worked out is that they had someone who facilitated the conversation, right? They followed up from the grievance department to get both perspectives of like -- how did this happen? Because they did have a good working relationship.

And so we wanted to explore and see if there was any way that both were willing to meet and talk and they both were. Carmen became very aware -- and she was open to, like, it was important for her to be able to say that the people over here where she was coming from, that she had a good intent and she was shocked at the impact. So for her, she's -- I remember her saying -- I'm never going to forget this. I'm going to pay attention. And realizing that one's intent doesn't always end up the way that one imagined.

For her willingness to say -- look, I didn't mean it but it doesn't have to be the end of this working relationship. I really enjoyed serving you. So let's talk about this, I want to apologize, and also became aware that even though they may have similar hair, it doesn't mean that people understand these terms. So it was like a big eye-opening process but I loved that her awareness led to action, which she took initiative.

I really want to stay with this client and I think the client was very impressed with her wanting to talk and say, well, then, I'm willing to talk with her, and that actually had a good -- it was a good outcome for both and I since heard that they have improved their working relationship. They do check in with each other.

Alana Nur: Thank you so much for reflecting on that. Andrew, I want turn you and ask a little bit about how you support Homebridge caregivers who may experience discrimination or racism from clients and how you support caregivers in those experiences.

Andrew Adams: Yeah, thanks for asking that question. As Melanie was referring to in professional boundaries, this is an area where having really good professional boundaries is important. And so unfortunately from time to time, there are clients we serve who do mistreat our caregivers along those lines. So we teach and train our caregivers a couple of ways to respond to that.

One is to do recognize that this person, the client may not be fully cognizant of what they're saying and the effect it has on them, to try and depersonalize that, to have compassion for that person in that situation, and to help them learn and grow of why their comment is hurtful.

Sometimes though, the situation can't be rectified in the moment. And so we also train our caregivers to -- it's okay if the situation is unsafe to stop services and leave the

client's home and contact their supervisor. At that point, our supervisor will go out and meet with that client, have a frank conversation and they're -- I'm happy to report, there are times where we've been able to kind of rectify that relationship and it's a real learning experience for everyone involved, and in extreme case, there are times where it's simply just not safe for our caregivers to go back to that person's home.

And so we have to let the City and County of San Francisco who's our funder, where we get our clients from, know that we can't provide services for that person any longer.

Alana Nur: Thank you so much, Andrew. MariaElena, you talked a little bit about some examples about paying attentions to clients' non-verbal cues and how important non-verbal communication is. Can you provide an example on some of the strategies or things to look for that you might suggest training direct care workers on around non-verbal cues?

MariaElena Del Valle: Yeah, we do the session on -- in communication about non-verbal cues. We do practice this on -- we do role plays on active listening, and so the demonstration role play intentionally focuses in a lot on the non-verbal so that people can see what is it that we're talking about here. So somebody will be speaking and the -- the person in the listening role will first demonstrate poor listening, where the eyes -- there's no eye contact, there is looking everywhere kind of very pre-occupied and people look at that and say -- Wow, that was not nice. They would even say as the facilitator. I don't think I'm liking you very much right now. They -- we have two PHI facilitators, the one who's doing the poor listening. People kind of like take issue with them for about 10, 15 minutes in the beginning of this exercise and then we do a second take which is demonstrating active listening, paying very close attention. When people see the difference, they naturally start sharing stories about -- Oh my goodness, I have to really pay attention to my client. I saw myself when you were doing that role play and I realized that I really need to stop and make sure that they know that I care and that I'm listening and I don't want to miss important information.

Alana Nur: Thank you so much, MariaElena.

Melanie, I want to ask you. Do you have recommendations for other direct care workers on strategies that you have found helpful either for reading that client's non-verbal -- their body language, or other signs that have come up for you that have been helpful? Any recommendations for other caregivers in similar roles?

Melanie Morehead: Usually, when we have our new hiring, the caregivers are going to come on board. Me and my counterpart, we always explain to them about some clients. We have a client who when he gets agitated, he has a tattoo on his right hand and this is a tattoo of a swastika. When he gets agitated at the caregiver that -- care supervisors sent out, he will point it at the tattoo and some of the caregivers have said -- This is where your patience come in at, because some of our clients are impaired and your patients -- try to understand if you feel uncomfortable. So you step out and call your care supervisor and let them know so they can make contact with our client.

Alana Nur: Thank you so much, Melanie. So we are at time. I really appreciate everyone for submitting your questions. If you have additional questions or comments, please email RIC@lewin.com. And thank you all of you, all of our speakers, for answering all of those questions that we were able to get through during our present time -- presentation time today.

For more information on the direct care workforce, you can visit PHInational.org and the Resources for Integrated Care website. You can also explore other continuing education credit opportunities through the direct website on other topics related to integrated care for duly eligible individuals.

Aside for today's presentation, a recording and a transcript will be available on direct website shortly. And as a reminder, additional guidance about obtaining credits, accessing the links to the post-test can be found within the continuing education credit guide and the resource guide on the left-hand side of your screen, or at the Resources for Integrated Care website.

Again, thank you all so much for joining us today for this presentation. Please complete our brief evaluation of our webinar so that we can continue to deliver high quality presentations. If you have any question for us, please email us at RIC@lewin.com.

Again, thank you so much, MariaElena, Andrew and Melanie for your presentations and participation today, and thank you everyone for joining us. Have a wonderful afternoon and thank you so much.