

Question & Answer (Q&A): Providing Culturally Competent Care – Meeting the LTSS Needs of Dually Eligible Beneficiaries

Webinar participants asked these questions during the Q&A portion of the Providing Culturally Competent Care – Meeting LTSS Needs of Dually Eligible Beneficiaries Webinar. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website: https://resourcesforintegratedcare.com/CulturalCompetency/2018_CC_Webinar/LTSS

Featured Webinar Speakers:

- Darci L. Graves, Special Assistant to the Director, CMS Office of Minority Health
- Jenna McDavid, National Managing Coordinator, Diverse Elders Coalition
- Lisa Waisath, Director, Nikkei Manor Assisted Living, Keiro Northwest
- Kiet Blakes-Thompson, Director, One Care LTSS Coordination, Boston Center for Independent Living
- Gabriel Uribe, Independent Living and Diversity Services Manager, Inland Empire Health Plan

Hiring and Training for Cultural and Linguistic Competence

Q1: What are best practices for agencies/service providers recruiting bilingual staff?

Gabriel Uribe: At Inland Empire Health Plan, we work with a group of around 500 community-based organizations. Therefore, we have established relationships with a lot of organizations that also work with the populations we serve. When we are recruiting for different positions, especially positions that have a high degree of member interaction, we promote these opportunities to this network of organizations in the community. We have been pretty successful at hiring people from the communities we serve that can meet the cultural and linguistic needs of our members.

Q2: What are the challenges with finding and keeping culturally competent direct care workers? How can one overcome these challenges?

Gabriel Uribe: One unexpected challenge to finding and keeping culturally competent staff may lie with the organization itself. We have found that organizational commitment to cultural and linguistic services can be a challenge. Organizations may treat cultural and linguistic requirements as checklists and may not connect these with program planning throughout the organization. Developing a data-driven approach allows professionals to demonstrate the need for cultural and linguistic services. As those services and interventions are developed, data can then be collected to assess internal impact and contrast it with external data sets for similar populations. In terms

of finding culturally and linguistically competent support staff, we have found that engaging community partners with this skillset as part of regular business has provided exposure of the plan's commitment to culturally and linguistically competent services and has given us the opportunity to recruit from members of the communities we serve as positions become available.

Q3: Can you provide best practices for working with translation or interpretation services? What mode of communication has proven most successful (e.g. phone, in person)?

Gabriel Uribe: Best practices for working with translation or interpretation services, in our experience, include having multiple options available. These could include telephone, in-person, and video remote interpreting modalities, among others. Access to services should be easy and systemic barriers should be mitigated accordingly. Lastly, allow members to choose the best option for themselves and clearly define access standards. For example, in-person translation may take three to five days to secure, video remote interpreting is widely available in urgent care and emergency room settings, and telephone-based interpreting is available at all contracted providers.

Evaluation and Assessment of Culturally Competent Care

Q4: Are there any good evaluation tools to help track and improve delivery of culturally competent care?

Darci Graves: The National Center for Cultural Competence, part of Georgetown University, has a large number of checklists and tools available on [their website](#). These checklists may not be perfectly tailored for your organization, but they are a great place to start.

Gabriel Uribe: Inland Empire Health Plan uses tools and questionnaires that we have developed for other populations. We work with consumer engagement groups, similar to focus groups, to get feedback about the tools we use to assess risk. This usually leads to adding or modifying certain things in the tool or the script we use to walk through the tool with the member. This ensures that when we ask about certain topics or ask for information about their health, the responses can be operationalized to address the members' needs from a culturally competent perspective.

LGBT Cultural Competence

Q5: Can you provide an example of the type of training that is recommended for staff who are serving dually eligible beneficiaries from the LGBT community?

Jenna McDavid: The SAGE Care training program is one example. We recommend that all staff are trained, from the receptionist, to maintenance, to doctors, to administrators. SAGE Care will train your staff in your facility or through a webinar platform and will teach your staff about what an LGBT identity may encompass, including sexual orientation and gender identity, some of the health disparities faced by LGBT communities, and, most importantly, what you can do to make your facilities more welcoming and affirming of LGBT people. You can get more information about this training through the Diverse Elders Coalition website, www.diverseelders.org, or SAGE's website <http://www.sageusa.care>.

Q6: Do you have recommendations for resources or strategies for LTSS providers on ways to assess LGBT individuals for their needs and preferences? What can LTSS providers do if they want to learn more about providing culturally competent care for LGBT individuals?

Jenna McDavid: SAGE's [National Resource Center on LGBT Aging](#) is currently working to adapt the Consumer Voice form [My Personal Directions for Quality Living](#) to make it more inclusive for LGBT older adults. An announcement will be made through the Resource Center's [monthly newsletter](#) when the updated form is available. The National Resource Center on LGBT Aging also has Best Practice Guides that can help agencies as they establish LGBT older adult inclusive services. You can download copies of the guides here: www.lgbtagingcenter.org/guides.

Q7: What resources are available to educate providers about LGBT individuals and to connect them to those members that feel like they are not receiving adequate care to meet their needs?

Jenna McDavid: SAGE runs a national training program for health care and social services providers who are seeking LGBT cultural competency training or consultation on LGBT aging issues. SAGECare also offers an opportunity for qualifying agencies to receive a national credential to highlight their commitment to LGBT older adult services and inclusion. To learn more about the training options visit www.sageusa.care.

Inland Empire Health Plan LTSS

Q8: How does Inland Empire Health Plan train the team that serves members with LTSS needs with regards to achieving cultural competence?

Gabriel Uribe: Inland Empire Health Plan uses an industry-leading curriculum, which was developed through the Health Industry Collaboration Effort (ICE). We also take advantage of experiences within the health plan interdisciplinary care teams, which meet weekly to discuss

cases. We share lessons from these through case studies and discuss them with incoming team members during the culture and linguistics training that we do for our team members.

Q9: Do Inland Empire Health Plan members have input in choosing the caregiver that works with them?

Gabriel Uribe: Yes, members seeking LTSS can choose their caregivers based on their health and social needs.

Q10: Since Inland Empire Health Plan uses three different units working with one member, does that make care confusing for the member?

Gabriel Uribe: Within the Plan, we establish a primary liaison for all units involved and ensure that an interdisciplinary group is aware of that point of contact. We rely on our MediCal Management System to record all interactions, and staff are asked to review notes relevant to a member's active case to bring that information to the point of contact as needed.

Cultural Competence in Assisted Living Facilities

Q11: How do the staff at Keiro Northwest assess incoming members for their cultural needs and preferences? What aspects of their preferences do the staff make sure to identify?

Lisa Waisath: When residents first move in, we conduct a nursing assessment just like any other assisted living facility would do to assess residents' care needs. However, part of our assessment process is to also ask about their preferences for language, food, activities, and social integration. We provide each new resident with a move-in packet that includes forms for dietary and social preferences. This allows us to learn more about them and what they would need to be comfortable and happy in our facility. We also have feedback forms available so that we can find out what they are enjoying, what they would like more of, and what they want less of. This feedback is used to develop and improve our programming. For the linguistic aspect, if a resident comes in and is only comfortable speaking in Japanese, we will conduct these assessments in Japanese. The inclusion of a native speaker into the process is very important for that initial assessment to ensure you are getting an adequate picture of the member you are serving.

Q12: How do you provide culturally competent care within assisted living facilities when residents come from different cultures?

Lisa Waisath: The main thing is to get to know your residents as individuals. We use a social and activity profile when residents first move in to learn about what things they enjoy doing (or have

enjoyed doing in the past, including church affiliations, cultural groups and activities), language preferences, and anything else they want to share with us that they feel is important for us to know about them. We use these profiles in multiple ways: as a means to develop our activity program to meet the needs of our residents, as a way to see what they might have in common with others, and as a first step for our staff to get to know the resident. If we get a resident with a cultural background we are unfamiliar with, we begin by talking with the resident and family to find out what is significant or important to them that we might be unaware of. We can also reach out to other organizations that support the cultural community the resident might be from to learn about cultural norms.

Q13: Have you been able to identify models similar to the Keiro Northwest model for different cultures?

Lisa Waisath: In Seattle, there are a few organizations that are using similar models. There is an assisted living facility down the street from our location that focuses on a broader Asian community. They are 100 percent Medicaid, and therefore most of their residents are dually eligible beneficiaries. They do a wonderful job at providing culturally competent care and have incorporated adult day health into their programming as well as intergenerational work with their adult residents and children at the childcare location directly next to them. There is also a skilled nursing facility in Seattle that focuses on providing culturally competent care to the Chinese population that is using a similar model. In our area, we have culturally competent assisted living and nursing facilities available for our Asian community members, but have fewer options available for other racial, ethnic or other minority groups. However, there is a skilled nursing facility in Seattle focused on providing culturally competent care to the LGBTQ community, so the larger community is growing its capacity to provide culturally competent care in that sector. The trend we are seeing now is people paying attention to the needs of particular groups.

Q14: Has there been any research or study to see if members that are in a culturally competent setting, such as Keiro Northwest, are healthier than older adults that are not in culturally competent settings?

Lisa Waisath: While I am unable to identify any specific studies that have been done, I can say anecdotally that we have six residents that are either 100 or 101 years old. I have never had as many in this age group in any other facility. The average age in our facility is 94. I do not know if that is a factor of their cultural lifestyle – their eating, their attitudes toward health, fitness and mindfulness – or if that is a reflection of our policies. My guess would be that it is a combination of both. I can tell you that we have heard from our residents and our family members that the

care they get at our facility, because it's culturally sensitive to them, has made an impact on their lives and their wellbeing.

Q15: Are there any resources, research or data related to disparities in assisted living communities?

Resources for Integrated Care: There are a number of resources available; one example is this [resource](#) from the American Society of Aging, which describes disparities in access to culturally competent assisted living for individuals from diverse backgrounds. The article can help providers and plans understand disparities and opportunities for improving care in assisted living facilities.

Culturally Competent End-of-Life Care

Q16: How do providers deliver culturally competent end-of-life or palliative care for individuals and families in LTSS settings?

Lisa Waisath: Again, get to know your residents as individuals so you know what is "normal" for them and what their preferences are. Talk to the families to find out what, if any, special ceremonies or rites are appropriate for those at the end of life, what their after-death beliefs are, and ask how you can support them. If they are Buddhist, for example, we might have the local Buddhist priest come in and provide spiritual care for them, help them manage their butsudan (personal Japanese Buddhist shrine) offerings if they are unable to do it themselves, and provide a space for the family to hold the one-year anniversary memorial after the resident has passed away.

Gabriel Uribe: We treat this as a group effort. We work closely with our palliative and hospice providers. They are aware of the plan's resources and the plan is aware of the provider's resources as well. We work together to meet the needs of a member and leverage community-based organizations as needed.