

The Lewin Group
Providing Culturally Competent Care -- Meeting the LTSS Needs of 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, *Providing Culturally Competent Care, Meeting the LTSS Needs of Dually Eligible Beneficiaries*.

Today's session, we'll include a 60-minute present-led discussion, followed up with 30 minutes for a discussion among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at 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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This webinar is supported through the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. MMCO is the developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle @integrate_care.

At this time, I would like to introduce our moderator. Renee Markus Hodin is the Deputy Director of 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, everyone. Good morning or good afternoon, depending on where you are. I'm just really honored to be moderating this webinar especially during Minority Health Month, and also to be working with the Lewin Group through the Centers for Medicare and Medicaid Services.

So the topic of this webinar is really near and dear to our hearts at Community Catalyst and the Center for Consumer Engagement in Health Innovation where we work to promote health equity for underserved populations in all health system transformation efforts.

I'm really pleased to be introducing our five speakers and also to offer a road map for our time together.

We'll start with some of the basics by providing background on the demographics of the dually eligible population, the prevalence of LTSS needs and what it means to provide culturally and linguistically appropriate services to these populations.

These topics will be covered by our first speaker, Darci Graves, who serves as special assistant to the director of the Office of Minority Health at CMS. In this role, she assists in the coordination and implementation of priority office-wide programs policies and products. In addition, she provides subject matter expertise in areas such as culturally and linguistically appropriate services, cancer, health disparities and health equity. Her work is built on a long career in the fields of cultural and linguistic competence and health education.

Once we've covered the basics, we're going to shift to talking about older adults who currently make up nearly 60% of the dually eligible population. To kick this part off, we'll hear from Jenna McDavid, who will discuss some of the existing disparities among various diverse older adult populations.

As a national management coordinator for the Diverse Elders Coalition, Jenna is wonderfully positioned to discuss this topic. The Coalition is an advocacy organization supporting policies and programs that improve aging in communities of color, American-Indian and Alaskan Native Communities and LGBT communities.

In her role at the coalition, she ministers aging policy and crafts coalition-wide responses to ensure that diverse communities are at the table when the decisions that impact their lives are being made.

Prior to working with the Diverse Elders Coalition, Jenna was the program director for the National LGBT Cancer Network, where she helped to build an LGBT culturally competency training for healthcare and social service providers.

Staying with older adults, we'll then turn to Lisa Waisath from Keiro Northwest. Lisa will provide a case example of how the values preferences and needs of Japanese older adults are honored at the Nikkei Manor Assisted Living facility in Seattle, Washington.

Lisa is the director of Nikkei Manor overseeing all operations of the facility and directing department managers responsible for all aspects of services provided. Lisa is certified as a geriatric wellness instructor as well as a facility based trainer and continuing education curriculum developer. She has over 15 years of experience in assisted living.

After Lisa, we'll shift gears to the other approximately 40% of the dually eligible population, adults 21 through 64 with disabilities. Getting us started will be Kiet Blakes-Thompson who will provide a case example from Massachusetts.

Kiet is the long-term support services program supervisor at the Boston Center for Independent Living. As program supervisor, she is committed to ensuring that BCIL's clients with disabilities receive high quality independent living services that meet their cultural preferences and needs.

Before joining BCIL, Kiet worked as a direct residential care counselor for the Home for Little Wanderers for At-Risk Youth and later at the Boston Public Health Commission Men's Homeless Shelter.

For our final speaker, we'll head back to West Coast and hear from Gabriel Uribe who will share with us how a health plan identifies and helps to meet the culturally competent LTSS needs of its members with disabilities.

Gabriel is the independent living and diversity services manager at Inland Empire Health Plan in California, a plan serving dual eligible beneficiaries through the state's demonstration project.

Gabriel has over a decade of professional experience in the delivery of public services for populations that experience social, educational and health disparities. His commitment to these issues runs deep. Currently serves as the President and Chairman of the Inland Empire Disabilities Collaborative and is a member of several advisory and stakeholder groups focusing on serving seniors and people with disabilities throughout the Inland Empire.

Again, I couldn't be more pleased to share with you all of our incredible group of speakers and let's get started with Darci Graves. Darci?

Darci Graves: Thank you, Renee. Good morning and good afternoon, everyone. We can go ahead and go to the next slide, which offers just a little bit of a framework of how we look at things with here at CMS and at the CMS Office of Minority Health about how we're going about trying to achieve health equity. And it really kind of focuses in on increasing understanding and awareness of disparities, developing and disseminating solutions to address those disparities and then implementing sustainable actions.

And where that kind of comes into today's presentation is, for an organization to be culturally and linguistically appropriate, they need to understand and be aware of those that they are serving, the solutions that they develop need to be culturally and linguistically appropriate and then obviously you hope that the sustainable actions are also in line with your stakeholder or community needs. So there's always a lot of talk. When we talk about cultural competency, what does that mean?

So when we go to the next slide, you'll see a very wordy, academic definition of cultural competency. And I won't read this to you. But what I really want to key in on is that cultural competency is the ability to work and effectively communicate in cross-cultural situations.

As one of my good friends and colleagues likes to say, every situation is a cross-cultural situation. We are a very diverse country, we are a very diverse world, and we move around so much more than we ever did before. So when we're interacting with new people, we have to sort of assume that we're in this new sort of cross-cultural setting, but what does that mean or what does that look like?

On the next slide, we're talking about culturally linguistically appropriate services, and this is really how I see when you operationalize cultural competency, this is what it becomes.

Again, I'm not going to read the definition to you. But what I want to note is that culturally linguistically appropriate services aren't additional services. They're making sure the services you are providing are culturally and linguistically appropriate. So it's not an add-on, it's looking at your daily routine, your daily activities and really seeing how it can be tweaked to be more inclusive, more -- have a higher recognition of the various individuals or community needs that you may have. In that vein, as we move to the next slide, we will talk about culture, what does that include?

This is a Venn diagram. It's a model that I developed for a presentation, workshop that I gave a number of years ago when I was still working at a medical school in the Midwest. And the reason I use this model to talk about culture is because, all too often when we talk about culture, we talk about it in silos. We talk about race and ethnicity. We talk about gender. We talk about whether they're in a rural community or an urban one. But we tend to forget that intersectionality, that word that we now use a lot of. But really it's this Venn diagram. We can't piece apart an African-American woman's perspective. We can't piece apart if some identifies bisexual Latino male. All three of those elements or all two of those elements impact the way that an individual receives and perceives information. And so those are all the different things that we have to take into account when we talk about culture.

One of the things that we also talk about in the definitions of cultural competence and then operationalizing culturally and linguistically appropriate services is points of contact. And often, when we talk about making sure something's culturally appropriate,

we target right at that -- we go straight to the clinician provider, patient, beneficiary or resident sort of perspective. That what happens within the four clinic walls or within the clinical encounter.

And it's really so much more than that. Because when an organization, no matter what you're doing interacts either passively or actively with stakeholders in a myriad of different ways. And this slide just kind of highlights that few of them. How did they learn about your organization? How did they help differentiate your organization from your competitors?

If they call and try to make an appointment, are they able to do that? Is the facility appropriate? Do nonclinical staff also have training in cultural and linguistic competency to make sure that they're aware of how to interact with individuals from different cultural or language backgrounds?

So now that we've kind of laid that very quick foundation, I just want to provide a couple of examples of what CLAS can look like. This comes from the HHS Office of Minority Health as opposed to the CMS Office of Minority Health as a set of standards that help organizations operationalize cultural competency and their called the National Standards for Culturally and Linguistically Appropriate Services and Healthcare also known as the National CLAS Standards.

And so these examples come from those standards. So that's where these example come from if you want to learn more about them. But again, that first one, it's about establishing culturally and linguistically appropriate policies. Not a policy on culture and linguistic competency per se, but are the policies on how you do outreach or how you treat a patient or how you interact, are those themselves culturally and linguistically appropriate?

We're talking about doing assessments and looking at data. And I'll talk a little bit more about data in just a moment. But knowing what we know, that first part of that path to health equity, being understanding and awareness.

Here we are looking at the data. I'm going to kind of contextualize from a dual beneficiary perspective, and then we'll drill down a little bit further into dual beneficiaries, dual eligible beneficiaries who work or utilizing LTSS.

And so this first graph shows a gradual shift in the age distributions that have happened between 2006 and 2016. And all of these, the first three graphs I'll show you all come from a data analysis brief that's on the MMCO website that I'm sure we can get the link to you.

The next two slides help illustrate the gradual shift in the racial and ethnic composition of dual beneficiaries between 2006 and 2016. So this slide kind of gives you the overall perspective. Then when we go to the next slide, you essentially see that zoom in. So this slide is the same as the previous one except that it excludes Whites so that you can get a

better view of these African-American, Hispanic, Latino, Asian and Northern American natives.

So in quickly transitioning to the next slide, and I realized as I was preparing my talking points with this, I could have made this slide a little bit more clear. So to contextualize this slide, 77% of dual beneficiaries do not currently utilize or partake of LTSS. But 23% do. And this table represents those 23% of duals that are using some sort of LTSS and their ratio on ethnic breakdown within those groups.

When we look at it by LTSS type, we look at home health or personal care settings, 6% of that 23% use home health, 8% of that 23% use nursing facility services and institutions, and then 1% uses other sorts of LTSS.

Before I turn it over to the next speaker, I just want to highlight a couple of other resources on this next slide that we at CMS Office of Minority Health have done. These are all part of our building an organizational response to health disparities portfolio. And they're all available on our website which is go.cms.gov/omh. And with that, I will turn it over to Jenna. Thank you so much.

Jenna McDavid: Thank you so much, Darci. Hi, everybody. My name is Jenna McDavid, and I'm the National Managing Coordinator for the Diverse Elders Coalition. For my piece of this presentation, I'm going to talk a little bit about our coalition and I'm going to share the highlights of some work that we did recently that shed light on the unique needs of diverse elders seeking long-term services and support.

So first, let's talk about who the Diverse Elders Coalition is and who we represent. We are a national policy advocacy coalition working on behalf of elders and communities of color, American Indian and Alaskan native communities and lesbian, gays, bisexuals, transgender and queer or LGBTQ communities as well as any elders whose identities may encompass more than one of those categories.

We know that the United States is growing older, but it is also growing more diverse. And currently one in five people in the United States is a person of color or an American Indian or Alaskan native elder. But by 2040, that number will jump at to one in three. And similarly, as acceptance grows for LGBT identities, more people are embracing their own sexual orientations and gender identities and coming out as LGBT.

As a result, there are more supports that are needed for the growing population of diverse older American. The coalition's work focuses on strengthening policies and programs that enhance the health and well-being of diverse elders. And we call on lawmakers and service providers to craft targeted programming that address health disparities and acknowledges the lifetime of discrimination that many diverse elders have faced.

Our coalition members include five national aging advocacy and service organizations. Some of whom you may already recognize.

These are the National Asian Pacific Center on Aging or NAPCA in Seattle, Washington; The National Hispanic Council on Aging or NHCOA in Washington, DC; The National Indian Council on Aging or NICOA with an I in Albuquerque, New Mexico; SAGE who works on behalf of LGBT elders and is based in New York, New York; and the Southeast Asia Resource Action Center or SEARAC based also in Washington, DC.

In 2010, the leadership of these five organizations came together to identify some projects and policies that would improve the lives of diverse elders. And since our founding, the coalition has built a strong collective political voice that advocates for the kinds of changes that will raise awareness of the unique aging needs of our communities and improve health equity for diverse elders.

So in 2016, the Administration for Community Living issued a public comment period on its guidance template for state and area agencies on aging. We asked the diverse elders in our networks as well as their caregivers and their family members to respond to this public comment period with their response on how their local aging agencies could better meet their needs.

Over the 60-day comment period, the Diverse Elders Coalition collected nearly 5,000 comments from elders and community members in all 50 states. And then we used print and digital comment cards that were translated into six different languages. We shared these comments with the ACL and we hope that they would use them to guide their policies and programs. But we also wanted to share the comments and our resulting recommendations of policymakers and service providers who worked with diverse elder.

One of the most common themes to the comments that we collected from all different communities was the need for culturally and linguistically competent services. The elders who responded to our request for comments overwhelmingly talked about the challenges that they faced when accessing programming and services in their communities. Many services were not sensitive to the unique cultural or linguistic needs.

I want to share a few highlights here from each of our coalition members. After this presentation, I invite you to contact us if you would like to be better connected to the communities and the community-based organizations in your area, so that you can analyze and respond to the needs of the diverse elders you serve. If you would like to read the full report, you can find it on our website at diverseelders.org.

So when we heard some Latino seniors during this campaign, we overwhelmingly heard about language challenges. A PEW research report from 2015 found that just 4% of the Hispanic American who speak English very well are 65 or over. And we know that about only 1 in 10 Latino older adults accesses Older American Act services like Meals on Wheels or the National Family Caregiver Support Program despite higher rates of poverty and chronic illness among Hispanic seniors when compared to White seniors.

Many of the comments complained about the complex forms that have to be filled out in order to access services. And if the forms or your outreach materials aren't available in Spanish, you're losing clients even before they walk in the door.

The comments that we received from American Indian and Alaskan native elders reflected a dearth of services in tribal communities. We heard from elders who live on reservations or in border towns where there are only dirt road, limited access to phone and internet services and very few medical or service providers were willing to travel out to Indian country.

It was really clear to us that these elders and their family members wanted more LTSS options and services, but their providers really just aren't there. And often when they are there, providers don't necessarily form strong bonds of tribal communities and tribal governments to ensure that the services being provided are sensitive to the traditions and the beliefs of American Indian elders.

One story I heard that just haunts me to this day was about an American Indian woman who had developed dementia and no longer spoke very well. But she often wore traditional tribal garments that were important and comforting to her. This woman was receiving care from in-home care workers who had not received training specific to the customs of her tribe. And on one occasion, they were unable to undress her. And they ended up cutting off her clothing in order to get her out. But in her community, those beliefs are that when clothing is cut from a person, it's only after they have died. So her family found out about this later and they were understandably upset about the breach of their tribal traditions.

Long-term services and reports in Indian country and serving American Indian and Alaskan native elders, the issues there stem not just from having few options available, but also making sure that the options we have for tribal community members incorporate traditional food and are respectful of beliefs and cultures will also deliver in quality care.

For LGBTQ older adults, we heard that it wasn't necessarily language or geography that prevents them from accessing services. Although, that can also be the case. But LGBTQ older adults' unique concerns really stem from a fear of discrimination.

Like other groups served by the Diverse Elders Coalition, LGBTQ older adults face higher rates of poverty and social isolation. But they also have lived and are currently living through a time when they are criminalized for who they are and who they love. Brand new AARP research just released last month, found that more than 60% of LGBTQ adults aged 45 and over, say that they worry that a long-term care facility might refuse care or provide reduced care because of their identities. They also fear neglect or abuse at the hands of caregivers.

So LGBTQ older adults overwhelmingly told us that they need health and social service providers to be open, welcoming and affirming to LGBTQ elders. Many of whom have no children or close biological family members to support them.

We've heard alarming stories from older adults who had to present as siblings or cousins in long-term care settings when in reality, they're partners. We've heard stories of care providers misgendering older adults who identify as transgender, both intentionally and unintentionally. And we heard about outright refusal to provide care from religiously affiliated service providers who think that their religious freedom grants them a license to discriminate against LGBT communities.

These policies and practices are having an enormous impact on the ability of LGBT older adults to age in good health and with dignity.

Finally, the last group I want to discuss is the Asian American Pacific Islander and Native Hawaiian or AAPI communities. Many people look at the research around AAPI aging and think, wow, the health of these communities seems quite good in comparison to other communities of color.

Their educational attainment is good but that's actually, the really insidious model minority myth, which masked some of the very real challenges and widespread discrimination that AAPI older adults access or face when they access their assistance and support. Providers have to remember that the umbrella term, Asian and Pacific Islander, actually encompasses as many as 25 different ethnic subgroups living in the United States who speak over 50 different languages.

And when you break down the categories you'll discover that some AAPI populations are faring much worse than others. Our coalition member of the Southeast Asia Resource Action Center created the infographic that you see on this slide based on the research from the National Asian Pacific Center on Aging as well as the comments that the coalition received during our campaign.

When we look at just the populations defined as Southeast Asian-American which include Vietnamese-Americans, Hmong, Laotian American and Cambodian-American we found that as many as 90% of these older adults are limited English proficient and many are living in households where no one speaks English at all.

The comments that we received from these communities spoke about the frustration of the experience when trying to use automated phone menus or read mail that came in from service providers. And in a lot of these cases there are few supports in their communities to help with filling out these forms, translating letters or helping older adults navigate the services and supports that are available to them.

So all the findings from comment card project including health disparities, sample comments and our three recommendations for policymakers and service providers are available in our report, Aging with Health and Dignity -- Diverse Elders Speak Up. This work is unique because the foundational material which guides our recommendations here as well our coalition's work moving forward is the voice of the elders themselves.

The remainder of our presentation today is going to speak to some of the strategies that LTSS providers are using to reach populations like those served by Diverse Elders Coalition. And at the end of the webinar, we'll have some additional resources for you to check out and again if you want to read this report, you can find it at diverseelders.org.

I now would like to turn it over to my colleague, Lisa. Thank you so much.

Lisa Waisath: Thank you, Jenna. And actually we do use NAPCA in our buildings, so it's wonderful to follow you in the step. So my name is Lisa Waisath, I am the Director of Nikkei Manor Assisted Living here in Seattle and I am part of Keiro, Northwest.

We were purpose built in 1975, the organization was by Nisei, which are the second-generation Japanese-American community, to build a skilled nursing facility for their Issei, first-generation parents, because they were seeing their parents in skilled nursing facilities here with no language capability and no foods that were appropriate to them and no activities that were familiar. And so they took upon themselves to build that. So we currently now have a skilled nursing facility and an assisted living facility that address those needs as well as an adult day social program and homecare. So between those four programs, we serve about 250 individuals. About 60% of those are dual eligibles and in my particular building, it's about 12 % that are dual eligible.

So in identifying those preferences back in 1975, they were looking at what their Issei parents or Japanese needed. Flash forward about 20 years and those Nisei folks realize they needed something for themselves, but it wasn't necessarily Japanese, it was Japanese-American. So that's when they created my particular building, my assisted living community.

Currently in my building, about 20% of our residents are Issei, they are Japanese. But 70% are Nisei and of those 70%, only about 50% are bilingual. So we really have to address a couple of different sets of needs in my community.

So because we were purpose built, there are some things that kind of came hardwired in for us to be appropriate to the culture we were serving. The first was architecture. The bottom picture is the picture of a Torii gate that is at the side of our property. It is a ceremonial entrance and that very much harkens back to the Japanese culture that started all of this for us.

But in the garden that you can see right there, that was actually built six years ago in coordination with the University of Washington School of Landscape Architecture. And those students did not want to be insulting and try to build a Japanese garden because they knew they didn't have the depth of knowledge. So they did focus groups with our residents and our participants to find out what they wanted and then they added what they termed Japanesque elements that were reflective of the culture.

So the structure that you see, which is the covered sitting area, the woodwork there is reflective of the Japanese aesthetic. The crane motif that goes through our entire building,

which is not visible here, was incorporated into that. The selection of the plants themselves and even the name of the garden which is Ichigo Ichie, which means one moment in time, is significant. So those were all incorporated into that garden.

Walking into our building, there is a lentil over the front door and we have two lintels, one over each dining room that came directly from a Shinto temple in Japan, so those were all reflective.

Again, being purpose built when you come into the core, it reflects the culture that we're serving. So we have a lot of natural elements with bamboo and woods, stone-look tile, those kinds of things and the color scheme. We have art that's reflective of the Japanese culture, but also of the Japanese-American culture. So we have local artists from the Japanese-American community who have donated art to our building so that that connection is there for our residents to see.

In the bottom picture, you'll see what looks kind like a mobile and that is actually a thousand origami cranes that have been strung together. And those origami cranes are a token of good luck and prosperity and so having a thousand of them is very auspicious. So we actually have a couple of those that have been made and given to us throughout the building.

Things that were originally identified by the Nissei for their Issei parents, food was one of the top things. They weren't getting the foods they were used to. So we have that incorporated into what we do. We have chopsticks at the table for the residents who prefer to use chopsticks. The plating is setup in a Japanese style. So instead of being on a white plate and all food in one place, it is set up on their own individual plates the way that they expect it to be. So the rice is in rice bowl, but the soup is in a soup bowl and they're very different. We also have some different condiments on the table. So they're soy sauce or furikake that they would explain.

We have also special occasion foods. So we have sakura mochi, which is this wonderful pounded rice treat that is pink and wrapped in green preserved cherry leaf for girls day in May or we have the osechi bento, which is a very special bento box for New Year's but very special foods that linked to the New Year.

The other thing that we have to help our staff understand if they're not Japanese by heritage, is that sometimes you have to put your Japanese nose on when you smell some foods because there are some very strong smell that come from either the mackerel or some of the other things and if you smell that in your own home you might be concerned. But to put in your Japanese nose, here you're like, "Oh, that's lunch." So that's kind of a different aspect that some of us have had to learn.

Another thing that was initially identified was the language. And so for here, we're very strong on this. All of our menus and our calendars are printed in English and Japanese for our residents. Resident council is held in both languages, and the minutes are printed in both languages. We hire bilingual staff especially for our front desk. And we also learn

from the residents, which is wonderful. They like to share their language. But in a more purposeful manner at our all staff meeting we have a word or a phrase of the month, so that all of the staff are learning whether they're care staff or housekeeping or dietary.

Currently we're doing Japanese and Cantonese because those of the residents we're serving, but don't speak English, but it also has included Korean in the past.

Another one of those initially identified items was activities. And so activities that are traditional to the culture like sumie calligraphy painting or the mochi pounding for New Year's or going out and doing the Japanese cherry blossom viewing at the University of Washington campus. Those were all things that are part of that culture that are really meaningful to our residents. So we've incorporated those.

Some of the decisions on what activities to run comes from our initial activity assessment with the residents but also from ongoing expression of interest from the residents. So we have feedback forms for activities as well as meals. So residents can tell us what we've done right, what we've done wrong and what they might like to see instead. There are some cultural ones that you'll never find on a Caucasian calendar for activities like corn husking which is a big activity in the late summer. The mochi making is a lot of fun. The Hyakkunin-isshu is actually a game that you to know Japanese poetry to play, but our residents love it and the fact that we have it for them is very special.

Some of the other activities are very popular are music and actually all three of our activity spaces have pianos to address that. So we have sing-alongs in English and Japanese both, we have performers that bring in traditional instruments like the taiko drums that you see there. We also have other performers that come in to do traditional dances.

We also bring in new music, so we have student groups that come in from Japan who will do performances for our residents and it's so fun to listen J-pop that they want to do with them. But we also have a lot of residents who are from Hawaii and so we have performers that come in and bring Hawaiian music to us so that we can enjoy that.

Other traditions and customs that we have made sure that we are cognizant of are things especially from the Buddhists traditions because we have several residents who are Buddhists.

So the upper left corner you see is a Butsudan, which is a small shrine that Buddhists may have in their home to acknowledge and honor their ancestors. And so we do some training with our staffs, especially with the housekeeping staff to understand what that is. So when they're coming in, they're not trying to rearrange it and clean it.

The fire department also we went to them and got a waiver so we could use incense so the residents could put incense on their Butsudan as they would have at home or when the Buddhist services come into the building they can use incense as they would normally.

We've also had to understand the gift giving etiquette of our Japanese traditions because there was a whole etiquette about which hand to use when you take the gift or when you give the gift, where you open the gift and how you reciprocate that. So it's very important to know those things.

The bottom picture is a little layout of a bedroom because one of the things that we learned along the way was that when somebody dies and they are put into ground, their head faces north and so you never want the bed head facing north in a bedroom. So now when we even do tours, I point out which wall is the north wall so they can figure out where they want to put their bed when they move in.

We have lots of celebrations just like every other community does. In most communities if you had somebody turning 80 or 90 or 100, those will be your touchstone years. For us, it's 88. Because 88 is an auspicious number times 2, 8 is amazing. So we have 88th birthday parties, which you probably wouldn't find in other places. But here it's a big deal. They send out invitations and do a huge do over them. If we have a big celebration, we might do the breaking of the sake cask, which you see at the top there. There's also a holiday called Keiro no hi, which is respect for elders days and that again harkens back to how your ancestors are very important. So we have a lot of these celebrations that you may not find in other communities.

Our particular community went through some very unique experiences in World War II with the incarceration in internment camps and also of those gentlemen who volunteered to serve in the 442nd and military intelligence services. So really that is kind of the core of the identity of the Nissei generation that we serve. We're very close to the Nissei veterans who are just down the street from us. But for the other things that are happening within the Japanese-American community to help our residents maintain that sense of identity we stay very close to them. So post flyers when they have events going on. Sometimes we turn things into an outing for them or we'll provide transportation if we can't put it on our own calendar, we've hosted some other events in our building, but we want to make sure that everybody continue to have contact. So with like the Japanese-American Citizens League, who's an advocacy group, or the Minidoka Pilgrimage who actually takes people to Idaho so that they can see what that internment experience was. We make sure that they stay in contact with those kinds of programs.

And ACRS is the Asian counseling service and we want to make sure we stay in contact with because the Asian concept of mental health is different in some ways than the mainstream white act idea of that. And so we want to make sure the access to those culturally appropriate services as well.

We also want to make sure we're in contact with the general community because again 70% of my residents are Nissei, they grew up here in the United State and they're part of the bigger community, not just that small or Japanese and Japanese-American community. So we want to make sure they can still go to the theater, in the opera, in the art museums, they can go down the street and see the Mariners play, those kinds of things.

The gentleman you see on the top corner in the hat, he's one of our Nissei veterans who lives here and he's presenting to the King County Council, so he is taking his Japanese-American experience and bringing it out to the wider community in that photograph. And we really want to make sure that they have the opportunity to do that.

The ICHS, which is a health service in the area, some of our residents believes in herbal pharmacy or they might want to use acupuncture so making sure they have access to those things. But overall we want to make sure they still have access to their normal life. So they're grocery shopping and they're contributing to the local community and going to church whether they're Buddhists or Methodists or even Presbyterian.

Lastly for our staff, we want to make sure that we are hiring for cultural competence. So for my reception staff, my activity staff, most of them are native Japanese. Some of my care staff are as well. But that's not true obviously for everyone. My front desk staff must be bilingual because they have to be able to answer the phone for families who are Japanese. But in saying all of that, when we bring people on, we do an orientation to give them a high level cultural background of the community they're going to be serving. We do that phrase of the month that I said in our all-staff meeting. We give information about cultural norms, like eye contact, so you don't hold it like you do in a Caucasian society, and what respectfulness looks like and means in this culture. We also have some staff that take upon themselves to go and take language lessons on their own, which I think is wonderful.

We also have -- what people are doing, they're working, if we catch that they have missed a cue, have missed some kind of cultural thing, we'll do an instant in-service so that they can see those things. And I know this is a lot of pictures and a lot of information, but these are things that you absolutely can do in your own community as long you get to know that you're serving appropriately.

So thank you for giving me all that time to tell you those things. But now, I'm going to pass it off to Kiet and let her speak.

Kiet Blakes-Thompson: Hi. I'm Kiet Blakes-Thompson. I'm the director of the One Care Long-Term Supports Coordination at the Boston Center for Independent Living.

Here at the Boston Center for Independent Living, we are a state IL and we follow the five core services that is required by the state federal government for IL's, peer mentoring, skills training, information and referrals, advocacy and transition.

A little bit about the One Care, BCIL partners with One Care, the One Care Program is the Massachusetts Medicare-Medicaid Financial Alignment Demonstration for adults living with disabilities who have Medicare and Medicaid coverage. They cap with financial assignment initiatives, offer services for these individuals in Massachusetts that when they came up with One Care program into three contracts to provide

comprehensive and coordinative care for those people that are being serviced in that demographic.

These programs implemented a consumer-driven care team comprised of medical professionals and long-term care coordinators. BCIL contracts with Commonwealth Care Alliance; One Care health plans provide LTSSC coordination services for their members.

LTSSC coordination, what LTSSC coordinators do to provide cultural competency for their members, once they're enrolled in the One Care program, members have the right to have an independent living center on their care team as well as an LTSSC coordinator on their care team. LTSSCs find resources and services within the member's community to help support their wellness and their independence to help them reach their recovery goals.

So what this means for the consumer and for the LTSSC is that we're literally maintaining what it is that they feel they need to live independently in their community. Whatever their definition of independence, we're literally there to meet their goals. So if that is speaking with somebody who speaks their native language, that is what we're there for.

LTSSCs are employed by independent living community organizations, such as BCIL, also Boston Home, elder services is also another IL service here in the State of Massachusetts. This ensures that LTSSCs can advocate for the member's needs in an unbiased manner. It kind of allows us to stay away from the medical term and where just literally embroiled in what the member needs.

How LTSSCs exhibit cultural competency. The health plans initiate referrals to BCIL. And I then start assigning and assessing the member's needs, for example, the referral should include information on the member's native language. This knowledge will be prevent -- prevent ineffective encounters and possible embarrassment and advert alienation to the member.

LTSSCs often travel to locations required by the member becoming familiar with these service areas and both satisfy a safety tactic and potential and rapport-building topic of conversation.

So for an LTSSC to walk into a member's home, it is, one, very important for LTSSCs to know who the member is. So when we get these referrals from One Care, we are literally looking at things that One Care is seen to be important. Who these people are, what defines them is whether it be their race or age, their ethnicity, if it's the area they live in, what is important to them before we walk in there. So at least we know how to address the situation before we walk in.

LTSSCs are matched to members through a holistic approach considering their cultural background and personalities. I personally do all of the referrals. So before I assign any members to an LTSSC, as I said, I go to the MDS report and I look at the members that I

have on my LTSSC team. And I see who has the personality that would best match with the member or the consumer coming into the organization as a new One Care enrollee.

LTSSCs have a major success using personal experience in their day-to-day interactions with members to relate to members sharing commonalities and -- such as language, education, family traditions and material -- marital status leads to a strong member-LTSSC relationships.

Achieving cultural competency. Here at BCIL, we strive to achieve cultural competency by hiring individuals from diverse backgrounds. For example, LTSSC candidate qualifications include cultural competency and ideal bilingual statuses with an emphasis on individual experiential knowledge. Sorry. What this means is we look for the unique in the community. There is no limits as long as you have something to offer and you're able to make a connection and advocate for your consumers.

We find this to be helpful when language is a topic. We have a vast majority -- a vast variety of different people here at BCIL that speak different languages so it doesn't become a barrier for us. BCIL staffs speak English, Spanish, Portuguese. We have staff members that speak Haitian Creole, Cape Verdean Creole, some French, German. We use the language lines to help for those staff members who are not fluent -- excuse me, who are not fluent in those languages. We also use American sign languaging because we are a community here that partners with people working -- that work and live with disabilities on a daily.

We use collaborative community organizations that help with the cultural competency. These organizations, such as BARCC, which is the Boston Rape Crisis organization here, we partner with them to help us deal with members who may be dealing with issues that don't necessarily -- they don't necessarily like working with male or female providers. So that helps us -- I'm sorry, that helps us help them deal with PTSD and some types of domestic violence that they may have dealt with in their past. So having LTSSCs that -- here have had some of that in personal experience to deal with that, to match them with a member or a consumer actually helps with the cultural competency.

Also, with staff trainings, we have a number of trainings that we actually help our -- at hiring. Our staffs are obligated to go which are held here at BCIL and as well as other sites around Boston through the Mass housing program. It helps us with social services, such as SSI and SSDI, food stamps, as we all know, the lower, the better. Those programs are geared to lower income families which are in our impoverished neighborhoods. So a lot of our members are in those neighborhoods in the city of Boston that are underfunded and underdeveloped. So having staff members who are well-versed in the city help us achieve our cultural competency.

Now, we're here to our case study, a consumer, Beverly, who is an African-American female in her mid-30's. Beverly's LTSSC happens to match her demographic of also an African-American female in her early 30's, the member was initially mistrusting due to past experiences that she had with others on her care team. The relationship that was

present at the beginning of the assessment with the LTSSC, she was very close off and sheltered. She didn't want to divulge much information but was kind of guided into the conversation as the assessment went on.

The LTSSC was able to make very personalized but not too personal connections. It was found out mid-assessment that the member -- both the member and the LTSSC went to the same high school. They played some of the same sports. They went to the same college. And by that fundamental meeting, that initial meeting, where they laid down who was going to be in charge in the relationship, the working relationship between LTSSC and the consumer, the consumer was then able to open up and give all of the information that was needed so that the LTSSC was able to set up all the social services that she was able to live the way she felt she needed to live in the community.

With the outcome to this case, it is still ongoing because she was a newer consumer for this LTSSC and they are currently working on providing educational goals -- meeting her educational goals. And from all reports back from this case, things are good.

Case study number 2 is Maggie. Maggie was actually a consumer of mine that I started with. She was an elderly Hispanic woman who was dealing with cancer, was diagnosed with cancer. Her initial date of going into surgery, she found that her -- coming out of surgery, her husband had had a heart attack and slipped into a coma. And when she came out she was struggling with PTSD and had a lot of stresses, of course, knowing her husband is in a coma three days after falling into a coma, she has learned that her husband has passed away.

She had a very hard time opening up to people. She was a native -- her native country was of Colombia, she came here, her and her husband had plans of building an apartment, a house back in Colombia, so she was dealing with a lot of emotional issues and she wasn't feeling very supported. And because I am not a native Spanish-speaking person I had a hard time articulating anything back to her, although I was able to understand and reciprocate what she was trying to tell me, I wasn't able to communicate back with her.

So, I thought it would be best to actually match her with an LTSSC, considering she had made it clear that in her goals and her initial assessment that she would like to speak in her native tongue because she felt more comfortable, she could express herself and these were things that were important to her to keep her living in the community independently.

So, I matched her with one of our LTSSCs who was around the same age, she was from Honduras. They were able to speak with one another, we were able to get some in-home therapies in for her because she didn't really want to leave the house too often, because this was a house that her and her husband shared. With working with the new LTSSC, we got her into in-home therapy, we were able to get her out of the house and traveling. Last summer she went on a trip back to Colombia to actually visit the apartment that her and her husband were sharing.

So, I feel as though all the hard work that our LTSSCs do to just be competent of what's happening in the city and what's happening with their consumers, it makes it easier for them to just build relationships because a lot of the things that we do, especially in this demographic, dealing with people with disabilities, or living in the community that's not necessarily built for them, we have to ensure that we're not talking to them in the medical terms. Because a lot of times on their care team it's just medical terms, they're just considered patients, they're not considered consumers, or they're not considered actual people, they're just known by their disabilities, so when we come in as LTSSCs and we sit down and we have a face-to-face conversation with them and we're able to see what it is that they want and they need, we're able to actually build that core foundation to make sure that they're living independently and happy and thriving.

I'm going to end it there and pass it along. Thank you guys.

Gabriel Uribe: Thank you Kiet. My name is Gabriel Uribe, I'm the Independent Living and Diversity Services Manager at IEHP. And I'll quickly cover a little bit of our cultural appropriateness in our LTSS program, primarily our long-term service and support programs that are focused on serving people in the community who have disabilities or who have diverse backgrounds.

IEHP is a -- quickly on that -- IEHP is a not-for-profit public health plan that provide Medicare and Medicaid services to residents of the Inland Empire. We serve about 1.2 million members, of whom a little bit over 25, 000 have the Financial Alignment Demonstration program, which, in California we call Cal MediConnect, which is basically for dually eligible. And about 48,000 members currently utilize long-term services and supports.

So, as I mentioned, I will be speaking to the long-term services and supports that are out in the community. We have -- we will cover three of them -- and how we provide culturally-appropriate services. Two of those are county-run programs and one of them is directly provided by us, the health plan. However, we do have a long-term services and support unit that engages the county services and navigates with members through the connection of the in-home support services, which is a program where members can hire a caregiver to help with cooking meals and cleaning, personal care, laundry and housekeeping. The multi-purpose senior services program, that is available to seniors ages 65 and above who are eligible to be in a skilled nursing facility or higher level of care and who can receive case management at home, receive funding for home modification so that the person can remain in their home for as long as possible.

And, thirdly, the community-based adult services in California, which is also known as adult day health care centers in other areas, that provide intermittent nursing and other monitoring and social services for seniors and person with disabilities.

The IEHP LTSS team was formed to address member needs in terms of communication between the health plan and the county services that are delivered by those entities. At

IEHP, all departments can provide referrals to our LTSS team and we train the departments to listen to key words when they are working with our members.

So, here I have a few examples of those things that a member may say. For example, if a member calls us and says, "I take so many pills and I often forget to take them, I tend to forget many things lately. The small print on the bottles don't help either. My son helps me sort them sometimes." Or sometimes we'll hear something like, "It is hard to find help taking care of my mom because she only speaks Mandarin and no one else at home does and I can't be home all the time."

So, in those two sentences, what we can do is as a person on our team, regardless of whether they are part of our long-term services and support team, if they are maybe care management or maybe our member services team, when we hear something like that, team members will provide a referral to our LTSS team and recommend that this individual receive long-term services and support and maybe also receive wraparound services that their health plan may provide; for example, the comment on small print on bottles, maybe we can provide assistance with alternate formats for that individual who is taking that medication.

All staff who have member contact are trained on in-house and cultural and linguistic competency, disability sensitivity and we utilize material from the industry collaborative that cover topics on the LGBTQ experience, immigrant experience and also other refugee experience.

When our LTSS unit works with our members, we assess for a couple of things, and we're looking for things that are primarily related to the services themselves. However, we look at different areas. So, we look at the social, the cultural and the linguistic.

In the social, we look for opportunities for peer and staff engagement to ensure that there is a cultural community connection for the individual. And I'll give a couple of examples as we go into each of the programs that are part of our LTSS groups.

We help connect members to culturally competent IHSS providers as this is the service that provides in-home services. While a lot of members may have a family member or friend that can provide a service to them, there are a few cases where members don't have a network of friends or family members who can assist them in being a caregiver. In that case we do work with our counties who have a -- they're called a public authority and they basically have a list of individuals who can work as a caregiver for our members. And while we don't have the information to identify culturally-competent or suitable candidates, there are ways that we can work with the member and also the counties to identify somebody who is able to provide culturally-appropriate care for the member.

So, IEHP works with the member or their family. We coach and we also coach the IHSS team at the county level to find that connection.

In terms of some of the wraparound services, IEHP also have a unit, it's the Independent Living and Diversity Services Unit, and it is designed to refer members to resources and community services through a network of over 500 community-based organizations that provide assistance to support groups, basic needs, things like food pantry, education and support services and assistance in housing.

We also coordinate language assistance services and alternate formats for not only the members who are receiving LTSS but all members of IEHP.

So, meeting the needs of our CBAS members. There is an interview process for individuals who are going into adult day healthcare. And during the assessment and interview of the caregiver or the member, we identify the social, linguistic or cultural needs and preferences.

There have been instances where members have told us that they really would like to go to a place that's really close by to them -- a center that's close by to them. And we offer them the ability to go and check it out, go see what's going on in that center. And many times members have come back and said, do you have any other options. And we say, yes, what are you looking for, what are the things that you would like to see in a center. And a lot of times, the information that we get back is relation to language; I want to make sure that I'm able to speak to other people in this center or that my son or my daughter or my parent is able to communicate with others. I want to make sure that the food is appropriate for my loved one. So, we have a roster of all the organizations that provide adult day healthcare and we kind of work with the member to let them know -- to answer those questions as best as possible so we can direct them to a center that supports their needs.

I do have a case study, about Mary. And Mary came to us, she's a 55-year old female who came to us, who presented with cancer reoccurrence, who had recently moved to California. She was seeking services with IEHP and she wanted to establish care. During that process we identified that she had a vegetarian diet and opted to treat the cancer through a naturopathic approach.

She also let us know that she observed a day out of the week as her Sabbath and requested that any in-home support services that we provided on that Sabbath day be from a non-paid caregiver for that day. During the screening, however, when we screened for IHSS, she was a candidate who was likely going to be receiving those services because of her conditions and we knew that we would have to work as an interdisciplinary care team to provide wraparound services.

On the next slide, we'll see some of the things that came to be. Working together in the different departments, the long-term services support unit shared the member's wishes with the county in-home support services division and the public authority and we communicated her cultural needs. And, internally, the independent living and diversity services team in the health plan also began linking the member to community-based resources. We were able to connect her with a faith community, the faith community that

she identified with, and we worked with her to place an ad on the church bulletin, the church's bulletin, seeking for a caregiver who was experienced in preparing vegetarian food and understood her needs on her Sabbath day. So, we were able to connect her with that group. She did post an ad and successfully identified a caregiver.

Our care management team helped the team member also to establish primary care with a provider at a medical group that was affiliated with the member's faith. So, part of the reason that the member had moved this area was because she knew that there was a large group of people who ascribed to her faith denomination. So, it was pretty easy to connect her to those resources as well. And we did already have some inroads there to make that connection happen.

Once she was connected, we heard feedback from her provider and we knew that the provider understood her approach. She did provide information about what the naturopathic approach would be like and working with them. The member was connected with her faith community, as I mentioned, and our care management team continued to work directly with the member to ensure that she was receiving the appropriate supports needed.

That's all for my slides, thank you.

Alana Nur: Alright. Thank you so much, Darci, Jenna, Kiet and Gabriel, for your presentations. You've been incredibly informative. Thank you so much, and at this time we have a few minutes for questions. If you have any questions for our speakers please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box and press Submit to send it.

I will start off with a question for Gabriel, since you just spoke. Can you tell us about the ways that IEHP trains the team that serves members with LTS needs with regards to achieving cultural and linguistic competence?

Gabriel Uribe: Absolutely. We work with curriculum that's developed with a couple of industry-standard collaboratives. But we also take advantage of the interdisciplinary care team that we have ongoing at the health plan. We have about four, what we call ICTs, going on every week and we memorialize some of the things that we learn from each of those engagements. And we use those later on in trainings for our staff to use them as case studies and also discuss them with incoming team members as they're coming in during the culture and linguistics training that we do for our team members.

Alana Nur: Thank you so much. Jenna, I have a question for you next. Can you provide an example of the type of training that is recommended for staff who are serving Medicare and Medicaid beneficiaries from the LGBT community?

Jenna McDavid: Yes, absolutely, thank you. At the coalition, we very intentionally include LGBT communities in our work, not only because there are LGBT people in all of our other communities that we represent but we also think it's important for providers

and lawmakers to think about LGBT issues at the same time as they are thinking about issues of racial and ethnic diversity, of political ideologies, of geography.

So we recommend that providers undergo LGBT culturally competent training for all of their staff, from the receptionist, to maintenance, to doctors, to administrators and SAGE, who is the DEC member who provides LGBT services and support has a SAGE care program which has so far trained over 200, 000 people, I believe, since it was founded five years ago. And they will come in to your facility, either in person or they will offer you webinar training where folks can learn a little bit more about what an LGBT identity may encompass, including sexual orientation, gender identity, some of the health disparities that are faced by LGBT communities and, most importantly, what you can do to make your facilities more welcoming and affirming of LGBT people. If you want more information on that you can go to our website, diverseelders.org, or you can go directly to the SAGE website, which is sagecare.usa.

Alana Nur: Thank you, Jenna. Then we have all these links at the end of the presentation as well for everyone. Next we have a question for Lisa, from Mariana from Community Health Services in California. Has there been any research or studies to understand that members that are in the type of setting that you are serving are healthier or have better outcomes than elderly in a community that is different from yours? I think what's been done is amazing, I'd like to know if there has been a health impact on the residents.

Lisa Waisath: Great question. I don't know of any specific studies that have been done but I can give you anecdotally that this year I'll have six residents that are either 100 or 101 years old. I've never had that many in any other building, that's more than 10% of my residents. My average age is 94. So, I don't know necessarily if that is a factor of their cultural lifestyle that -- they're eating, their attitudes toward health and fitness and mindfulness -- or if that is a reflection of what we're doing here. My guess is that it's a little bit of both. And, if there is a study out there I'd love somebody to send it to me because I would like to see that. But, anecdotally I can tell you that we have heard from our residents and our family members that the care they get here, because it's culturally sensitive to them, has made an impact on their lives and their wellbeing.

Alana Nur: Thank you, Lisa. Next, I'll open up any of our providers to answer this one or anyone else that would like to chime in. It's a question from Janice in Massachusetts. Have any of you identified a stellar evaluation tool to help track and improve delivery of culturally competent care? Any agency-wide tools available for this?

Darci Graves: So I can speak to a little bit of this. Depending on what kind of tools you're looking for -- and again, this is Darci Graves from CMS Office of Minority Health. The National Center for Cultural Competency, that's a part of Georgetown University, has a large number of checklists and tools on their website.

As we've already heard during the course of these presentations, you know, cultural competency looks different depending on what type of organization you have and who

you're serving. So these checklists may not be perfect or completely tailored for your organization, but I think they're a great way to start.

So if other people are familiar with other assessments, I would love to hear about those too, but those are ones that I know off the top of my head.

Gabriel Uribe: Hi, this is Gabriel. So what we do as well here at IEHP is we many times use some of the tools or some of the questionnaires that we have for other populations, for example, the health risk assessment is a tool that we have to use to assess the risk or acuity of some of our members' conditions.

One thing that we do with that assessment is we often work with our, we call them community or they're consumer engagement groups that we have that are similar to a focus group. It's primarily members who will tell us or give us feedback about some of the tools that we're using to assess their risk. And many times we end up adding additional questions or modifying certain things in our script to make sure that when we ask about a certain thing or information about their health, they can provide it in a way that we can then operationalize the information and address the members' needs from a cultural competency perspective as well.

Alana Nur: Great. Thank you so much Darci and Gabriel. Next, Keit, I have a question for you? What are some of the challenges with finding and keeping culturally competent direct support staff? And what have you done to overcome those challenges?

Kiet Blakes-Thompson: Well, I haven't actually had to face that challenge luckily. We have a total of five staff, not including myself, two of which speak Spanish fluently. The other is we have two, one being a woman, one being a male who are of African-American descent. And we have one Caucasian LTSC. So we kind of have a vast variety of different backgrounds that are here at BCIL and to the office, there are multiple nationalities that flourish in here. So I think we just created an environment and a community that is accepting of everything and everyone. So it's easy to like fall in love and just want to be at work here all the time. So I don't think there is any magic to it.

Alana Nur: Thank you, Kiet. That's great. Lisa, I have a question for you. Have you been able to identify any similar models for potentially different cultures available in any other state in the US?

Lisa Waisath: Here in Seattle, we actually have a couple. We have an assisted living just down the street from us that is, I believe it's 100% Medicaid. So most of their residents are dual eligibles, that focuses on a little bit broader Asian community than we do. And they do a really phenomenal job. They also incorporated adult day health into their programming and do some intergenerational work with an adult -- or with a childcare that's located directly next to them.

Also, there is a skilled nursing facility here in town that focuses on the Chinese population and an assisted living that has been built in a neighboring city that is focusing on the Chinese population. And they're also doing some similar things.

So I'm seeing it in a more broad sense in our Asian community here. I haven't seen it quite as much in our area with some of the other groups, but we do have a skilled facility that focused on the LGBTQ community. So I am seeing it come up, I am seeing people paying attention to the particular needs of particular groups and hopefully that is much less big paint strokes, it's little more refined and I'm seeing a lot more of that.

Alana Nur: Thank you, Lisa. Next one, I'll open up to ask in terms of addressing linguistic competence, what are some of the ways in which you may specifically reach out to recruit bilingual staff. Gabriel, do you want to speak to this or if anyone else would like to answer?

Gabriel Uribe: Yeah. So our approach is out of those 500 organizations that I said, our community-based organizations that we work with, we established relationships with a lot of subgroups or organizations while working in subpopulations that we currently serve.

And when we do recruit for different positions, especially high-touch positions that have high member engagement, we do communicate that through a couple of ways, through the disability collaborative that we do. We also have a group of -- or a monthly meeting that IEHP does with community partners where a big portion of those 500 organizations will come here to the health plan and see some of the initiatives that either IEHP is currently operationalizing or maybe other community partners are doing. And we promote our positions with them as well.

So that's been great. We do have pretty diverse community in the Inland Empire, primarily about two languages or the primary key ones is recognized by CMS and DHCS. But we do have a lot of individuals, about 2% of the health plan population that speak other languages. And whenever we look at recruitment, we take that into consideration. And we've been pretty successful at acquiring people from the community that can meet those needs for our members.

Alana Nur: Thank you, Gabriel. Would anyone else like to speak to the plan as well? Great. Then Lisa, I wanted to ask you a little bit about when you have new residents coming in, how do you assess them for their cultural needs and/or preferences? What are the things that you do to make sure you're identifying what those needs are?

Lisa Waisath: So when people first move in, we do a nursing assessment, just like any other assisted living would do to find out what their care needs are. But part of that assessment also asks about their preferences for languages, it asks about their preferences for food and asks about their preferences for activities and social interaction.

They also, in our move-in packet, we have specific forms for dietary preferences and activity and social profiling so that we can find out more about those people and find out what they want and what they need to be comfortable and happy here. And as I mentioned during the presentation, we also have feedback forms. So once they're living here, we have meal feedback forms and we have activity feedback forms so we can find out what those things are that they're enjoying, what they want more of, what they want less of. And we use that to develop our programming.

And with the language, if somebody comes in and they need a particular language, if they're native Japanese speaker and they're only comfortable in Japanese, then we'll conduct the assessment in Japanese. I have a nurse who is and she'll be the one who does the assessment to make sure we're getting adequate information and appropriate information. Because I'm sure a lot of you understand that if you're dealing with a different group, that especially like if you're doing the mini mental exam and you're trying to find out what their level of cognitive ability is, if there's a language barrier, that number is going to look much lower than it really should be. So having those native speakers come in and do those assessments with us also gives us better information about the medical side.

Alana Nur: Great. Thank you so much, Lisa. Thank you to all the speakers. If you have any additional questions or comments, please email ric@lewin.com. And on the next slide, you'll see the contact information of the speakers or emails and their websites for additional information.

And also as a note, many of our speakers have mentioned resources throughout this presentation. You'll see a list of those resources with hyperlinks at the end of this presentation on the last slide.

As part for today's presentation, a recording and a transcript will be available on the Resources for Integrated Care website shortly. At this time, the post tests for this webinar are now open. Additional guidance about obtaining credits and 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.

Thank you everyone for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high quality presentation. If you have any questions for us at all, please email us at RIC@lewin.com. That concludes our webinar. Thanks again to all of the speakers. Have a wonderful afternoon and thank you so much for your participation.