Considerations for Cultural and Linguistic Differences in Community Education and Information Dissemination

Community Education and Dissemination Council
(CEDC)
Webinar Series

September 5, 2017

- Introductions
- Presentation
- Q & A
  - How to Ask a Question
  - You can ask a question by pressing the □ then # key to request the floor. Questions will be answered in the order they are received.
  - If you're using the microphone on your computer, you can raise your hand by clicking the little icon at the very top of the screen that looks like a person raising her hand.
  - Type your questions into the 'Chat' box below the slides and the moderator will read the questions.
- Survey
  - Please complete our short survey to give us feedback for the next webinar!

AUCD
Association of University Centers on Disabilities

Dr. Maria Mercedes Avila is Associate Professor in the Department of Pediatrics and the Leadership Education in Neurodevelopmental Disabilities (LEND) Program Director at the University of Vermont College of Medicine. She has been involved in numerous SAMHSA and HRSA's MCH programs. Dr. Avila provides training and consultation on Cultural and Linguistic Competency and has trained more than 2500 providers in 46 organizations and across 6 states. Since 2011, Dr. Avila has been invited to lead 28 national presentations and 55 regional sessions on topics related to health disparities, social justice in health care, culturally responsive care and practice, and cultural competence in advocacy and leadership. Through her local, state and national work, she has been nominated for eleven teaching, service and research awards. Dr. Avila was most recently recognized with the 2016 Child Mind Institute National Change Maker Local Hero Award, the 2016 Association of University Centers on Disabilities (AUCD) Multicultural Council Leadership in Diversity National Award, and 2017 Outstanding Faculty Woman Award.

Dr. Christine Vining is a bilingual Navajo Speech-Language Pathologist at the Center for Development & Disability, Department of Pediatrics, Health Sciences Center, University of New Mexico in Albuquerque, NM. She provides clinical services, and helps to build capacity and resources across the state through training and technical assistance and information dissemination. She represents the speech-language pathology discipline on the faculty team for the NM Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. Her interest and work has included improving cultural competency and advancing diversity, equity and inclusion efforts. She facilitates opportunities for infusing cultural and linguistic competence within the LEND curriculum. Presently, she serves as co-chair for the AUCD Multicultural Council and serves on the AUCD Board of Directors, as well as serve on other national boards and committees.

CONSIDERATIONS FOR CULTURAL AND LINGUISTIC DIFFERENCES IN COMMUNITY EDUCATION AND INFORMATION DISSEMINATION

Presenters:

Maria Mercedes Avila, PhD, MSW

Associate Professor of Pediatrics

Vermont LEND Director

Christine Vining, PhD., CCC-SLP

NM LEND/Center for Development & Disability

Objectives

Participants will

- Describe cultural diversity and cultural and linguistic competence in technical assistance, community engagement, community education and information dissemination.

- Understand underlying disparities in access to services for underserved populations.

- Describe strategies for integrating cultural diversity in dissemination activities such as infographics, briefs, and training.

Community Education & Dissemination Council (CEDC)

- CEDC serves to meet any community education and dissemination needs and promote collaboration the LEND programs and IDDRcs

- Two core functions of UCEDDs
  - Community service activities
    - Community education
    - Technical assistance
  - Information dissemination activities

- Activities occur for or with individuals with developmental disabilities, their family members, professionals, paraprofessionals, trainees, students and volunteers

Considering diversity in the mission

Questions to consider:

- How to address inequities experienced by individuals with DD from underserved racial, ethnic, and linguistically diverse groups?

- How to increase the workforce to meet the needs of an increasingly diverse population?

- How to advance innovation to address inequities?

- How to engage diverse communities and disseminate information in a culturally and linguistically appropriate manner?

Incorporating diversity

- Advancing the work of DEI in community education, technical assistance, and information dissemination

- Includes:
  - Identifying and discussing issues
  - Representing the voice of network regarding interests and concerns related to community education and information dissemination interests
  - Influencing policy and initiatives
  - Sharing resources, exemplary programs, dissemination practices

These efforts require knowing your audience

Culture impacts our work

- Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world.

- It is transmitted through social and institutional traditions and norms to succeeding generations.

- Culture applies to racial, ethnic, religious, political, professional, and other social groups.

National Center for Cultural Competence

Includes:

Rituals

Practices

Manners

Customs

Communication

Beliefs

Values

Practices

Languages

Roles

Expected behaviors

Why consider diversity in the work of CEDC?

A series of projections from the U.S. Census Bureau estimates:

- In the year 2045 the nation will become "majority-minority" (all people except those that are non-Hispanic, single-race white)

- The population under 18 years of age will reach this status by 2018 or 2019

- The working age population is projected to become majority-minority between 2036 and 2042

Underserved Populations

ACL definition of underserved populations:

- Racial or ethnic group

- Low-income

- LGBTQ

- Limited English proficiency

- Living in a rural area

- Having a disability

How do we partner with these communities to achieve improved outcomes for individuals and families?

The Developmental Disabilities Assistance and Bill of Rights Act of 2000

- **SEC. 102. DEFINITIONS. [42 USC 15002]**

The term *cultural competence* means services, supports or other assistance that are conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language and behaviors of individuals who are receiving services, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program.

Source: Retrieved on 4/19/15 from
http://www.acl.gov/Programs/AIDD/DDA_BOR_ACT_2000/p2_tI_subtitleA.aspx

Cultural Competence

Cultural competence is typically a term that is defined as the ability to function effectively in the context of cultural differences.

Five elements:

1. Awareness, acceptance and valuing of cultural differences

2. Awareness of one's own culture and values

3. Understanding the range of dynamics that result from the interaction between people of different cultures

4. Developing cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge

5. Ability to adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

Adapted from Cross, Bazron, Dennis, Isaacs (1998). Towards A Culturally Competent System of Care. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistant Center.

Linguistic competence

- Linguistic competence is the capacity of an organization and its personnel to communicate effectively & convey information in a manner that is easily understood by diverse groups
  - persons of limited English proficiency,
  - those who are not literate or have low literacy skills,
  - individuals with disabilities,
  - those who are deaf or hard of hearing

- requires organizational and provider capacity to respond effectively to the health literacy and mental health literacy needs of populations served – so individuals understand health information and make health decisions

Goode & Jones, Revised 2009, National Center for Cultural Competence

Languages spoken is important consideration

Language Spoken in the U.S. in 2013

Total Population 5 years and over	293,358,760	
English Only	79.2%	
Other than English Languages	20.8%	
Speak Spanish or Spanish Creole	38,417,235 (13%)	
Speak Indo European languages	10,685,918 (3.6%)	[French [Patois, Cajun], French Creole, Italian, Portuguese, Portuguese Creole, German, Yiddish, Other West Germanic languages, Scandinavian languages, Greek, Russian, Polish, Serbo-Croatian, Other Slavic languages, Armenian, Persian, Hindi, Urdu, Other Indic languages]
Speak Asian and Pacific Island languages	9,819,037 (3.3%)	Chinese, Japanese, Korean, Cambodian, Hmong, Thai, Laotian, Vietnamese, Tagalog, other Pacific Island language
Other Languages	2,826,550 (1%)	[Navajo, Other Native American languages, Hungarian, Arabic, Hebrew, African languages, other]

Data Source: U.S. Census Bureau, American Fact Finder, 2013 American Community Survey-1 Year Estimates, Table S1601

Limited English Speaking Households

Limited English Speaking Households or (linguistically isolated) refers to households in which no member 14 years old and over: (1) speaks only English or (2) speaks a non-English language and speaks English "very well."

Linguistically Isolated Households in the Unites States in 2013	
All households	4.5%
Households speaking:	
Spanish	23.2%
Asian and pacific Island languages	26.0%
Other Indo-European languages	16.0%
Other languages	17.3%

Data Source: U.S. Census Bureau, American FactFinder, 2013 American Community Survey- 1 Year Estimates,

Language Access

In 2012, National Council on Disability implemented its language access plan for assuring effective communication with individuals who are considered to have limited English Proficiency (LEP).

- Guiding principles for language access include that:
  - Services and supports are delivered in preferred language
  - Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of populations served
  - Interpretation and translations services comply with all federal, state, and local mandates.
  - Consumers are engaged in evaluation of language access

Considering linguistic differences in translation

Guidelines for translating written materials

1. Consider whether if is appropriate to translate the material

2. Consider method you will use
   "one –way" from English into the target language, using one or more translators

   "two way" or "back translation" – one person translates, a different person translates it back to English and compare the original English and translated English

3. Use professional translators who have the cultural knowledge and the skills needed to do a good translation

4. Translate for meaning in a cultural sensitive way

5. Review the translated text for accuracy, ease of use, and cultural/linguistic appropriateness

Source: http://www.cms.gov

TOOLKIT for Making Written Material Clear and Effective , Part 11: Understanding and using the 'Toolkit Guidelines for Culturally Appropriate Translation

Strategies for community services

- Include clients, families & communities as partners in determining outcomes

- Recognize differences in pragmatic behaviors

- Learn about appropriate ways to gain entry into communities

- Consider beliefs in traditional/alternative medicines

- Consider reading levels

- Consider exposure to English/native language

- Review tools and materials for bias

- Allow for alternative methods of sharing experiences and communication: storytelling, oral tradition

- Employ strategies (visual aids, interpreters) when client is not proficient in English

- Seek assistance from interpreters/bilingual staff or community members

EXAMPLE: AMERICAN INDIAN DD COMMUNITY NEEDS

NA Developmental Disabilities Needs Assessment

- Conducted by NARTC, Sonoran UCEDD, AUCD

- Key findings:
  - Strengths for people with DD include family relationships and tribal service agency staff who care and know the communities
  - AI/AN communities face challenges in trying to provide community services and supports for individuals with DD and their families.
    - Transportation not available to DD staff located off reservation and few tribes provide DD services and supports.
    - Issues of poverty, drug and alcohol use, mental health, and lack of jobs in many AI/AN communities make if more difficult for people with DD to live inclusive community lives.

Needs Assessment Continued

- Most AI/AN people with DD and their families access services locally from their tribal health clinic, tribal schools, or tribal VR.
  - Accessing DD services and other state services are not easy for AI/AN people living outside metropolitan areas.

- AI/AN communities for the most part do not have a high degree of knowledge or connection to the DD Network but are interested finding out more about the network and having more contact with the Network.

- AI/AN individuals with DD and their families want service systems to respect their culture and customs and provide information, training and services that are relevant and appropriate.

Recommendations for increasing DD Network effectiveness:

1. Increase connections to people with DD by forging relationships with respected community collaborators. To be successful in partnering with communities, relationships is necessary.

2. Increase the availability of info about AI/AN individuals with DD for all agencies working with AI/AN communities.

3. Ensure connections to people with DD and their families in AI/AN communities are sustained through capacity building. This reflects AI/AN communities desire to develop their own service models.

Continued

4. Promote education and training on DD.

5. Build a national one-stop resource for info on AI/AN and DD.

6. Promote connections that are based on mutual respect and understanding of the culture, laws and customs of a population. Learn about their culture in order to order to be able to provide the services and supports needed.

7. Promote connections that are based on AI/AN community needs (for community-based services/supports, more information and training, and better family support).

EXAMPLE: REFUGEE DD COMMUNITY NEEDS

Rationale of the Study

- **To respond** to current and projected demographic changes in the United States

- **To eliminate** long-standing disparities in the health status of diverse racial, ethnic, and cultural groups

- **To improve** the quality and accessibility of services for all communities

- **To advance** knowledge related to mandates (Title VI, I, IX, accreditation, etc.)

Considerations in culturally responsive research

- IRB processes
  - University
  - Hospital
  - Community

- Knowledge -or lack of- health disparities and culturally responsive research processes

Study results – FORMER Refugee participants

- Speech delay was identified as the main concern in refugee children

- Parents feel negatively judged when their children have developmental or behavioral concerns (varies by community)

- The primary community supports identified are neighbors, elders, friends

Study results – former refugee participants

- Use of interpreters by providers varies by refugee group

- Family members are unclear about the referral processes

- Family members unaware of provider organizations in the area

- Parents' perception: early intervention providers wait for children to turn 3 so that the schools provide services

# Essential Elements of Culturally Responsive Practice

- Value Diversity

- Have the capacity for cultural self-assessment

- Being conscious of the dynamics inherent when cultures interact

- Have institutionalized cultural knowledge (Title VI, LEP, etc.)

- Have developed adaptations to service delivery reflecting an understanding of cultural diversity

- Engage in ongoing professional development at all levels of the organization

Adapted from the National Center for Cultural Competence – Georgetown University

Equality vs. Equity in Community Education and Information Dissemination.
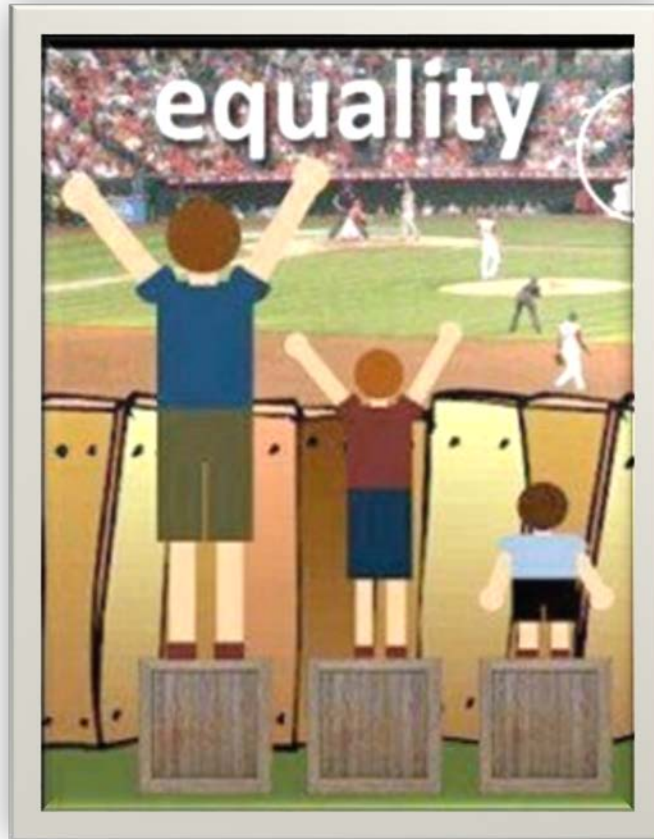
EQUALITY=SAMENESS

GIVING EVERYONE THE SAME THING
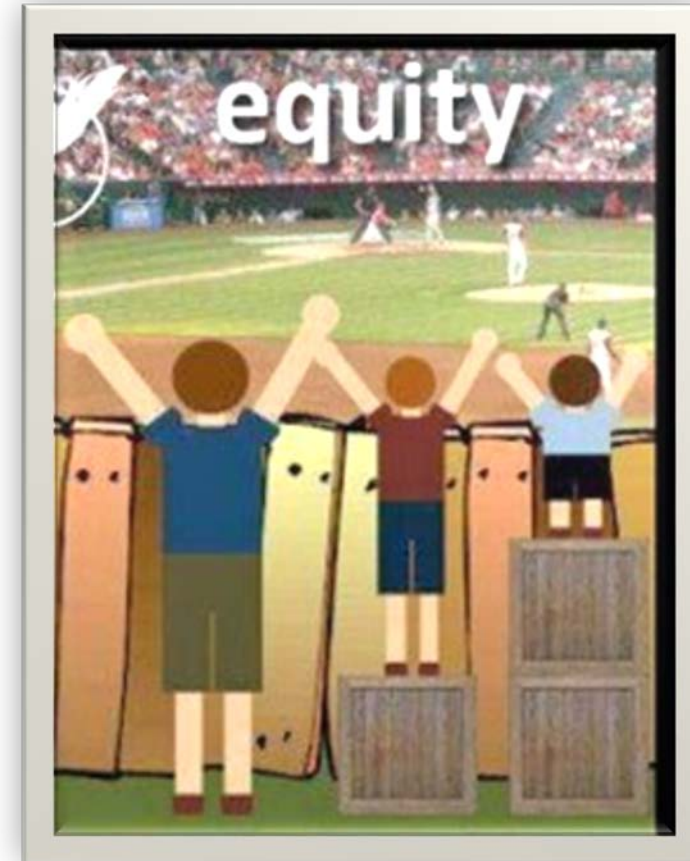
EQUITY=FAIRNESS

ACCESS to SAME OPPORTUNITIES

What are Health Disparities?

"differences in health which are not only *unnecessary and avoidable* but, in addition, are considered *unfair and unjust*" (World Health Organization, 2010); and "occur by gender, race or ethnicity, education or income, disability, living in rural localities, or sexual orientation" (Healthy People 2010 & 2020)

Study results – retrospective observational study

- January 2014 to December 2015

- All patients (n=70 site 1) and 90% (n=44 site 2) had a screening done as young as 8 months through 33 months

- Children were 15 to 21 months at the time the ASQ or MCHAT was done

- 5 of the 6 ASQ questions were answered

Study results – retrospective observational study

- 1 site stopped using ASQ and MCHAT and is now using the

  SWYC (Survey of Well Being of Young Children)
  - Comprehensive screening tool (development, behavior, ASD risk, family context)
  - Introduced in 2011
  - Targeted age range: 1- 65 months
  - Parent report measure
  - May be administered by pediatricians, other clinicians, early educators
  - Available in English, Spanish, Burmese, Nepali, and Portuguese

Levels of Trauma in Refugee Populations

- Level 1: Country of origin

- Level 2: Displacement to refugee camps

- Level 3: Country of relocation

NEW

- Level 4: Current social and political climate in the US

Manifestations of Oppression & Workforce Diversity

- Ethnocentrism → *Major obstacle to achieve effective CALC*
- Prejudice/Biases
- Discrimination
- Exclusion
- Marginalization
- -ISMS → Racism, Sexism, Classism, Ableism, etc.

MISSING PERSONS:

MINORITIES IN THE

HEALTH PROFESSIONS

A REPORT OF THE SULLIVAN COMMISSION ON

DIVERSITY IN THE HEALTHCARE WORKFORCE

(2004)

Workforce
9% nurses
6% physicians
5% dentists

Faculty
<10% nursing
<9% dental school
4% medical school

Study results – Provider informant interviews

- Two sites (UVM Medical Center New American Clinic and the Community Health Centers of Burlington)

- Providers reported similar barriers to screening:
  - Scheduling
  - Transportation
  - Child care
  - Trained interpreters

# Study results – Provider informant interviews

- Other key findings:
  - Cross cultural validation of tools
    - Questions
    - Language
    - Response options
  - Early intervention not taking referrals seriously because of high number of referrals
  - Lack of understanding of bilingualism
  - Paperwork and home visits involved in referral processes
  - Lack of early intervention providers (SLPs, DEs, OTs, PTs)

State of America's Children 2014

- 1st in gross domestic product
- 1st in number of billionaires
- *Second to worst in child poverty rates (just ahead of Romania)*
- *Largest gap between the rich and the poor*
- 1st in military spending
- 1st in military weapons exports
- *1st in number of people incarcerated*
- *Worst in protecting children against gun violence*

- 1st in health expenditures
- *25th in low birthweight rates*
- *26th in immunization rates*
- *31st in infant mortality rates*
- *35th in life expectancy*
- *Second to worst in teenage births (just ahead of Bulgaria)*

CDC & the Social Determinants of Health
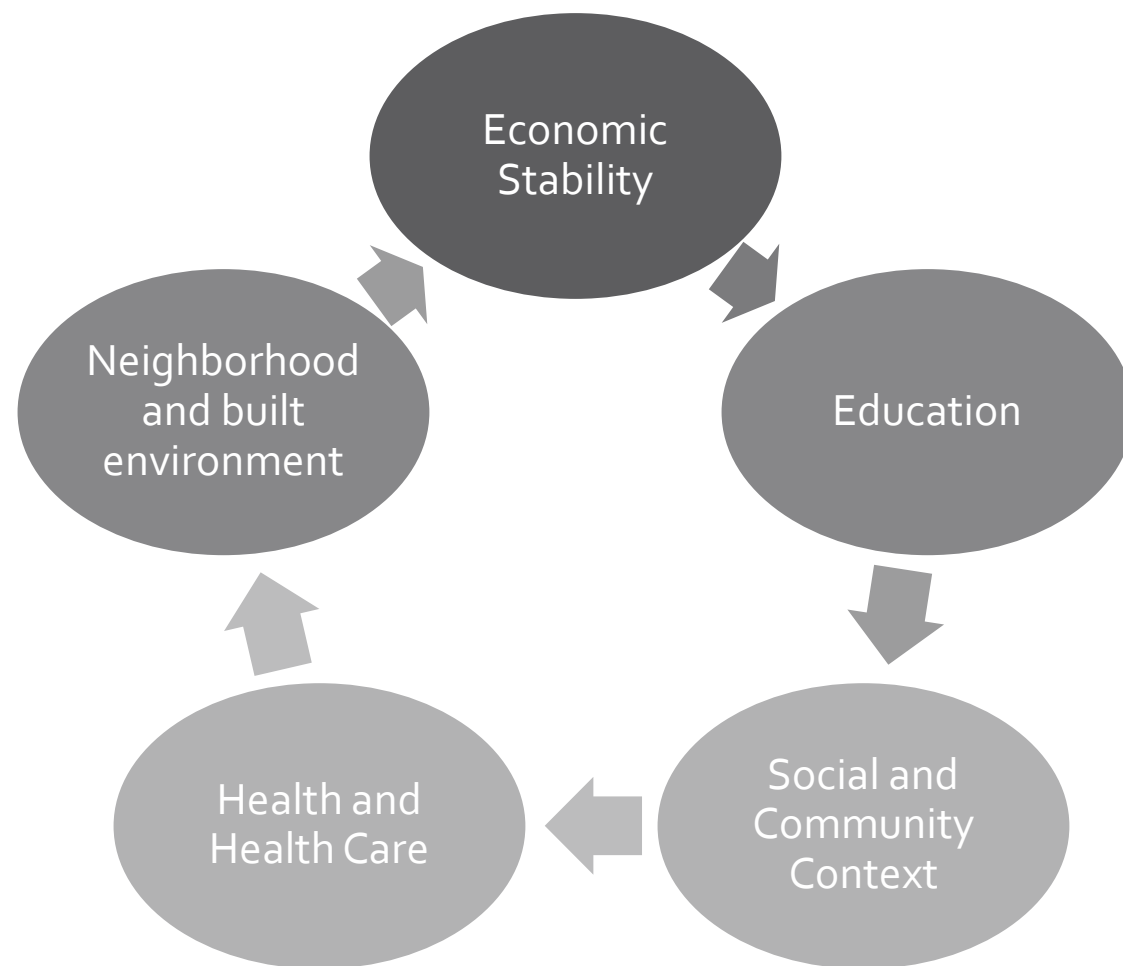
Addressing Provider Bias

"overall health of the American population has improved over the past few decades, but not all Americans have benefited equally from these improvements. Minority populations, in particular, continue to lag behind whites in a number of areas, including _quality of care, access to care, timeliness, and outcomes._ Other health care problems that disproportionately affect minorities include _provider biases, poor provider-patient communication, and health literacy issues._"

(U.S. Agency for Healthcare and Research Quality, a division of the U.S. Department of Health and Human Services (HHS), 2013)

In the Aug. 11, 2015 issue of the Journal of the American Medical Association, a Viewpoint co-authored by The Joint Commission's medical director, Ronald Wyatt, MD, MHA, calls for immediate action to address racial bias throughout the U.S. health care system

National CLAS Standards

- Receive effective, understandable & respectful care

- Workforce reflects population

- Workforce skill development

- Organizations conduct initial & ongoing self- assessments

- Data on the individual consumer's race, ethnicity, spoken & written language are collected in records

Recommendations for CEDC

- Advance knowledge related to integrative medical approaches

- Ensure state and federal mandates are followed

- Enroll and advocate for more providers to work with unserved and underserved populations

- Employ more community outreach workers

- Hire, train, retain and promote bilingual/bicultural providers

- Improve education among diverse populations and providers

Source: E. Hansen and M. Donohoe, 2003; HHS OMH National CLAS Standards 2013

"WE DO NOT SEE THINGS THE WAY THEY ARE, WE SEE THINGS THE WAY WE ARE"

TALMUD

- # How to Ask a Question
  - You can ask a question by pressing the ✳ then **#** key to request the floor. Questions will be answered in the order they are received.
  - If you're using the microphone on your computer, you can raise your hand by clicking the little icon at the very top of the screen that looks like a person raising her hand.
  - Type your questions into the 'Chat' box below the slides and the moderator will read the questions.

Visit the Websites

- AUCD Website: http://www.aucd.org
- Community Education and Dissemination Council (CEDC)Website:
  http://www.aucd.org/template/page.cfm?id=52

Questions about the CEDC?

- CEDC Chair - Jerry Alliston Jerry.- Alliston@usm.edu

Please take a few minutes to complete our survey!