Applying Cultural Competency to Emergency Risk Communication

Moderator: Loretta Jackson-Brown

Presenters: Darci L. Graves, MA, MA

Date/Time: July 14, 2011 2:00 pm EDT

Operator

Welcome and thank you for standing by. At this time all participants are in listen only mode. To ask a question please press star then one on your touch tone phone. Today's conference is being recorded, if you have any objections you may disconnect at this time. I'd like to introduce your host for today's call, Ms. Loretta Jackson-Brown. Ma'am, you may begin. (00:00:15)

Loretta Jackson-Brown

Thank you, Evan. Good afternoon. I'm Loretta Jackson-Brown and I'm representing the Clinician Outreach and Communication Activity (COCA) with the Emergency Risk Communications Branch at the Centers for Disease Control and Prevention. I am delighted to welcome you to today's COCA webinar "Applying Cultural Competency to Emergency Risk Communication." We are pleased to have with is today Darci Graves, here to discuss culturally competent emergency risk communication strategies that clinicians can use during any crisis. You may participate in today's presentation by audio only, via webinar, or you may download the slides if you are unable to access the webinar. The PowerPoint slide set and the webinar link can be found on our COCA Web page at emergency.cdc.gov/COCA. Click on COCA calls. The webinar link and slide set can be found under the call-in number and call passcode. Here to provide an introduction to navigating today's webinar is this Ms. Callie Campbell. (00:01:23)

Callie Campbell

Welcome to the "Applying Cultural Competency to Emergency Risk Communication" webinar hosted by the Centers for Disease Control and Prevention. My name is Callie and I am going to walk everyone through the procedures and tools available. This webinar should last approximately an hour. If you have a question for one of the presenters, you may use the Q&A button located at the top left portion of your screen. Type in your question and then hit Enter to send the question to the presenters. If you are addressing a specific presenter, please state that in your question. Presenters will read the selected questions out loud to the group. At the top right hand side of your screen you will see a "Feedback" tool has a colored square next to it. If you select the drop down arrow next to the feedback, you can alert me if you are having trouble hearing or if you need help. This meeting is being recorded. If you have technical difficulties at any time during this presentation, you may call our technical support line at 1-877-283-7062.Thank you all for coming, Loretta Jackson-Brown is your host, and she will be taking over the presentation from here. (00:02:23)

Loretta Jackson-Brown

Thank you, Callie. At the conclusion of today's session, the participant will be able to define cross-cultural communication and its role in emergency preparedness and response; discuss the significance of delivering culturally appropriate preparedness messages and how preparedness messages are perceived across various cultures; describe strategies for culturally confident communications during a public health emergency and demonstrate how to incorporate these strategies into day-to-day activities and rolls. (00:02:57)

In compliance with continuing education requirements, all presenters must disclose any financial or other associations with the manufacturers of commercial products, suppliers and commercial services or commercial supporters as well as any use of an unlabeled product or products under investigational use. CDC, our planners, and the presenter for this presentation, do not have financial or other associations with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. This presentation does not involve the unlabeled use of a product or products under investigational use. There was no commercial support for this activity.

Today's presenter, Darci Graves is senior health education and policy specialist, SRA international incorporated. Darci serves as the deputy project manager and primary cultural competence and health disparity content expert and curriculum development specialist for the SINK cultural health project sponsored by the Department of Health and Human Services, Office of Minority Health. She is the task lead for the national standards for culturally and linguistically appropriate services and health care enhancement initiatives. Darci manages multiple advisory panels comprised of nationally recognized experts in the areas of health, health disparity, public policy, and cultural competence. She served as the primary author of an online continuing education program dedicated to cultural competence and disaster responders. Darci is in the final stages of completing a doctorate in public policy at the University of Maryland, Baltimore County.

Again the PowerPoint slide set and webinar link are available from our COCA Web page at emergency.cdc.gov/COCA. At this time please welcome Darci Graves. (00:04:59)

Darci Graves

Good afternoon, and thank you, Loretta, for that kind introduction. It is a pleasure to be here speaking with you all today on what I perceive to be a very important topic in the area of disaster preparedness, response, and recovery. Loretta did a great job of sharing some of my background. I am also a former medical school faculty member, so I come at this with a variety of lenses and hopefully, that will help inform the presentation and some of the ways that I convey the information. I have been with SRA international for nearly four years and all four years I have served on the Office of Minority Health Project, within cultural health site, which I will talk about in a little bit. And, of particular interest to anyone on this call would be one of our continuing education programs that we have on the site for, that Loretta mentioned, which is the cultural and competency curriculum for disaster preparedness and crisis response. (00:06:08)

Okay, so setting the stage, today we're going to talk about culture and its role in how people act and react in times of crisis and disaster. Just to set the stage, people prepare, respond, and recover from emergency or disaster within the context of their culture. And I will talk about what I mean by culture here in another slide or two. But, at its core, culture offers a protected system that is both comforting and reassuring. It defines what appropriate behaviors are and furnishes a support system and identifies a shared vision for recovery. And, despite the strength of culture,

responses from some groups may make them more vulnerable than others. There are many individuals out there who perceive cultural competency as political correctness this run amok, is one of the quotes I've heard frequently or that this is something that is common sense and that people should just inherently know this or learn this from their family or in their households. And I can understand why some would perceive it as common sense; however, it is not as common practice as often it should be. (00:07:45)

Sometimes it is because of bias, but more often than not, I think it is because we forget. We are simply in our own heads and processes and habits, so that our hope is to make—so our end goal needs to be to make cultural competency part of our habit. When I worked with reluctant medical students, there were always concerned about something being extra or something—oh no, I have yet another thing to think about during this encounter. And what I really hope that the take-away message is at the end of this presentation, is a shared understanding that it isn't extra; it is something that should inform all of the things that you do and hopefully can become inherent in how you practice in the best environments or in worst-case scenarios like the disasters in crises we're talking about today. (00:08:48)

But, before we talk about disasters and life-and-death situations, I wanted to share a few humorous ways that culture has impacted some commercial entities and share what some of those take away messages might be. When McDonald's launched its first restaurants in India, sales were slow to take off. Apparently, the company had not acknowledged the fact that Hindus, who account for 85% of the population in India, do not eat beef. (00:09:29)

It is difficult to believe that something that fundamental could have been overlooked, but it was. And I think the take-away from this is to make sure that you know your audience. And, that you know the community in which you are practicing or, if you are being deployed or responding to a disaster, who is it that you are going to encounter when you're going to that location. We will talk more about the importance of that as we proceed through the presentation. An American TV ad campaign for deodorant showing an octopus applying the product under each arm flopped in Japan. As it turns out, the manufacturer later learned that in Japan, octopuses do not have arms; they have legs. So what are arms to some are legs to another. Effective communication relies on the exchange of information so that what is sent and received are taken with the same intention and the same message. I am sure we've all encountered patients, when you ask them, "Do you drink alcohol?" And they say, "No, but sometimes I drink beer." People have operationalized different words to mean different things, and as it turns out, different animals to have different body parts. And so, it is so important that we make sure that our communication is clear and—to use the colloquial—that we are always on the same page with those individuals we are communicating with, so that the messages being received are the same as the messages being sent. (00:11:10)

Those of you who might remember, Chevy had a car called Nova not too long ago, and they chose to market this model in Mexico; however, when Nova is translated into Spanish, or Nova in Spanish, means "doesn't go." So not a very successful message to individuals who you are trying to get to buy your vehicle. So, the take-away for this in our scenarios are, when developing messages and materials for your community or audience, be sure to vet them with individuals in the community. Do focus groups, or better yet, have members of the community on the committees assisting in the development, so that you don't have a car that doesn't go in a country you are trying to connect with. (00:12:10)

Now, while those were some amusing examples, the lessons learned are very applicable to health and healthcare systems, as well as emergency settings. A friend of mine is an American sign language, or ASL interpreter, and she worked in a hospital that had a very large deaf community that came and received services there. And, as part of one of their public health campaigns, I think it was part of the push to make sure you wash your hands regularly to fight the flu, they created an "It's okay" campaign, and they had posters all over the hospital, and the posters showed individuals holding up their hands and making the "OK" symbol. Now, to most individuals, they would look at that and see the word "okay." Well, that symbol, or that gesture in ASL, or American Sign Language, is a not so nice word. So the entire campaign had to be taken down and begun again. It was not only expensive in terms of lost time and resources, but they had to go back and make sure that they reconnected with the community to make sure that they didn't burn any bridges there. (00:13:36)

Because, they did not want anyone to perceive that they were being disrespectful or rude by posting that, from the ASL perspective, demonstrating an inappropriate word. To ensure that we are effectively communicating today, I want to spend some time looking at some of the basic terms and concepts that I'll be going through during the course of today's conversation. So, when we talk about culture, what is it that I am referring to? Culture is the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated wholly or partially on racial and ethnic groups as well as religious, spiritual, linguistic, biological, geographical, or sociological characteristics. Now, that may seem like a lot, but as we go through this, hopefully, we'll see how all of these things influence how we act and react within the world. To drill down just a little bit further, I want to make sure that we're clear on the various categories. I have this slide, which I developed years ago, showing culture as a Venn diagram to illustrate how culture is lived. Because, while frequently we talk about culture in a very siloed way, we talk about the experience of a racial group, or a religious group, or a linguistic group—individuals who don't speak English or don't speak English well—or we talk about individuals in rural areas and while that works to an extent, the fact of the matter is that I cannot tease apart the fact that I am white, from the fact that I am a woman, that I grew up in the Midwest, and that my primary language is English. All of those things inform how I perceive and react and act every day. So, to try to think about culture in any kind of siloed way is to diminish its impact or not give you the full picture. (00:15:59)

So, linguistic characteristics include language spoken, dialect, primary language, generalizable, or generational issues when you learned the language, where you are in your lifespan, religious and spiritual characteristics include beliefs, practices, and support systems related to how an individual finds and defines meaning in their life. Those sorts of issues come into play especially following a disaster. Biological characteristics can include age, sex, sexual orientation, gender identity, physical ability, or limitations. Geographical characteristics can include where one resides, whether it be urban, rural, or suburban; one's country of origin, one's environment, and surroundings. And sociological characteristics includes a whole variety of topics, including socioeconomic status, generation, gender, political beliefs, perceptions of family, perceptions of health, perceptions of diet and nutrition, what occupational group you belong to, if you are a part of the military, what educational level you have achieved, and what you consider as your family and household composition. And why are all of these things important? Well, the World Health Organization's commission on social determinants of health states that inequities in health and avoidable health inequalities arise because of the circumstances in which people grow, live,

work, and age and the systems put in place to deal with illness. The conditions in which people live and die are in turn shaped by political, social, and economic forces. (00:17:50)

And, that is why it is so important to be able to recognize and understand how important culture weighs in. One of the tools that we use in all aspects of health, but one that can be particularly helpful in emergencies, is the concept of cultural and linguistic competence. And when we talk about that, we are talking about the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations, which many argue, are all situations. The fact that we are on a webinar and that we're exchanging information doesn't make this any less of a cross-cultural situation. So we need to adopt, through the adoption of implementation of strategies to ensure appropriate awareness, attitudes, and actions and through the use of policies, structures, practices, and procedures and dedicated resources that support this capacity. (00:18:52)

So, you know, it is not a small undertaking, but as I said, if you embed this in the framework and it becomes part of your habit, and it becomes part of how you do your day-to-day things, it becomes second nature. I try to equate it to driving a car. When we first started to learn how to drive, you had to think about now I'm going to put on the break, now I'm going to turn on the blinker, now I'm going to parallel park, and that means XY&Z. But now, as popular culture and research shows us, we frequently are multitasking in our cars. We are on our phones, we are eating our fast food, maybe not, hopefully not, too much fast food, we are doing many things, we're carrying on conversations, we're changing the radio stations, and no longer do we have to think about now I am going to shift gears, now I'm going to put on my blinker. We just inherently do it. (00:19:57)

And that is the hope and ultimate goal of cultural and linguistic competency. That you may have to think about it at first, but as time goes on, it will become ingrained and become part of your process. One of the frameworks that the Office of Minority Health has set up to help embed that into the process are the National Standards for Culturally and Linguistically Appropriate Services, also known as the CLAS Standards. They were originally released in 2001 and they are currently 14 standards organized into cultural competency, labors access, and organizational supports. We began an initiative last year to enhance the standards, bring them up to date, make sure they reflect the latest trends, information, technology, that have occurred over the last 10 years because as we all know, the fields have advanced greatly in that timeframe. (00:20:55)

So, to bring it to what brings us together today is risk communication, which is a reciprocal activity, grounded in trust and respect. And, you will see as we go through, cultural competency and culturally competent communication are at the core of establishing trust and respect, making sure that the messages you send out, especially those in times of trouble, are received properly, and that would be the reciprocal portion, you know, we need to make sure that they are culturally competent. So, in the next section of this presentation, I'll just explore more fully the significant role that cultural competency can play in preparing, responding, and recovering in times of disaster or crisis. Sometimes variations in cultural perspectives are as basic as how we perceive, receive, and react to the world around us. This is something that I pulled from the healthcare Georgia foundation document that I found. It kind of helps illustrate just the very basic natures of how many different cultures approach information. So, the dominant American culture is " Make it better." (00:22:21)

If something is broken, we need to fix it. And other cultures perceive to accept things with grace; to take things slightly more passively. That waiting and seeing is just as valid a response as taking immediate action. So, these sorts of behaviors and these sorts of differences can greatly inform and impact how an individual may prepare, respond, or recover for a disaster whether it be one that is predictable or one that is spontaneous. And, there are many cultures that feel that if you are preparing for a disaster, that you might in fact be opening the door or welcoming a disaster to happen. So preparedness would be frowned upon. So figuring out how to communicate with them, so that they are equally prepared becomes an important aspect to what we do. (00:23:25)

I think we kind of have already touched on many of these things, but I wanted to highlight them anyway. The need for cultural competence and this list comes from a policy brief that the National Center for Cultural Competency released several years ago. But, I find that the rationales or the needs are equally valid today. And I tend to group the top three together and the bottom three together, because in my experience, over the last 10 years of working in the field of cultural competency, there tends to be the two camps, if you will. The social justice camp, those who want to do cultural competency because it is the right thing to do: We respond to current or projected demographic changes; we want to reduce long-standing health disparities; and we want to improve the quality of services, and that is why we do cultural competency. And then there is the camp that says that is all very well and good, but what does that mean for my resources, what does that mean for my time, and what does that mean in terms of money and the bottom line? Well, cultural competency is compliance with legislation -- legislative, regulatory, and accreditation mandates. Many states now require their positions to take cultural competency courses as a part of their licensure. (00:24:49)

As an organization or an institution, cultural competency can be a great, competitive edge in the marketplace. If you are able to earn the trust of particular communities, they will come to your facility versus one that isn't able to meet their needs. And therefore, I have this fuller population or patient base. And, it decreases—cultural competency has been shown to decrease the likelihood of liability and malpractice claims. Just like with the ethics and communication trainings and those things of years past, what people find is that when patients are happy and patients are perceived to be respected and content, they are less likely to file malpractice or liability claims. So that's kind of our need for cultural competency, now let's apply it in the areas of disaster. Now, the evidence indicates that racially and ethnically diverse populations suffer disproportionately at every stage of a disaster. So, when you are preparing for a disaster, are you prepared? Are your patients prepared? Do they know how to act and react in case the worst happens? (00:26:12)

When you're responding to a disaster, what do you need in order to survive? What do they need in order to survive and/or maintain a basic quality-of-life? A study that Kaiser did several years ago on health impacts—the health impact following Hurricane Katrina, they had many personal stories, and one woman responded, they give me 60 pills and what I am supposed to be doing is taking two pills a day, and instead what I've been doing is taking just one a day so the medication will stretch out over a longer period of time. That is her way of coping with the lack of funds, with a lack of information, with a lack of resources following a disaster. And then, recovery. What will it take to recover? What will it take to—for them to recover? You know, we will talk a lot about the community and how to reach out and why it is so important to know who is within your population base and who is within your areas. Some research that just came out

from the Joint Commission – or, not the Joint Commission, the Joint Center Health Policy Institute, shows that African-Americans are five times less likely than whites to live in census tracts with supermarkets that are more likely to live in communities with a high percentage of fast food outlets, liquor stores, and convenience stores. Black and Latino neighborhoods also have fewer parks and greener spaces than white neighborhoods and fewer safe spaces to walk, jog, bike, or play, including fewer gyms, recreational centers, and swimming pools. And, low income communities and communities of color are more likely to be exposed to environmental hazards. For example, 56% of residents in neighborhoods with commercial hazardous waste facilities are people of color, even though they comprise less than 30% of the US population. (00:28:19)

Why does this matter? Because, all of these factors are exacerbated following a disaster. When you look at life expectancy by ZIP code, in New Orleans, just within New Orleans itself, life expectancy by ZIP code indicates that there is a 25 year gap between various parishes within New Orleans. So communities separated by mere miles have grossly different life expectancy numbers. A few quick examples of how language and culture can impact things and how import language is, when we say the word—obviously when we say take something, take once daily we know that once means one time a day. But, if I were to read this and my native language was Spanish, once means eleven, and there have been many, many case studies that have seen, or stories that have shown that people have overdosed numerous times because they misinterpreted once for ohn-say. A first responder had a case where they assumed that the new enough Spanish to get by, they interpreted the term intoxicado to mean intoxicated rather than nauseous or feeling sick to the stomach. This led to a delay in diagnosis in the emergency room, which resulted in a potentially preventable case of quadriplegia, and ultimately a significant malpractice settlement for the family. Another story from someone responding to an emergency, this couple called 911 in order to get an ambulance to transmit the woman who was in labor to give birth to their child to the hospital. (00:30:35)

They said, the hospital—or the ambulance arrived, they say to the husband, " You can come with us." And he says, "No, I can't. I cannot leave the house because now you know that we are not home and you know where we live and you may rob us. You know, usually in America there is instant trust, just with a uniform, but this does not translate or carry the same weight in many other cultures. So it is very important to know what the perceptions are of your community members. A study conducted after Hurricane Katrina to determine the factors that influenced African-Americans to not evacuate New Orleans before the hurricane hit; the major reasons that they found were that feeling safe because they had survived previous storms and had religious faith. There was a misunderstanding and miscommunication regarding the severity of the storm. The financial constraints and neighborhood crime, and perceived racism and inequities in the communities around them. But, what happened to those who didn't leave or those who chose to come back? What did their health system look like? Well, New Orleans before Katrina had 2,269 staffed, inpatient beds. Six months following Katrina, 453. Before Katrina, 2,664 physicians. After, 1,200. Before they had 4,954 nursing home beds; following, 2,735. This is important because it impacts how people receive the care, how care is perceived, and how individuals continue to operationalize their lives following a disaster. Various complications included being able to get to these limited healthcare facilities, transportation was almost nonexistent and the primary hospitals that these individuals went to beforehand were no longer viable. (00:33:07)

You saw many of the same things following the Joplin tornadoes that we had, that Missouri had, just a few years ago—a few months ago. A few weeks ago, actually. Insurance, posed a huge barrier, especially if individuals had to relocate to another state. Time and time again individuals realized that there was not enough mental health support in the area. So, strategies for culturally competent communications and how to incorporate them into your day-to-day, for the purpose of this call, I developed a mnemonic called REACT, which hopefully just provides a very concrete way of remembering some of the basic stages to ensuring that your phases of a disaster are culturally competent. So, REACT stands for recognizing differences, engaging stakeholders, ensuring that your messages are audience centered, making sure that you communicate effectively, and remembering that trust is key. (00:34:09)

So, recognizing differences, again we see the Venn diagram and we see just outside the Venn diagram how beliefs and customs, preferences, attitudes, and behaviors and knowledge are all informed by these and therefore, how do they relate to how you respond to a disaster? What do you know before; how do you go about making sure that you are prepared; how do you help your patients be prepared to respond and be sure that they are ready to respond to any of their unique needs; what does it look like in the long term, because as we have said, disparities that exist before a disaster are multiplied after. So we need to make sure that we know and be aware that if the community has special economic considerations, are there recognizable groups with special needs, what are the rental properties versus people who own their own homes. Knowing who is in the community can be as simple as checking the census, looking at organizations such as the Modern Language Association, which can provide you great information on what languages are spoken in your area, and then recognizing and identifying these pieces are critical to the next steps of engaging stakeholders. (00:35:31)

So, you know, identify and invite community partners to the table, explore opportunities for collaboration and partnership with diverse communities, ensure community engagement and collaboration is an ongoing process, make sure that you are able to locate and identify groups within your community, identify their preparedness, beliefs, norms, and preferences. Conduct a community resources inventory and needs assessment and ensure that it is an ongoing process. Doing it once every five years may not be enough if you live in a community that changes greatly over time. During a response, what organizations are you connected to? The research shows that not being connected to the Red Cross or the National Guard can negatively impact your ability as a healthcare provider to respond to a disaster in a timely fashion. Because, if you are not associated with one of those primary organizations, you may not be receiving the messages properly, you may add to the chaos of—the word pandemonium was thrown around quite a bit in reaction to the earthquakes in Japan. And, healthcare providers responding in an uncoordinated way. (00:36:52)

And then in recovery, how are coverage and access issues going to be addressed? How do you restore services? And what about financing and how are individuals going to be able to pay for these services? Audience centered messages: Is your emergency preparedness plan appropriate from a culturally and linguistically -- linguistics standpoint? Communications are there various communication channels in place and appropriate for reaching all affected populations? In the case of wildfires in California, the way that they connected with many of the populations was through autodial tones. The messages were only available in English and therefore the 30 to 40% of the population in the San Diego area whose English was not their primary language, didn't receive the messages. Preparedness: Are the key messages translated in advance and distributed

to communities through appropriate channels? Whether it be community centers or churches or other institutions of faith. Making sure that things that can be done in advance are so that they receive the information the way you intended. In the moment of a disaster, how are you able to reach them? Do they have—you know, we use—on college campuses they do a lot of texting and smartphones and those sorts of things. But is the community you are working with or attempting to connect with—you know, do they have access to those resources? And then, what do these messages, formal and informal, look like…when you are in the recovery process? Again, from the Kaiser study, there was a woman who went to the doctor following Katrina—and they asked me—this is what she had to say. "I went to the doctor when they ask me the name of the medicine I didn't know. So, the doctor couldn't give me nothing." It's a woman from Baton Rouge. What she walked away with is the knowledge that she is not being able to be helped, that recovery is not going to be easy for her, that there, you know, being prepared in her instance could—you know, simply knowing what medicine she is on, making sure that information is available and with her on a regular basis can be huge. Communicating effectively: Will information be available in other media? So Web, telephone, etc. and will people be able to access—will the access method be linguistically and culturally appropriate. It's great if you have a website, but if most of your individuals don't have Internet, you are missing out or if the website is only available in English and your individuals don't speak English or don't have a working knowledge in being able to read English, again, this passive form of communication isn't going to work with them. Many of us have interpreting services either by the phone or through the videos and some in-person interpreters. (00:40:32)

What happens in the case of a disaster when telephones and video are not able to be accessed? Following Katrina, following 9/11, following the tornadoes in Joplin, cell phones were down for four and five days at least. And so, how do you go about communicating with individuals who need those kinds of technology. You have to find alternate ways and have backup plans in case of those things happening. And then will printed copies of information be available? And how and where do you distribute those? During the recovery phase and during even the latter stages of the response phase, people will be looking for information more than ever, because they will be looking to make sense of chaos around them. So making sure that they are able to see the messages and able to receive the messages and have a hope and have a plan are huge. (00:41:39)

So all of those things contribute and result in establishing trust within your community. It's so important to know what your organization's reputation is in the community. There is many populations that have a distrust, a fear of government and health institutions, and if you are a governmental health institution, sometimes doubly so. Refugees and immigrant populations may not know or may not have positive views on systems, simply because of where they came from originally. And then there are communities within United States, who have experienced a great, different deals of prejudice and racism and issues, experimentation, such as the Tuskegee syphilis data. You know, all of these things impact how you are perceived as an organization or as an institution. Some of you might be familiar with a book called *The Spirit Catches You When You Fall Down*. It is about a Hmong girl who lives in California in Western terms, she has epilepsy and within her culture, it is perceived that part of her spirit has left her. Part of the culture that came through with her family as they emigrated and were refugees from Laos was that they were discouraged from coming to Western hospitals because in Western hospitals, people eat your brains. Now, that is a pretty significant barrier if you're, you know not you

know, to going and seeking care, because if somebody—if you think somebody is going to eat your brains, chances are that's going to be your very, very last resort. (00:43:40)

And then we can think about, you know, one of the anecdotes I shared earlier about the man who wasn't even able to go with his wife to the hospital to see the birth of his child because he was afraid that the EMS workers would come back and rob his house. So it is necessary to have an understanding of what your organizations reputation is. Surveys, focus groups, meetings with local leaders and community-based organizations and requesting feedback and input on how to improve or change your reputation. Sometimes it's simply because you haven't been connected in the past and that is where the disconnect is. (00:44:17)

But letting people know that services are available, letting people know that you are interested in seeing them, regardless of their cultural background, can be huge knowing that you are a welcome ally to them and their community can be monumental. We should always be thinking about what we have learned from the past from tornadoes, earthquakes, pandemics, terrorism, and hurricanes. Each of these provide great insight into how to do things better, how to maybe not do things or how to do things even with greater ease. So, in summary, make sure that when you do start to look at cultural and linguistic competencies, make sure that these services are routinely addressed, updated, and managed. We have a lot of moving communities these days and populations can change over just a couple of years. Can there be work teams within your individual counties or organizations in cities that focus on these sorts of tasks? Will there be an ongoing dialogue and sharing of best practices on the topic, and if so, where and what venue? This should be included as part of the organization's overall mission and objectives as a component of all services and not just emergency preparedness. And then reacting with cultural competence aids in the establishment of trust and rapport, which is key when and if and emergency occurs. I encourage you to not only learn from the past, but to learn from local leaders, social service workers, and community members from the cultural groups about values, family norms, traditions, community politics, et cetera. Ideally, this would occur before a disaster strikes. Involve staff and community outreach workers who are bilingual and bicultural whenever possible. Involve trusted community members to enhance your credibility. Allowed time and devote energy to gaining acceptance, beware of aligning your efforts with a particular -- with any particular agency organizations that are mistrusted by the community you are trying to reach. Take advantage of associations with valued and accepted organizations. (00:46:44)

Be dependable, nonjudgmental, genuine, respectful, well-informed, and credible to the community. Listen for verbal and non-verbal cues and modify efforts accordingly. When in doubt, ask your community members. Determine the most appropriate and acceptable ways to introduce yourself and define your program and services to be culturally sensitive; recognize cultural variation and expressions of emotions, manifestations, and descriptions of psychological symptoms, mental health problems, and views of counseling. And then, provide community education information in multiple languages and invite multiple mediums via radio, TV, or church and synagogue announcements. Focus on problem-solving and concrete solutions. Be action-oriented and empower clients through education and skill building. And finally, assist in the eliminating barriers to health. Interpret facts, policies, and procedures and provide advocacy and resource assistance in dealing with these barriers. (00:47:52)

So, finally, to truly impact change within our health institutions, public and private, academic and implied, we all need to evolve to reflect culturally relevant and sensitive formats. The key to

this evolution will be ongoing and long-term. We need to ensure that we have a journey mentality; that we are not going to arrive there tomorrow; that training is key in making sure that all the individuals who come in contact with people from the community are trained; collaborate, you don't have to do this alone; find expert partners and, you know, make allies of them. Do research, do internal and external policy reviews. Make sure your methodology is sound and determine what a shared understanding of success may be. Please feel free to—we are about to start question-and-answers, but please feel free to e-mail me at darci_graves@sra.com if you have any questions or some of the resources I have mentioned today, as well as additional cultural and linguistic competency resources are available on the website sponsored by the Office of Minority Health, HHS Office of Minority Health, at www.thinkculturalhealth.hhs.gov. With that I will turn back to Loretta and we can answer any questions that anyone might have. (00:49:34)

Loretta Jackson-Brown

Thank you, Darci. We will now open up the lines for the question-and-answer session. Again, you may submit questions via the operator or by webinar. Evan?

Operator

Yes ma'am. If anyone would like to ask a question via the phone, please press star one at this time. You will be prompted to unmute your phone and record your name as your name is required to introduce your question. Once again, star one if you have a question. (00:50:01)

Loretta Jackson-Brown

So Darci, while we are waiting for questions via audio, or via the webinar, what about some best practices of organizations or institutions that have really kind of nailed it on culturally competent communication? Does anyone stick out in your head? (00:50:25)

Darci Graves

There are some great examples of connecting with communities that have come out of like the Seattle and the International District. And again, it really comes down to ensuring that the relationship of the community is there so that your communication is on par and as valid as possible. Making sure that messages are culturally and linguistically competent in terms of interpretation, making sure that when you have documents translated, it is not just word for word translation, but meaning for meaning translation. You can go back to the Nova example. If you do the direct translation, that is "no good." So making sure that dialects are taken into account, that the meaning of the message is conveyed, as well as the context. So, I am sure I can pull together a couple of best practices, resources, and share those with you so you can distribute them to the group. (00:51:43)

Loretta Jackson-Brown

Excellent! We can definitely post those to our COCA Web page for this particular call under "Additional Resources." So again, the information for this call will be posted to our COCA website and, as Darci stated, she will provide us with some additional resources. Evan, do we have any questions from the phone? (00:52:03)

Operator

At this time, ma'am, we have no questions from the phones.

Loretta Jackson-Brown

Okay and I'm showing no questions from the webinar. Darci, is there anything else you'd like to add before I conclude the call?

Darci Graves

No, not off the top of my head. Sorry. (00:52:21)

Loretta Jackson-Brown

Right, no problem. So on behalf of COCA, I would like to thank everyone for joining us today with a special thank you to our presenter, Darci Graves. If you have additional questions for today's presenter, please e-mail us at coca@cdc.gov. Put Darci Graves in the subject line of your e-mail, and we will ensure that your question is forwarded to her for response. Again, that e-mail address is coca@cdc.gov. The recording of this call, and the transcript, will be posted to the COCA website at emergency.cdc.gov/COCA within the next few days. Free continuing education credits are available for this call. Those who participated in today's COCA conference call and would like to receive continuing education credit should complete the online evaluation by August 14, 2011 using course code EC1648. For those who will complete the online evaluation between August 15, 2011 and July 14, 2012, use course code WD1648. All continuing education credit and contact hours for COCA conference calls are issued online through TCE online, the CDC training and continuing education online system at www.2A.cdc.gov/TCEonline. To receive information on upcoming COCA calls, subscribe to COCA by sending an e-mail to COCA at coca@cdc.gov and write subscribe in the subject line. Again, thank you for being a part of today's COCA webinar. Have a great day! (00:54:12)

Operator

This concludes today's conference, you may now disconnect.