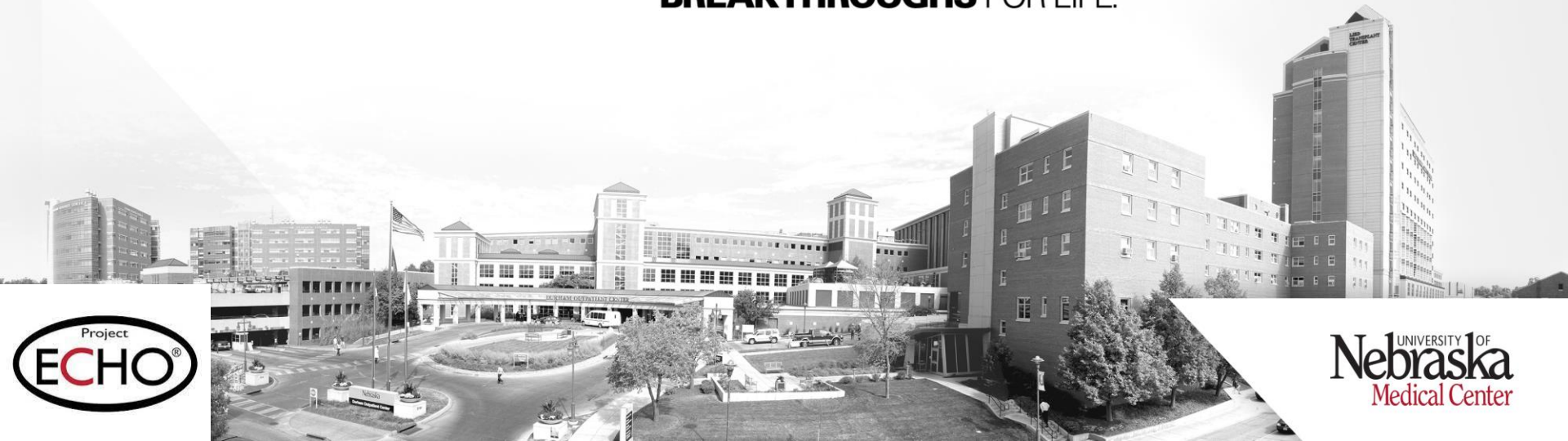
UNMC[SM]

BREAKTHROUGHS FOR LIFE.®



Project ECHO®

University of Nebraska Medical Center

UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 36

Project Funded by Nebraska DHHS through a CDC grant

Housekeeping Reminders

- Discussion makes sessions work best!
- Please stay muted unless you are speaking
- We love to see your face!
- Sessions will be recorded and available upon request
- Attendance is taken by filling the survey in the chat
- All the session presentation are available on our website

- Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. This data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to create new initiatives.

https://www.unmc.edu/intmed/divisions/id/echo/health-equity/index.html

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Erica Stohs, MD, MPH
- Kelly Cawcutt, MD, MS
- Jonathan Ryder, MD

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD

Health Equity & Cultural Sensitivity Team

- Nada Fadul, MD
- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Andrea Jones, MD
- Precious Davis, EdD
- Samantha Jones, Program Manager
- Dan Cramer, NP

CE Disclosures

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UNMC ID Health Equity and Quality Improvement ECHO Project

Topics:
HE: Disability + American Sign Language

Free Live ECHO Project
April 19, 2023
CID 57619

University of Nebraska Medical Center

TARGET AUDIENCE

This accredited continuing education activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.
The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- List important needs deaf and hard of hearing (DHH) American Sign Language (ASL) users have when accessing healthcare.
- Identify different accommodation and interpreting needs among DHH, including ASL users.
- Discuss strategies for increasing inclusion for DHH ASL users at your healthcare institution.

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
    a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
    b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hour(s). Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 1.5 general continuing education credits. **Social work level of content: Advanced.**

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

Activity code: I00054696 Approval Number: 230001146

To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE DECLARATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

FACULTY

The below faculty have nothing to disclose:

- Michael Argeny, MD, MPH, MSW
- Regina Daniels, MA

Disclosures

PLANNING COMMITTEE

M. Salman Ashraf, MBBS
Merck & Co, Inc: Industry funded research/investigator

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

- Valeta Creason-Wahl, HMCC
- Precious Davis, EdD, MSN, BSN, RN
- Nada Fadul, MD
- Samantha Jones, CSW
- Mahelet Kebede, MPH
- Heidi Keeler, PhD, MSN/MBA, RN
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Jonathon Ryder, MD
- Jeff Wetherhold, M. Ed
- Bailey Wrenn, MA

www.unmc.edu/cce

POLL

Project Updates

- Approval received from the CDC for project extension
- Focus on providing consultation on QI projects
- Invitation to everyone throughout the state of NE

Participant Interviews

- 30-45 minutes each
- Focused on how you hope to apply what you are learning to your work
- Helps us improve program content

Schedule an interview:

Poll Results

Health Equity:

Disability & American Sign Language

Presenters: Regina Daniels, M.A., ABD, DI
Michael Argenyi, MD MPH MSW AAHIVS

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Objectives

1. List important needs deaf and hard of hearing (DHH) American Sign Language (ASL) users have when accessing healthcare.

2. Identify different accommodation and interpreting needs among DHH, including ASL users.

3. Discuss strategies for increasing inclusion for DHH ASL users at your healthcare institution.

POLL

Hearing Loss Language

- **Deaf & deaf:** Historically “Deaf” referred to someone with a cultural identity, whereas deaf was more of a general term for severe-to-profound hearing loss; now there is movement toward “deaf” as a broader term, encompassing both instead of being divisive
  - Many youth and young adults with cochlear implants want to identify with community and may sign
  - WHO definition: So severe that amplification doesn’t help

- **Hard-of-hearing:** Typically, someone with mild to moderate/severe hearing loss, perhaps someone with hearing loss due to aging or noise exposure, but used very broadly

Hearing Loss Language (cont.)

- **Late-deafened:** Typically, someone with onset of hearing loss post-lingual (or post-childhood)
- **Person with hearing loss:** Person-first term, not used broadly but may see this.
- **Hearing-impaired:** Used by very few, generally considered an offensive term and medicalized, though if the person opts to use it, please honor that choice.
- **Deaf-Blind:** Persons with both hearing loss and vision loss, often due to conditions like Usher's Syndrome, and may benefit from additional and integrated services (e.g., tactile sign).

Social Constructs of Disability and Audism

- **Disability**: The interaction of environmental (physical, attitudinal, communication, and social) barriers with a person's abilities

- **Audism**: Stigma and discrimination resulting from the belief that hearing is superior; also, can be applied to English/clear spoken language as superior communication (*a variant of "ableism")*

Epidemiology

- There at least 500,000 ASL users nationally, and the majority (90%) are born to hearing parents who may have no experience with hearing loss.

- **Deaf adults are:**
  - More likely to be obese
  - More likely to have experienced IPV and sexual assault
  - More likely to smoke or drink

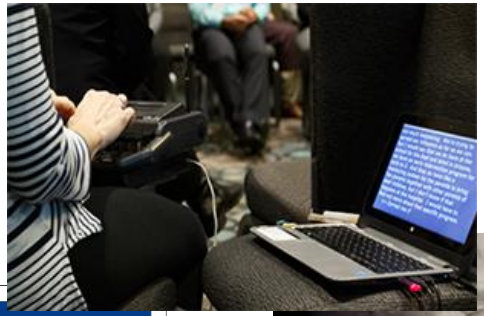
- **Adults with hearing loss are:**
  - More likely to be in poor or fair health (e.g., more hospital and ED visits, frailty)
  - More likely to have other concurrent physical problems (e.g., smoking-related, CVD, arthritis)
  - More likely to have experienced psychological distress (e.g., social isolation, cognitive decline)

Epidemiology (cont.)

- **Children**: Overall health disparities may be lesser, but Black and Brown kids have lower rates of cochlear implantation and poorer outcomes post-implantation.

- Medical trauma via misdiagnosis (miscommunication), medical mistrust (eugenics), and belief discordance (medical model)

Communication Diversity



BEST

Non-dominant hand held in front of body with thumb extended. Extended thumb of dominant hand brushes up non-dominant thumb twice.

Intersectionality

- Intersectionality is the interconnected nature of social categories such as race, gender, class, and disability, creating unique experiences of oppression and privilege.
- Diversity of identities and experiences within the Deaf and Hard of Hearing Community makes intersectionality particularly relevant.
- Understanding the unique experiences of marginalized groups, such as Black Deaf individuals, is crucial.
- Other factors such as language background, socioeconomic status, and geographic location can impact access to resources and opportunities within the community.

ASL Needs and Interpreter Representation (including DI)

- **American Sign Language (ASL)** is a visual language used by many Deaf and Hard of Hearing individuals in the United States.
- It is important to recognize that there are variations within ASL, such as Black ASL, which has its own unique vocabulary and grammar.
- In addition to ASL, there are other forms of visual communication that may be used by Deaf and Hard of Hearing individuals, such as Visual Gestural Communication (VGC) or tactile signing for those who are Deafblind.

ASL Needs and Interpreter Representation (cont.)

- It is crucial to ensure that interpreters are provided to facilitate communication for Deaf and Hard of Hearing patients in medical settings, and that these interpreters are representative of the diversity of the community they serve.

- Efforts should be made to provide training and support for interpreters to understand and address the unique needs and experiences of Deaf and Hard of Hearing individuals from diverse backgrounds.

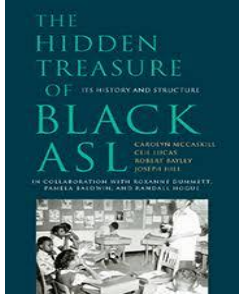
Deaf Interpreters

- In addition to ASL interpreters, Deaf and Hard of Hearing people may require a *second* interpreter, called a **Deaf Interpreter.**

- This is a Deaf person who is fluent in mediating between standard ASL and other variants of ASL, including home sign and Visual Gestural Communication.

- The concept is that an ASL user may understand another native ASL user better than an interpreter.

Black American Sign Language (BASL)



- Black American Sign Language (BASL) is a variation of American Sign Language (ASL) used within the Black Deaf community in the United States.
- BASL incorporates elements of African American English and has its own distinct grammar and vocabulary.
- BASL is not a separate language but a distinct dialect of ASL.
- Understanding and recognizing BASL is crucial for providing effective communication and healthcare services to Black Deaf individuals.
- BASL is an important aspect of Black Deaf culture and history, and recognizing its value is important for promoting diversity and inclusion within the Deaf and Hard of Hearing Community.

POLL

Video Remote Interpreting (VRI)

- Rapid rise with COVID-19 because of isolation and availability and masks.
- Technology-laden and presents multiple limitations, including freezing, poor view of interpreter (positionality of the screen).
- May be a patient preference out of concern for shared medical information with local interpreters.

Impact of COVID-19

- Reliance on VRI
- COVID-19 mask mandates incredibly isolating
- No transparent N-95 version
- Microaggressions of negotiating access with every mask user
- Constant burden of educating others about transparent masks
- Health literacy often reliant on friends and internet contributing to misunderstanding of COVID-19 risks and mandates

Inclusion: You're Here Already!

Learning

Developing cultural intelligence (CQ)

Recommendations

- Ask
  - Single screener is very effective: “Do you think you have hearing loss?”
  - If yes, ask what are their communication preferences/needs and know that these may change from one situation to another.
  - Recognize unique linguistics needs that may go into understanding equitable ASL interpretation.

- Design systems with clear (visual) door signage, EHR language/communication alerts, and diagnostic codes to facilitate accessibility from door-to-door.

- Be proactive in constructing inclusive spaces (architectural consulting, etc.) to create a visually accessible environment: alarms, visual aids, removing obstructions (the WOW, vases), clear masks, facing the patient, writing down medication names, times, instructions, websites.

Recommendations (cont.)

- Have a highly visible accommodation request process.
- Include a budget for accommodations (captioning, interpreters).
- If the community learns that your events will be accessible and welcoming, they will come.

Case Discussion

Today's Topic

SDOH – Transportation

Case Discussion

You are a clinician. You are seeing a patient with Long-COVID who was supposed to come in for their 6-month follow-up, but who has not been in for over a year. You're frustrated that they didn't come in after you set-up this important appointment. The patient explains through an interpreter that they missed their last appointment because they couldn't coordinate with the transportation provider due to hearing loss.

Breakout Room Questions

1. How would you respond when the patient shares this with you?

2. What elements of interpretation might have been overlooked in this situation?

3. What services might a patient who is deaf or hard-of-hearing need to access care in this situation?

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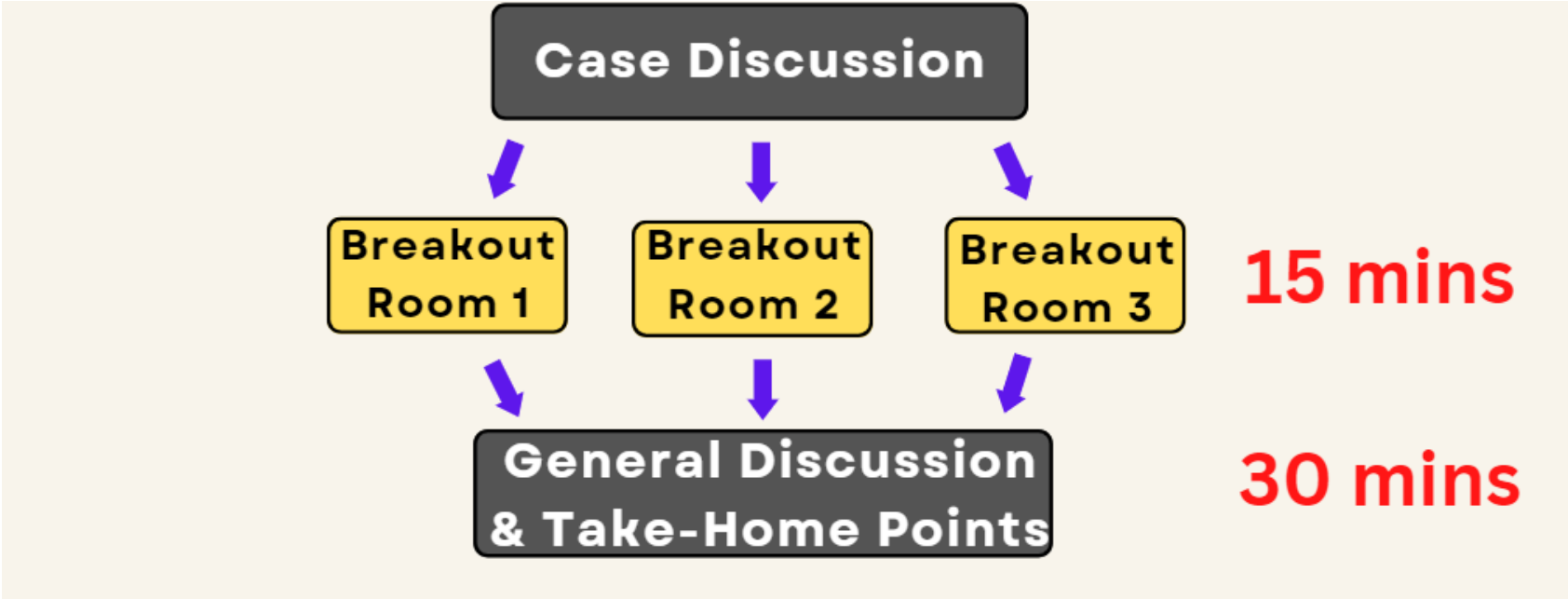
Miro Board


Case Discussion
Breakout Room 1
Breakout Room 2
Breakout Room 3
15 mins
General Discussion & Take-Home Points
30 mins

Ground Rules

1. Be present & turn on your videos
2. Make Space, Take Space
3. ELMO: Enough Let's Move On
4. Take the lessons, leave the details
5. Assume positive intent
6. Be open to learning
7. Building, not selling
8. Yes/and, both/and

You are a clinician. You are seeing a patient with Long-COVID who was supposed to come in for their 6-month follow-up, but who has not been in for over a year. You're frustrated that they didn't come in after you set-up this important appointment. The patient explains through an interpreter that they missed their last appointment because they couldn't coordinate with the transportation provider due to hearing loss.

	Breakout Room 1	Breakout Room 2	Breakout Room 3
1. How would you respond when the patient shares this with you?	• Express compassion • Share resources with patient • Understand how patient expresses their hearing loss • Denote this accomodation in EMR for the future with their consent	• Ask what they need, refer resources where available • Acknowledge straightforward answer, expressing gratitude • Express empathy • Apologize • Ask about resources previously used •	• Apologizing to the patient that this has happened • Ask additional questions needed in this case • Prepare responses that haven't been shared with the patient, for example, did we publicly share/advertise our translation services with patients?
2. What elements of interpretation might have been overlooked in this situation?	• Different forms of interpretation • System/process for tracking accommodations • Dialect choice for language	• Communication strategy beyond the exam room • Impact of interpretation availability on patient • Recognition of individual's needs • Documentation of needs in chart, chart flagged • Evaluation of social/non-medical needs • Coordination with other team members • Do we understand providers' needs in working with interpretation? • Automatic alerts to team members who can help (social work) • Responsibility to communicate with patient •	• Asked: What went wrong during the patient's first visit? Did it take place at a different site, therefore the services and availability at that site were different? • We didn't make the arrangement. Who made it? how was it made? what did they do? Was this already all set up or was it a probelm of interpretation and not the service? • Are the case management and social workers available in the clinic?
3. What services might a patient who is deaf or hard-of-hearing need to access care in this situation?	• Access to interpreter who meets their accommodations • Case management to ensure access and follow-up • Education on process and available resources • Ensure all accommodations are met in their medical care	• Reminders in appropriate language/format • Integration with scheduling • Knowledge of preferred/available transportation services • Case mgmt services, coordination with vendors on available supports • Early ID and intervention of patient needs •	• If it worked the first time, did we do the exact same thing the second time, or did we miss an important step? • Did we miss an important communication step? • Do we know what kind of communication the patient had available or did we make our own assumptions on calls and text messages?

General Discussion

Reflecting on our case study:

What next steps can you take to ensure that this patient receives the additional services identified in our breakout groups?

Current State of COVID-19 in Nebraska

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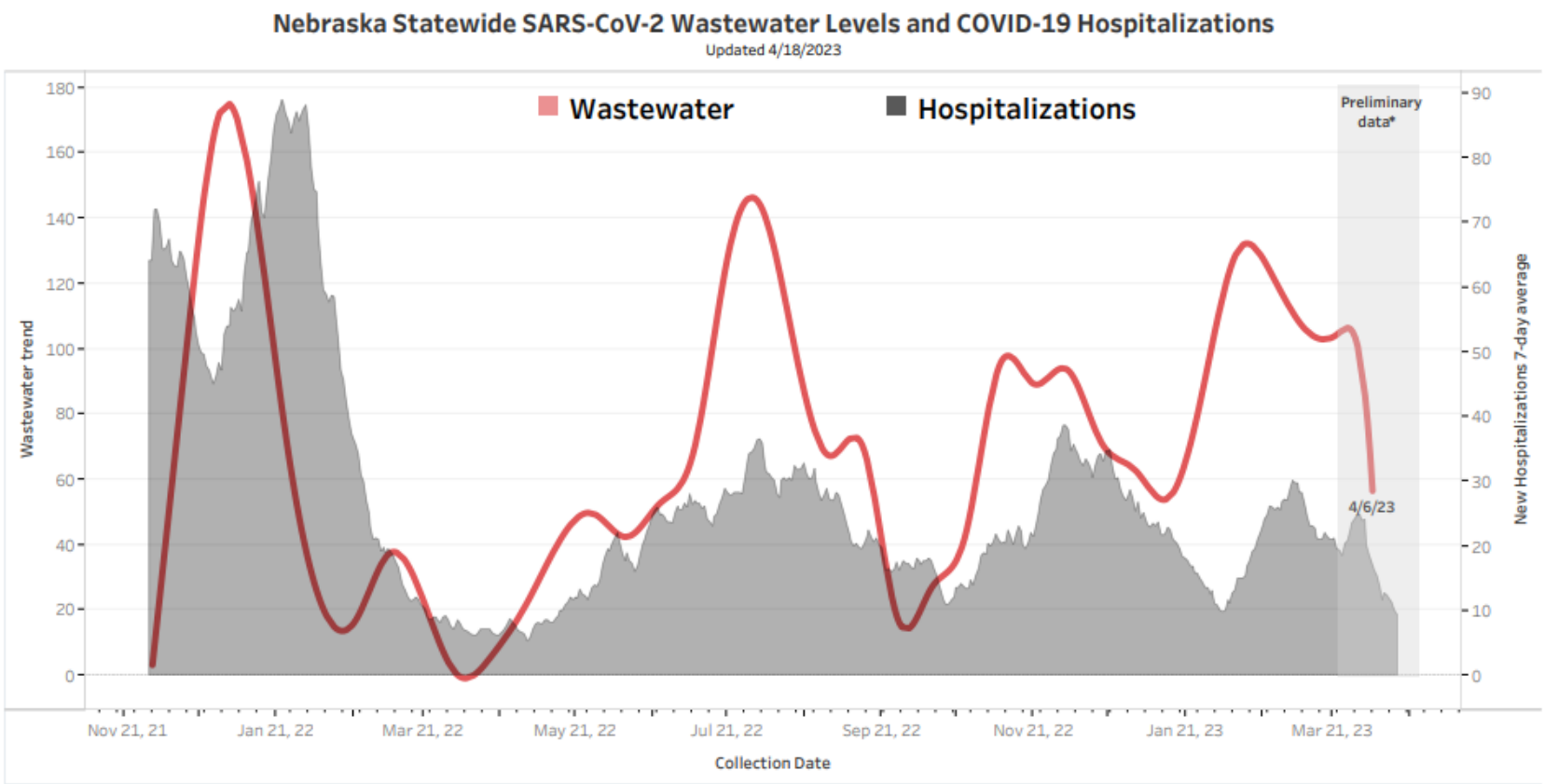
Nebraska COVID-19 Statistics

Nebraska SARS-CoV-2 Wastewater Surveillance Report

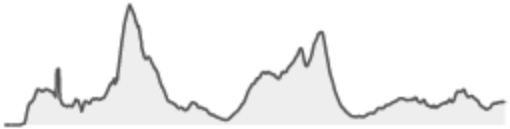


https://dhhs.ne.gov/Pages/COVID-19-Genomics-and-Wastewater-Surveillance.aspx

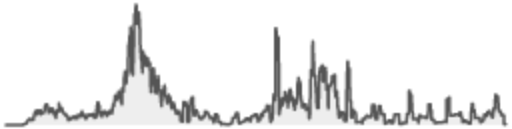
Nebraska COVID-19 Statistics

Test positivity rate

Hospitalized



Deaths



	DAILY AVG. ON MAR. 23	PER 100,000	14-DAY CHANGE
Cases	216	11	–1%
Test positivity	15%	—	–3%
Hospitalized	193	10	+5%
In I.C.U.s	24	1	+34%
Deaths	<1	<1	–94%

About this data

https://www.nytimes.com/interactive/2021/us/nebraska-covid-cases.html

Nebraska COVID-19 Statistics

Week	Weekly Cases*	Weekly Admits*	COVID-19 Hospitalizations	% COVID Hospitalizations
4/5/23	75.0	8.5	193	4.0
4/19/23	38.0	4.3	N/A	3.2

POLL

Poll Results

Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email

2. Next session will be on **May 3rd** on:

- Didactic: Health Equity & Cultural Sensitivity Wrap-Up and Case Studies

Health Equity & Cultural Sensitivity Poll

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Session 37

For our final HE/CS session, we will deep dive into three case studies.

1. Intersectionality.

2. A HE/CS "solution" to a QI project conducted by one of your peers.

3. **You pick!** What topic would you like to focus on for the third case study?

    - Communicating health equity and emotional intelligence
    - Leveraging clinical/public health data to eliminate health disparities
    - Enhancing sensitivity to cultural similarities and differences
    - Community and stakeholder engagement
    - Trauma-informed approaches

Poll Results

Thanks