



Engaging Partners to Advance and Sustain Cultural and Linguistic Competence in the Current Climate

February 20, 2018



OBJECTIVES

Participants will:

1. Describe strategies to engage partners and others in difficult conversations about cultural and linguistic competence (CLC).
2. Identify approaches to obtain “buy in” for CLC from leadership, faculty and staff, advocacy communities, and other partners concerned with developmental disabilities.
3. Define what equity and inequity mean within the context of developmental disabilities services and supports and how to partner with others to take action.



PANELISTS

Stephanie Autumn

A local, national, and international policy expert focused on inequities that affect American Indian youth and communities

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Christine Pisani

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Tawara D. Goode

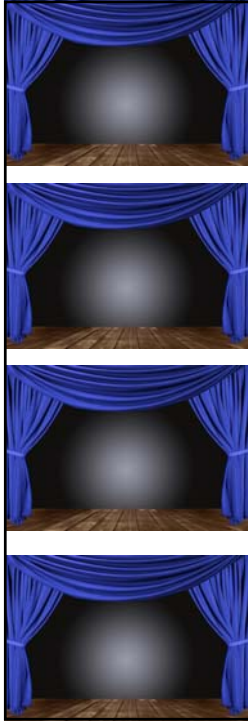
PI, Leadership Institute for Cultural Diversity and Cultural and Linguistic Competence
Director, Georgetown University National Center for Cultural Competence
Director, Georgetown University Center for Excellence in Developmental Disabilities

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Setting the Stage

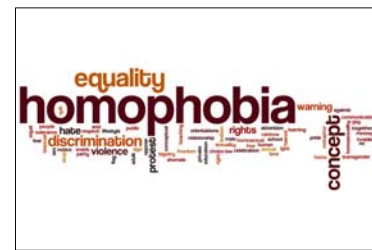
In our work to advance and sustain cultural and linguistic competence, one of the most difficult conversations in which to engage partners is those that focus on the “Isms.”

These conversations are even more difficult to have given the current socio-political climate.

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The “Isms” is an umbrella term used by the NCCC to refer to a range of attitudes and behaviors that involve perceived superiority, oppression, prejudice, and discrimination based on such factors as race, national origin, ethnicity, language, class, disability, sexual orientation, and gender identity and expression.



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POLLING QUESTION

1. Have you ever attempted to engage partners in conversations about the “Isms”?
 Yes No
2. Have any partners ever attempted to engage you in conversations about the “Isms”?
 Yes No



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Having Difficult Conversations



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Having Difficult Conversations about the “Isms” Four Strategies

1. Assess your comfort level.
2. Find comfort in discomfort
3. Be vulnerable
4. Address strong emotions

Source: Adapted from Let's Talk! Teaching Tolerance. Retrieved on 2/19/18 from www.tolerance.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf

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Having Difficult Conversations about the “ISMs” Four Strategies

1. Assess your comfort level.

We often avoid conversations about the “ISMs” – particularly racism – for any number of reasons.



Source: Adapted from Let's Talk! Teaching Tolerance. Retrieved on 2/19/18 from www.tolerance.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf

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POLLING QUESTION

Having Difficult Conversations about the “Isms” Strategy 1. Assess your comfort level.



Select one that best describes your feelings.

- I would rather not talk about the race/racism.
- I am very uncomfortable talking about race/racism.
- I am usually uncomfortable talking about race/racism.
- I am sometimes uncomfortable talking about race/racism.
- I am usually comfortable talking about race/racism.
- I am very comfortable talking about race/racism.

Source: Adapted from Let's Talk! Teaching Tolerance. Retrieved on 2/19/18 from www.tolerance.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf

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Having Difficult Conversations about the “Isms”

Strategy 1: Assess your comfort level

Strategy: Complete the thoughts below for yourself and invite others to do the same.

- The hard part of talking about race/racism is ...
- The beneficial part of talking about race/racism is ...



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Defining Racism

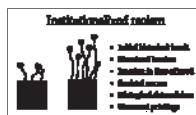
“Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call race), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”



Camara P. Jones, MD, MPH, PhD
Senior Fellow
Satcher Health Leadership Institute
Morehouse School of Medicine

Kaiser Permanente Institute for Health Policy. How Racism Makes People Sick: A Conversation with Dr. Camara Jones, MD, MPH, PHD. Retrieved on 1/16/17 from <https://www.kpihp.org/how-racism-makes-people-sick-a-conversation-with-camara-phyllis-jones-md-mph-phd/>

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Dr. Camara Jones asserts there are three types of racism and defines them as follows

- **Institutionalized racism** – differential access to the goods, services, and opportunities of society by race.
- **Personally mediated racism** – differential assumptions about the abilities, motives, and intents of others by race; differential actions based on those assumptions. Evidenced by prejudice and discrimination.
- **Internalized racism** – acceptance by stigmatized races of negative message about own abilities and intrinsic worth. Manifested by self-devaluation, resignation, helplessness, hopelessness.

Source: Levels of Racism: A Theoretic Framework and a Gardener's Tale. <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.8.1212>

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Having Difficult Conversations about the “ISMs” Four Strategies

Strategy 2. Find comfort in discomfort.

- Talking about the “Isms” requires courage.
- Talking about issues that raise strong emotions can indeed be uncomfortable for some.
- Being uncomfortable is not the same as being unsafe.
- Have the courage to move from “safe spaces to brave spaces.”



Source: Adapted from Let's Talk! Teaching Tolerance. Retrieved on 2/19/18 from www.tolerance.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf

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From Safe Spaces to Brave Spaces



- Controversy with civility
- Owing intentions and impacts
- Challenge by choice
- Respect
- No attacks

Source: Arao, B. & Clemens, K. (2013). From Safe Spaces to Brave Spaces: A New Way to Frame Dialogue Around Diversity and Social Justice. In The Art of Effective Facilitation. Sterling, VA: Stylus Publishing, LLC. https://mli.presswarehouse.com/sites/stylus/resrcs/chapters/1579229743_otherchap.pdf

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Having Difficult Conversations about the “Isms” Four Strategies

Strategy 3. Be vulnerable.

We often avoid conversations about the “Isms” because of our own fears and vulnerabilities.

- Think about and list at least **3** vulnerabilities that you believe could limit your effectiveness in having conversations about the “Isms.”
- List at least **3** strengths.
- Do this with your partners.



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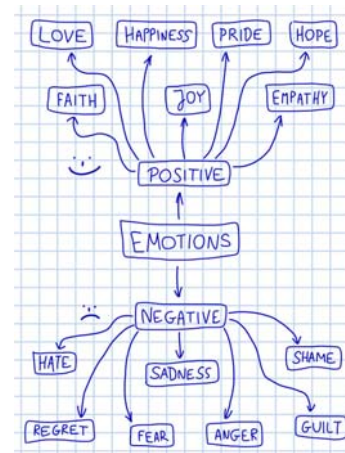
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Having Difficult Conversations about the “Isms” Four Strategies

Strategy 4. Address strong emotions.

- It is common to experience feelings of guilt, shame, denial, anger, pain, blame, fear, empathy, compassion or being overwhelmed when discussing the “Isms.”
- The “Isms” are present in our everyday lives .
- Be attentive to the emotions that they evoke in you and others.
- Assume personal responsibility for your own emotions.



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POLLING QUESTION

1. Have you ever used any of these strategies to engage in conversations about the “Isms”?
 - Yes
 - No

2. Could you see yourself using these strategies to lead conversations about the “Isms”?
 - Yes
 - No
 - Not sure



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Getting buy in requires...



- A shared vocabulary, shared understanding of CLC
- Ensuring an inclusive process
(*Invite those naysayers!*)
- Tailoring “buy in” messages to address individual and group interests and needs
- Creating a shared vision for CLC

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Now let's hear from our panelists



Christine Pisani



Max Barrows



Maria Mercedes Avila



Stephanie Autumn

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Max Barrows

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Now let's hear from our panelists



Mercedes Avila

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LEARNING AND REFLECTION FORUM: Engaging Partners to Advance and Sustain Cultural and Linguistic Competence in the Current Climate



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FEBRUARY 20TH, 2018



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Overview

- Strategies to engage partners
- Leadership “buy-in”
- Collaborative partnerships
- Professional development & mentorship
- Addressing health disparities & work towards equity



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Strategies to Engage Partners

- Meaningful representation of communities in advisory councils
 - Advocate for community voice within programs
- Research based approaches and using data to build cases
 - What is the data telling us about disparities and inequities?
- Demographic changes
 - What do our communities look like?
- Role model “speaking up”
 - How do we understand equity?
 - How are we approaching this work?



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VT LEND Advisory Councils

VT LEND has two advisory councils:

- State/Partner Organization Advisory Council
- Health Disparities & Cultural Competence Advisory Council
 - 90%+ racially/ethnically diverse
 - LGBTQ
 - Disability
 - Immigrant status
 - Religious/spiritual beliefs
 - SES



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Leadership and program “buy-in”

- Diversifying programs, identifying gaps in knowledge and creating plans
- Education, education, education
- Advancing this work in every aspect of our lives
- Partnering (meaningfully) with community organizations



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Collaborative Partnerships to Advance this Work

- Title V
- Family Organizations and families
- Refugee/Immigrant Serving Organizations
- Self-Advocacy Organizations
- Other UCEDD/LEND programs



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Understanding the importance of this work

- Ethnocentrism → **Major obstacle to advancing CALC**

- Prejudice
- 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)**

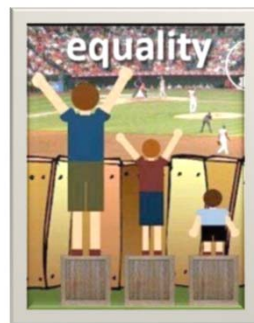
Workforce
9% nurses
6% physicians
5% dentists

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



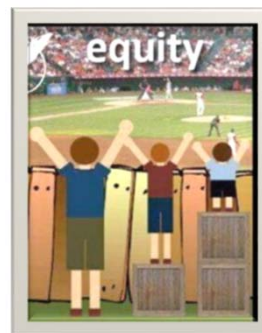
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Equality vs. Equity



EQUALITY=SAMENESS

**GIVING EVERYONE THE
SAME THING**



EQUITY=FAIRNESS

**ACCESS to SAME
OPPORTUNITIES**

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Professional Development & Mentorship

PROGRAM LEVEL (VT LEND):

- CALC training for faculty & staff
 - Performance evaluations
- CALC training for trainees
- Ongoing CALC organizational and personal self-assessments
 - CLCADO (National Center for Cultural Competence)
 - TACCT (Association of American Medical Colleges)



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Professional Development & Mentorship cont.

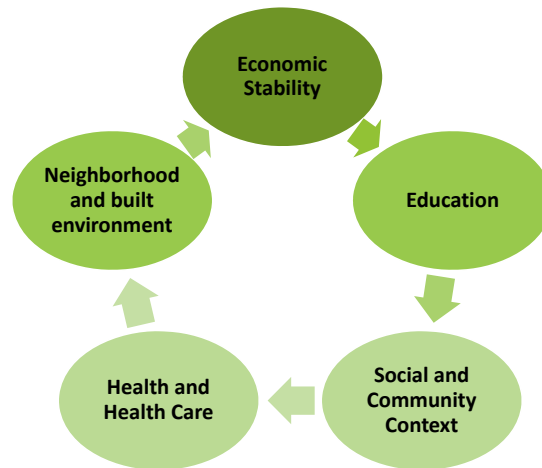
CAMPUS LEVEL:

- Search, Admissions, and other Committees
- Teaching related courses
 - HLTH 155 Racism and Health Disparities in the US
- Medical School
 - Health Equity and Inclusive Excellence Position
- Medical Residents
 - Required CALC professional development during orientation week



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Addressing Health Disparities and Work Towards Equity



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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)



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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

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Faculty/Staff Recruitment

- ***Intentional*** recruitment of diverse workforce
- Creating ***pipelines*** of trainees/fellows into staff/faculty positions and then leadership
- Establishing/strengthening ***connections*** with University Departments to support recruitment of diverse faculty
- ***Active*** members in advisory councils, state groups, search committees



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Addressing Disparities and Work Towards Equity

- Explicitly addressing & understanding the connection between racism, ableism, disparities & cultural and linguistic competence
- Explicitly teaching and learning about historical trauma of groups
- Advocating for the integration of culturally responsive and integrative systems of care and policy
- Advocating for adherence to federal mandates informing this work



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We don't see things the way they are.
We see them the way We are
Talmud

**"PRIVILEGE IS WHEN
YOU THINK SOMETHING
LEMS**

First They Came for the Jews

First they came for the Jews
and I did not speak out
because I was not a Jew.
Then they came for the Communists
and I did not speak out
because I was not a Communist.
Then they came for the trade unionists
and I did not speak out
because I was not a trade unionist.
Then they came for me
and there was no one left
to speak out for me.

- *Pastor Martin Niemöller*



the victim.
the tormented.

the irrelevant.
ed because of their

~ Elie Wiesel

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Now let's hear from our panelists



Stephanie Autumn

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Concepts and
Definitions from
the Literature

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EQUITY**EQUITY****EQUITY****EQUITY**

POLLING QUESTION

1. Has your organization defined equity and what it means for its core mission?
 - Yes
 - No
 - Don't know

2. Has your organization defined equity within the context of developmental and other disabilities?
 - Yes
 - No
 - Don't know

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Our literature is lagging behind that of other fields

FACT**FACT****FACT**

We have not yet defined nor reached consensus on what “equity” means within developmental disabilities – including a conceptual framework that addresses the concepts of multiple cultural identities and intersectionality.

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EQUITY IN HEALTH DEFINED

“Equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy.”

“Health is essential to well-being and to overcoming other effects of social disadvantage.”



Source: Braveman, P. & Gruskin. Defining equity in health. *J Epidemiol Community Health* 2003;57:254-258. retrieved on 9/7/16 from <http://jech.bmj.com/content/57/4/254.full.pdf+html>

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INEQUITIES IN HEALTH DEFINED

Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health.



Source: Braveman, P. & Gruskin. Defining equity in health. *J Epidemiol Community Health* 2003;57:254-258. retrieved on 9/7/16 from <http://jech.bmj.com/content/57/4/254.full.pdf+html>

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Defining Racial Equity: *An Example from the Literature*



Racial equity is the condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. When we use the term, we are thinking about racial equity as one part of racial justice, and thus we also include work to address root causes of inequities not just their manifestation. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them.

Racial Justice [is defined] as the proactive reinforcement of policies, practices, attitudes and actions that produce equitable power, access, opportunities, treatment, impacts and outcomes for all.

Source: <http://www.racialequitytools.org/glossary#racial-equity>

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Defining Equity at the Intersection of Race, Ethnicity, and Disability: *An adaptation from the literature*



Equity is the condition that would be achieved if one's identity — or multiple cultural identities — no longer predicted, in a statistical sense, how one fares. When we, within the disabilities community, use the term equity, we use it understanding that it is one part of social justice, and thus we also include work to address root causes of inequities not just their manifestation. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes or fail to eliminate them by race, ethnicity, disability, and other identities.

Social justice [is defined] as the proactive reinforcement of policies, practices, attitudes and actions that produce equitable power, access, opportunities, treatment, impacts, and outcomes for all.

Source: Adapted from <http://www.racialequitytools.org/glossary#racial-equity>

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Engaging Partners to Advance and Sustain Cultural and Linguistic Competence In the Current Climate

What is the role of the leader?



1. There are two types of challenges: technical and adaptive.
2. People need a certain amount of tension to do their best work, but the amount of tension needs to be productive.
3. There is a difference between the role of authority and the exercise of leadership.
4. Work avoidance (resistance) means that people are outside the productive range of tension.
5. Reflect in action by spending time on the balcony *and* the dance floor.

Source is based on the work of Ronald Heifetz.
<https://www.healthcatalyst.com/why-adaptive-leadership-is-critical-skill-healthcare-leaders>

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