PRIYA: Hello everybody and welcome. We're going to get started in just a moment.

INTERPRETER: (speaking in Spanish).

PRIYA: Hello everyone and welcome to webinar 3 in the series, Tools2Use: Improving Healthcare Outcomes Through Effective Communication. My name is Priya Penner, and I'm with the Partnership for Inclusive Disaster Strategies.

INTERPRETER: (speaking in Spanish).

PRIYA: I use she/her pronouns. And I am a brown woman with long curly, black hair. I'm going to get us started with a few accessibility and technical support reminders and pass it off to Sarah who's going to get us started and take it away.

INTERPRETER: (speaking in Spanish).

PRIYA: This webinar is being provided in English, Spanish, and ASL, and we also have CART captioning available in English and Spanish.

For the first several minutes you'll note that I'll be speaking in English and I'll be pausing for the Spanish prepration. This method of interpretation allows us to successfully provide instructions on how to access the interpretation feature. Once we provide those instructions the webinar will then have the Spanish interpretation happen at the same time as the speaker.

INTERPRETER: (speaking in Spanish).

PRIYA: As I mentioned, today we'll be using the Zoom interpretation feature which has already been activating for folks and accessing that looks a little bit different depending on the device you're joining from. If you're on the computer you'll like the globe icon at the bottom of your Zoom screen. And on a tab let on phone, click on the button entitled more and a menu pops up. Look for the language interpretation option.

INTERPRETER: (speaking in Spanish).

PRIYA: And again to listen to the interpreting channel and the interpretation you'll like that globe icon and then choose the language you would prefer to listen in.

If you can't here the interpreter and you need to, please ask for help in the chat or raise your hand.

INTERPRETER: (speaking in Spanish).

PRIYA: If you can't access the chat, please let us know of any issues or technical support issues and/or issues accessing the language interpretation channel by e‑mailing us at priya@disasterstrategies.org.

INTERPRETER: (speaking in Spanish).

PRIYA: And now we will switch into simultaneous interpretation. Again, please do let us know if you're having any issues via chat or via e‑mail.

INTERPRETER: (speaking in Spanish).

PRIYA: This is Priya, I'm hearing Spanish interpretation on the English channel.

INTERPRETER: (speaking in Spanish).

INTERPRETER: (speaking in Spanish).

PRIYA: And you may have noticed that we have chosen to leave the chat open, but please do keep that in mind we have limited capacity to provide interpretation of the ‑‑ .

INTERPRETER:  ... I'm not finding the chat my apologies.

PRIYA: Okay. To access the English CART captions, which is embedded in Zoom, you can access them via the link in chat. You can also access them via the show captions or CC button and the navigation bar at the bottom of your Zoom screen.

And you can also edit the font size and text color via the subtitle settings button which can be accessed via the small carrot within the CC button.

You can access to Spanish CART captions via the link in chat and we'd be happy to e‑mail that all over to you if chat is not accessible to you.

We also have our ASL interpreters spotlighted for folks. To adjust the size of the slides and speakers, interpreters in Zoom, you can crag the divider that separates the speakers and interpreters to the right and left.

And again let us know if you can't access any of our language access accommodations here today.

When you have questions about the content of today's webinar, please use the with, and A feature. If you can't access that box, again you can e‑mail those questions to us. We do encourage you to ask your questions as they come to you. We have folks monitoring the Q & A, and we'll highlight your questions during that section.

Please raise your hand or type in chat for any technical assistance issues.

And then finally this webinar is being recorded for folks, and the accessible archives will be fable the coming weeks. In fact, our facilitators will be talking about how you can access the archives for the past two web as far as, but you can also access the ‑‑ with those archives ever kiefs will be the slide decks and the transcript of the presentation.

And with that, I'm going to turn it over to you, Sarah.

SARAH: Thank you, Priya.

Welcome all to the third and last of our webinar series. This one is integrating tools to improve healthcare outcomes through communication access.

I want to thank all of you for coming.

My name is Sarah Blackstone. I'm an 80 year‑old woman, white woman, with a background in speech language pathology.

I have a hearing impairment, and I'm failing retirement.

My pronouns are she and her.

On the slide there are 4 logos from our collaborating organizations. Ability Central. CERV ... is the project grantee. The Patient‑Provider Communication Network, which is a website and network, was established in 2009 and focuses on the topic we are addressing today still and probably forever.

The Partnership for Inclusive Disaster Strategies is producing the webinar for us.

Together we share a very strong commitment to improving healthcare outcomes through effective communications, specifically for people who have disabilities.

Next slide, please.

We want to give a shout out and thanks our funder, Ability Central. A nonprofit organization in Oakland, California, with a goal to expand

PRIYA: This is Priya. Sarah, looks like you were muted.

SARAH: Oh. Well, thank you.

PRIYA: Absolutely. We heard you up until the slide.

SARAH: Okay. So it was muted after this first slide?

PRIYA: You can start here right here on thanks to our funder.

SARAH: So anyway. The funder is Ability Central. It's a nonprofit in Oakland California. And expands communication access for people with disabilities and has been doing this for many years.

Next slide.

So today we're going to be discussing integrating tools to improve healthcare outcomes through effective communication.

We have our panelists today include some you've met before, Jessica Gormley and Tami Altschuler and John Silva.

June Kailes is the director of our project will be joining us during the discussion, which is something we're going to do new today, vehicle a discussion among the panelists first and then we will be witnessing your questions.

Because throughout the year we've had many discussions with subject matter experts and participants on the Patient‑Provider Communication Network. And many questions have been raised and we thought we would actually do a panel this time.

We still have the same ground rules. Webinar time. Keep to time. And we want definitely to save time for your questions so we can address them.

Next slide.

In the first two webinars, we focused on providers and consume. We asked our panelists to tell stories that illustrate the complexity of issues people face that have communication access problems.

Jessica also introduced that communication access tool which the project staff has developed.

We also considered and briefly discussed actions related to how to encourage change, what use would the tool, for example, be to individuals.

There is something we all can do. So we'll be discussing that more fully today.

In the third webinar, next slide.

The goals are to identify some actionable items to meet accommodation needs.

The graphic represents a provider and a patient working together to establish effective communication.

The goals for today's webinar reflect our previous efforts to identify solutions to work together building teams and hopefully systems over time and to document.

It not easy to make change unless you have the data that supports its need.

Next slide.

This is ‑‑ I'm passing this over to Jessica Gormley who will continue.

JESSICA: Hi everyone.

As Sarah mentioned, my name is Jessica Gormley. I'm a speech language pathologist by background and an assistant professor at the University of Nebraska Medical Center.

I use she/her pronouns. And I'm a white woman in her 30s.

You can go the next slide.

Now, as Sarah mentioned, we can all be change makers in healthcare. Many of the panelists and viewers of this webinar series have highlighted how they were able to support communication access in their personal healthcare appointments or in their clinical practice.

But where do we begin to make communication easier, more accessible, and more far reaching in a healthcare team or a healthcare system?

Sometimes making a change may feel like the picture on this slide, and for visual description it's a man training to push a giant Boulder up a hill.

Change is not always immediate and it's not always guaranteed.

And especially if team in teams do not have a plan to try something new and track it over time.

For example, on average, research tells us that it takes about 17 years for 14 percent of new scientific discoveries to be adopted into daily clinical practice.

And a third or less of guidelines are routinely adhered to in clinical practice.

But there is good news.

Go to the next slide.

Research and clinical experience shows us that mindful use of some specific strategies can support the implementation of new discoveries, new habits, and more accessible healthcare.

Here are just a few actionable strategies that you could use.

You could complete a needs or readiness assessment by asking the following questions, is my team ready for a change? What might make this change hard? And what might make this change easier?

Another strategy could be finding and accessing a new funding source. For example a foundation or a grant.

Go to the next slide.

More actionable strategies to support change can include ‑‑ creating a team. Changing the physical space, equipment and/or record systems.

Train people.

Make educational tools.

And create communication champions.

In the next few minutes I will share how a team I worked with used some of these strategies to make a change to support communication access. In intensive care units for people who needed some unique strategies to express themselves.

Go to the next slide.

And I work within a pretty large healthcare system. And for this project, a team was formed that included nursing staff, administrators, clinical training specialists, speech language pathologists, and a family of a patient on the unit.

Member.

We developed and shared some surveys to understand challenges experienced by speech language pathologists and nursing staff when communicating with patients in the intensive care unit.

And these surveys were on just like Google or Microsoft, whatever our healthcare system had available to us.

We discussed the survey results as a team to brainstorm ways to overcome some existing barriers that people were experiencing.

And using those questions that I said before, right, what might make the change hard? What might make changes easier? What's actually happening on the unit?

Go to the next slide.

From the survey we learned that people did not have the tools or the knowledge that they needed to support communication.

So we codesigned a communication toolkit package including a decision tree and specific communication materials like clear masks, dry erase boards, eye gaze boards, communication boards of the top 8 languages used in the hospital, and a communication app on an iPad.

We also created as a team a short online training that showed people how to use the materials and when to use the materials.

We also even added a patient story to though show the need and power of the tools on the consumer experience.

Go to the next slide.

All right. And now how did we test out the change? Well one way is to do small tests of change, and one way to do that is through something called a plan do study act project. Sometimes I'll call that a PDSA project.

And we used some helpful free materials, one of which is linked in the slide. For the plan stage we planned to have nursing staff on this ICU watch the communication training and use the tools with people on the unit who needed communication support.

We hoped that this would produce nurses knowing how to request a speech language pathology consultation, know where the toolkit lived on the unit (chuckling) and also provide the appropriate tool for patients or consumers.

And the steps to make this phase of the probability happen included making the tools and decision are tree available. So we shared the training with all of the nursing staff who completed the training during their monthly mandatory education.

Which we had administrators support to do this.

And after they completed the training, they were able to share the certificate with their supervisor to get credit for that training.

At the end, they completed a survey about their experiences and what they learned.

And then us as a team, we were observing to see ‑‑ made a plan to see how the tools were used.

And then for the do step, we tried it out for a month and wrote down some observation. We found in that time all nursing staff were able to complete the training and the surveys. And the tool kids consider being used by speech language pathologists and nurses.

For the study step, as a team after that month, we all came together to talk about what we saw and what the survey results were. And to discuss like what did we learn and did we meet our goal?

For this particular project, most but not all nurses knew how to make those speech language pathology referrals to support communication.

But all nurses reported that they tried to use at least one tool that they ‑‑ and they experienced some success with the tool.

We learned that the toolkit was being used, but there were still some people who did not have access to the tools or a speech language pathologist to help them.

But in general we saw some increased use of materials some increase in knowledge of strategies people could use, and some increase in knowledge of how to contact speech language pathologists.

The last step. After those meetings what did we learn and conclude from this cycle? What would we do next? Well, the team decided to continue to include training in mandatory nurse education, especially for new staff or new people to the unit.

And we also implemented something new. We needed to try out some more frequent interactions with speech language pathologists and nurses, so we created 35 minute communication check‑ins with the lead nurse and a speech language pathologist to discuss challenges and discuss patient's ongoing communication access needs, just to make sure that no one was really being missed and those communication academic ins happened twice a week, just for 5 minutes each.

F and then we also since we knew the tool kids were being used, we asked administrators permission to see if we would be able to have tool kids and have the training provided for all of our ICU in the hospital. Which we were able to accomplish in the months following the project and it was received really well.

That's just kind of an example what that plan, do, study, act, cycle could look like. And my major take care is that anyone can really start a change in the healthcare system. But it's really important to know what change you're trying to make, who to partner with, how to measure the change, and also how to set realistic goals and check‑ins to know when to continue on your path, adapt your path, or stop and move in a different direction.

With that, I'm going to end my little talk here and I'm going pass it along to John who's going to share another example within his health system.

>>: Okay. Thank you. That was nice presentation. Nice story. And example, Jessica.

My name is Dr. John Silva. My preferred pronouns are he/him. I'm a brown‑skinned male in my 60s.

>>: Starting my video.

>>: There you go.

>>: Okay I'm on?

Okay.

And I would like to speak about ‑‑ oh, I'm sorry ‑‑ I practice in the community in many roles, position educator, work for residency program for many years. Probably my most fulfilling role was working for a federally qualified health center searching there as medical director and QI chair and have accomplished much on health equity, specifically language issues in Latino population.

Next slide.

I would like to share my experience about a patient and what was lacking in terms of his care or the family's care. And what approaches could have been taken at that time. This case goes back to the turn of the century, 1999, 2000 or so.

I finished hospital practice with medicine approximately 7 years ago

This particular population in Salinas California has always been challenged with language and health literacy matters.

And this particular patient, Juan, also had physical disabilities.

I began caring for Juan in 1999. And basically the point of the case study is to show how we tried to accommodate him both physically and communicationwise in how we weren't successful and what could have been done different.

I would often see Juan in the office. He had cervical spine disorder that was worsening. P it was quite challenging seeing anymore the office. The office had an inadequate waiting room, which was too small. The exam rooms were too small. They were regular patient delays as is common in primary care office.

So I ended up to accommodate his physical disability, seeing Juan often in the emergency room. Even scheduling visits in the emergency room, which you can imagine is a very costly work around.

A particular challenge in this case was when I had to transfer care to others, either to specialty physicians or more often I would have to transfer care to my colleagues. And this was in the day of paper records that we did not have an electronic record at that time.

So most of the transfer of care discussions were via chart notice and phones. There was no tool like in communication access tool available at this time. Much depended on voice, personal transfer and written word.

How did this go for Juan? Juan thankfully had a wonderful mother. She had been with him of course from the start. And she was able to help us communicate.

And as Juan's medical problems withered, as his communication challenges did as well. And toward the end‑of‑life with Juan, I would say for the last year, we were not able to communicate tie effectively one‑on‑one.

A strength in Juan's case was his mother, as I referred to earlier. She was a diligent historian. Father wasn't as helpful. He was a deaf man. Brothers and sisters were typically out of the picture in terms of Juan's health.

Barriers included his speech became progressively garbled, she lost the ability to write, he could shrug and very good at patient expressions which are known to be like all nonverbal communication, very hard to correctly interpret.

Despite these communication issue, summand dated medical care was doable. We did work successfully, we being myself, Juan and his mother, Linda, worked successfully to develop an end‑of‑life care and plan for Juan. And one those forms including the advanced directive were completed, they were placed in his record and mother was given a copy.

A paper copy of the cat at that time could have been shared in the hospital record and with mom. Although it would have been a paper document and would have been photocopied into the chart.

In terms of experience or satisfaction, I don't know really have a good sense for what Juan or Linda thought of the care.

>>:  (inaudible) .

>>: I'm sorry? (laughter).

>>: (Robot voice).

>>: I was quite frustrated and disheartened and actually ashamed of the care we were providing.

I felt it was inadequate.

>>: (Robot voice).

>>: I also felt there was no outside resource or guidance that could help me as Juan's condition deteriorated.

As a basic primary care physician and emerging medical director, I unfortunately didn't have the stamina to be a champion for Juan's needs.

In terms of determining impact, at that time we had of course had a quality assurance department. Should be the Q A department should be a beacon of speak management of safety challenges for patients. But then and even now I feel it's quite lacking in terms of patients with disabilities.

And again, admittedly, I haven't had in hospital experience for 5‑7 years now.

Currently though all modern quality improvement efforts begin with collection of data, and that kind of data that does exist right now.

>>: John? I'm going to interrupt. I think ‑‑ do you need to advance the slide?

>>: Let's see. Yes, please. Thank you.

So in terms of quantitative data, I don't think I've talked to the present medical director. They give me no guidance on quantitative data.

Qualitatively, there are surveys out there. The state of art survey developed by Health and Human Services is called the CAHPS, Consumer Assessment of Healthcare Providers and Systems. We started using that in 2010. It's a very general tool. It's very cumbersome. I took it once. It ended up being 58 questions long.

There are supplemental mobility questionnaires within it, and there's also a supplemental patient‑centered medical home edition of the CAHPS. But I don't think there's great capture with this tool.

>>: John, we've got a request from the interpreters to slow down just a little bit.

>>: Okay.

>>: You've got time. We started your section early.

>>: I think that telephone ringing in the background through me off.

So there is a supplemental to the Consumer Assessment of Health Providers and Systems survey, one for folks with mobility impairments. Additionally there's one for offices trying to be patient‑centered medical homes. But, again, that's quite challenging to use.

I learned from my time as Q A chair to implement safety and satisfaction initiatives requires buy in from leadership and the campaign would require resources as Jessica talked about, staff resources would be needed financial she sources would be needed.

Really would have been looked as a campaign.

The assistance of the Q A QI department would be vital.

You want to first get a handle on the size of the challenge, even in an office setting. So sometimes patient care registries would be helpful.

Additionally, once data starts to come Nit's great if there's an on site champion within the clinic or unit that has a particular interest, doesn't have to be a physician, it could be ‑‑ should be someone who's close to the care.

And ideally that champion or individual would employ the same model Jessica talked about this, Q A tool of small measurements of change also referred to as rapid quality improvement.

Beside the PDSA cycling, these methodologies include tracer audits where an individual would accompany the patient flu the office visit and take notes down about the challenges and the successes the patients would experience as they went through the flow.

And then finally focus groups is another way to initially get information. Ideally then the information would be worked through the PDSA cycles.

>>:  (inaudible) .

>>: And as the cycles matured, evident changes would be evident, and they could be brought to scale.

>>: Call from ‑‑ (Robot voice)

>>: I'm going to stop now as my phone is continuing to pester me.

>>: So, yeah, yes, we all have our experiences in our quote unquote home offices.

>>:  (laughter) That was unexpected. So ideally the changes could brought to scale. Additional resources would be required at that time. So stop there and say thanks for the opportunity to share and look forward to discussion where I might be able to offer another example.

SARAH: And it's time for Tami Altschuler tam, so can we have the next slide? There you go.

Thank you, John.

>>: My name is Tami Altschuler. I'm a speech language pathologist and clinical specialist in patient provider communication at NYU Langone Medical Center.

I'm in New York City.

I'm also a Ph.D student? Rehabilitation sciences at New York University hoping to study the healthcare disparities that people with disabilities experience.

I'm a subject matter expert for IHOTEC here.

And I'm a co‑organizer, coleader of the Patient‑Provider Communication Network.

I'm a white woman in my mid 40s with long, dark, brown hair.

Next slide.

I will speak on several actionable solutions for communication access., which can be implemented in the hospital setting.

Today I will highlight 3 examples that have been successfully in place at NYU Langone Medical Center for over 6 years.

Achieving success with these solutions requires strong enter professional collaboration, ongoing commitment, and continuous efforts in maintenance.

Next slide.

I will discuss first the education and training provided to ICU, intensive care, residents. Second, the automatic referrals for communication access for all patients on ECMO, which is ExtraCorporeal Membrane Oxygenation or hear‑lung life support machine. And the finally, the tangible resources in the form of a communication toolkit.

At NYU we provide comprehensive training for all ICU residents on communication access. This initiative began years ago, and it was sparked by a really challenging patient provider communication experience.

This situation involved a patient who was intubated, meaning a tube was placed through their mouth and into the airway to help him breathe.

He was awake, but unable to speak, making communication difficult.

The doctor attempted multiple times to understand the patient's wishes regarding treatment options. However, the patient was unable to write or type.

The patient was then asked to raise one finger if he wanted the breathing tube removed, understanding that this could lead to passing away within minutes, hours, or days.

Alternatively he was asked to raise 2 fingers if he wished to undergo a tracheostomy which would involve a surgical opening in the neck or breathing tube that could prolong his life.

Despite the doctor's efforts the patient did not raise any finger, leaving to doctor ask his family to make the decision.

The family, however, felt really overwhelmed and uncertain about making such a significant decision.

At that point, I was asked to assist by establishing a communication method for the. Using an eye tracking system is it patient was finally able to communicate and chose to proceed with the tracheostomy. Days later, once he could speak, he explained he hadn't raced any fingers earlier because he was uncertain about what to do. He mentioned that he wished he had been given the option to raise fingers to indicate a need for more time to think.

He actually told me he felt like I saved his life. He felt I was his angel because I gave him a way to communicate and discuss and talk out some of the options.

That experience had a profound impact on the ICU doctors, and it really served as the catalyst for the communication access engage and training I now provide to all ICU residents.

The training includes, number one, the importance of commune abscess and impact on patient care. Two, an overview of communication barriers. Three, an introduction to augmentative and alternative communication tools. And 4, hands on training with the tools and devices as well as practice with partner assisted scanning, is a strategy to use when patients are unable to physically point to items on a communication board independently.

Next slide.

Another effective solution we implemented is the referral process for communication consults. Several years ago we recognized that patients on ECMO the heard lung life support machine, are often unable to speak because of their breathing tubes. We wanted a proactive approach to ensure these patients would have communication access.

We collaborated with the ECMO team to include a communication consult in the automatic order set, which is placed in the electronic medical record when a patient is placed on ECMO in the operating room.

By automatically triggering a referral, patients receive the necessary communication resources without any unnecessary delays, reducing frustration, and ensuring they can express their needs and participate in their own care.

Since we started this in 2018, 100 percent of our parents on ECMO are screened and/or evaluated for communication access.

Last slide.

The final actionable solution I'll discuss is the use of tangible resources through a communication toolkit. These tool kits were developed for ICU bedside providers. This includes doctor, nurses, physical therapists, respiratory therapists, chaplains, many more I haven't named to have immediate access to essential communication aids.

While these tool kits to not request a formal communication consult, they can address urgent communication needs right away.

The toolkit includes communication boards in English and the 6 most commonly requesting translation languages at our hospital, along with the selection of communication devices, dry erase boards and voice amplifiers.

Additionally I created a decision tree to guide the ICU staff in selecting the most appropriate communication tools based on each patient's level of alertness, cognition, sensory and motor abilities.

As I said in the beginning, all of these solutions, these are just 3, that I've highlighted, we have many more that are just as impactful, but they all require strong interprofessional collaboration between many disciplines, an ongoing commitment and a lot of effort in maintaining these.

SARAH: Thank you, Tami. Before ‑‑ and John and Jessica.

And before we begin the panel discussion, we want to highlight the communication access tool and ask if you haven't already to please take a look at it.

It's an interactive tool that addresses communication access in multiple areas, specifically hearing, seeing, speaking, learning, understanding, remembering, and moving. All of which you've heard something about through this webinar series, but hardly enough. We understand that.

The tool is something you can fill out, print out, and take with you. Or you can offer it to others, suggesting that it documents something that relates to communication access.

As a consumer or a provider, you can use it right now. Print it, take it, share it.

And you might be something used during an outpatient visit as a consumer or an inpatient visit.

Very briefly, I just had a doctor's appointment. I printed out my CAT. And it showed that I had a severe hearing impairment and I was going to an outpatient appointment.

I handed it to the guy at the desk, who takes my blood pressure and temperature and I said, are you aware I have a severe hearing aim patient? He said no. I then gave it to my doctor, and she said I know I put this in your record, but it doesn't show up on your portal, of course. It's not ‑‑ it's just in our office.

So she said can I have this? I said of course. She said I'm not only going to put it in your record, I'm going take it to the hospital administration and tell them we need this information up front if I can't communicate with my patients, I can't treat them appropriately.

So we'll see. Stay tuned.

So the next slide please.

Please take a look at the tool.

We ask you to become involved. When you go and see the tool, rate it. Please provide us with contact information so we can keep in touch with you.

Please give us feedback.

And also please share resources you find useful that we can highlight on the website as we develop the resource section for people who have a range of communication access issues.

Thanks.

Okay. Now, on to the next slide.

First we're going to have a discussion with our panelists, and I see some great questions that are coming in the chat. I don't see anything in the Q & A.

but we will try to get to as many of your questions as possible.

But before we begin the discussion, I would like to ask June Kailes, which could you go to the next slide, who's our project director to join us. And June, do you want to let us see you? And John and Tami and Jessica, can we see all of you?

There's Tami. There's Jessica. There's June. Looking for John.

Okay.

John, when ‑‑ there you are.

Okay, those are our panelists. And June do you want to introduce yourself briefly

>>: Sure. I'm June Kailes, disability policy consultant. Pronouns are she and her. And I have a lifelong lived disability experience. And my work focus is on healthcare and emergency services.

And project director of this

SARAH: Great. Now we've written each other questions, and so we're going to start with a few of those.

The first one is how long did it take for your teams to get the projects started? To get them finished, and what would you have done differently?

Who would like to start?

>>: Jessica ‑‑ I can talk a little bit about the one project I shared a lit about.

So the project that I shared, that was the first like cycle (laughter) and that we were going through.

And the great thing about these projects is they keep continuing growing and changing as the healthcare system and the needs can grow and change.

So the first one that I shared, it took about 6 month, I would say, for us to try it out on that single unit. So say about we took ‑‑ met every other week for about 2 months and shared the survey, created the materials as a group, and came to be ‑‑ it took us a month to try out.

The mandatory training and toolkit and then after that, I think it took us about a month to just kind of reflect and think what's happening next. So I would say maybe 6 months for that whole cycling.

Scaling it up across the hospital, took about a year to get it on all of the other ICUs and deal with some details about, oh, on the cardiovascular ICU, this place won't work before the toolkit and kind of thinking about unique things for other units.

But I would say about a year after that, everything's been in all in place and sustained as we go along, and that includes our communication check‑ins with the lead nurse and an SLP a couple times a week. So that's also been scale up.

So about a year to get the bus going and it keeps on going and morphing as times goes on.

What I would do different, is I would see in that planning process, I would have liked to talk to the current families and people on the unit receiving cure to get their input when we were designing it. We had one family member who was helping us out and really taking charge on that experience, but I think that it would have been really cool to make sure that we were doing that loyalty bit more systematically and including more input from the patient consumer perspective.

Yeah.

SARAH: That's great.

And, Tami or John or whoever would like to also tackle that question? How long did it take for your teams to get it started

>>: I would like to say that's a very good question (John. I done work with my public health colleagues, and the model that they like to put ahead of us in the clinic is the o so‑called logic model, where we meet with stakeholders ahead of time, determine dependence and how important it is to clarify expectations to the stakeholders.

And they remind me and I've seep that oftentimes the healthcare outcome data is delayed. It may take, 9‑12 months before you start seeing improvement in outcome data.

And the stakeholders would still want to be understanding, okay, well I hear that it's going to be 9 months before I see this nudge in the data. What things are you tracking? What are the process measures? The so‑called process measures? How many people are being tested? Is there any preliminary experience of the people that have been tested? Are the providers buying in? So I like the think of outcomes in sort of this bimodal way, those related to how the process is rolling out and constantly managing the stakeholder expectation the actual, physical, eye popping outcome data change is going to be a little bit longer. I think that's a word of wisdom.

SARAH: And patience is hard. Particularly for parents. (chuckling).

>>: Mm‑hmm.

SARAH: Tami, I know that when you went to NYU, you were actually hired to be a patient‑provider communication liaison, correct.

>>: Yes. Yes.

SARAH: So do you have anything to add?

>>: To answer the question, I think I could compare and contrast two of the things that I highlighted, because it shows the key players who are involved and how they can drive different initiatives for the education and training for the ICU residents; that was led by the physician who was involved in that patient and immediately asked me to start the training, and all I had to do was get on a calendar with the chief resident and that's been going on for many years.

So it was easy because I had the physician driving that.

And the lift really is all on me. I'm going all of the work to come up with the training and test it and make sure that it's actually effective and get the feedback from the residents.

For the getting the order for all of our patients on ECMO, that was driven by my service. And it took about 2 years to get people to understand why I would want that. At first the physicians were saying, why would a speech pathologist be involved with someone who's that critical and who can't speak?

 (laughter) and so I had to say what we can do for those patients. But also to show them that there's no harm that we would do. I don't know why that took so much convincing, bust it did.

What I would do differently is something I am working on. For the first initiative with the education and training with the residents, I would expand outside of the ICUs before a patient ended up in an ICU or in the situation of having a breathing tube and unable to communicate if we could be involved, if that's anticipated.

And also with the orders for the patients who are on ECMO, ECMO is usually a very urgent situation so there's not a ton of planning involved. But there are patients who we can see that trajectory for them, and it would be a lot easier for someone to learn a communication tool when they're more awake, alert and cognitively intact than when they have had that sudden change H their medical status.

So little comparing and contrasting who's involved, who's driving the initiative, and who's responsible for the execution of it.

SARAH: Yeah and the complexity of each individual in each situation, obviously, as John and as you're all described.

This kind of leads into another question, which is ‑‑ and June I'm going to ask you to take the lead on this ‑‑ as a small, independent family practice provider with one and a half staff, I don't have a quality improvement team or other team to talk to or interface with.

I'm concerned about cost to make these accessibility changes. Any advice?

JUNE: Um, okay. (laughter) yes first acknowledging it is a very different world for a very small individual practitioner who may not eve been part of a group practice, except for maybe on call, emergency follow up.

So I think first it's important to mention that there are behavioral change issues in a CAT that don't cost anything. Is just changing behavior. For example, reminding ‑‑ a remind tore look at Sarah when you speak to her because she reads lips or because she's very hard of hearing, can reduce background noise.

For someone else, it may be the need for extra time because their speech is very slow. Or to check out their understanding of what you're saying.

And genre minded me of another low cost no cost important piece, which is if an individual needs an accommodation and you as a practitioner are making a referral, call the referral entity and make sure they can accommodate the needs of who you are referring.

The other piece that I used over time in a few practices and a few practitioners use is kind of an exchange or even a barter system, a trade. For example, if you're in a medical office building, close by to other practitioners, that for example, do have an accessible exam table or an accessible scale for your person who needs that, can you use their space in exchange you would help pay for their sign language interpreter for a couple patients that they have or you may lend that office your receptionist who happens to be a real pro at helping them understand people with unclear or difficult speech to understand.

So sometimes tradeoffs have worked over time.

And for our practitioners with very, very limited budgets, sometimes the health plans you work with, that your patients are members of, have foundations or other giving programs that make available some barrier removal funds that may be of help in maybe replacement a very high exam table or whatever.

I mean, there's a lot to explore, to trade off. There's oh things we can talk about, but those are just some ideas of some of the elementary kind of things that could be used.

So any ideas from the rest of you,'s peopled panelists

SARAH: Thank you, June. That is great.

Really practical and doable.

John, do you want to give just a short ‑‑ give us some information about your work with community health workers? I think that's another ‑‑ it's not a small office, but they're out in the community, and we see them in increasingly, at least in California as people who are able to communicate directly with individuals who may not be getting very good healthcare.

And the role of recognizing communication issues in that group.

>>: , yeah, thank you, Sarah. There are a couple of things. First of all, yeah, this are many, many benefits of small practice. You really get to know your patients quite well. You get to know your community quite well.

So that needs to be said.

Number 2, there are new resources and affordable resources plus minus resources available for practices now. As you described, this job classification referred to as community health workers.

Recently community health workers are starting to get reimbursement for their services in California on the state Medicaid program, number one.

Number 2, I understand from colleagues of my bigger et cetera institutions that Medicare has begun reimbursing for community health worker provided care in chronic disease perishes.

Thirdly, the cost of hiring a community health worker, which yes I'm in the process of creating several, ranges at least in month ray county California the wage is running somewhere between 20‑$30 an hour.

And I don't think that's small practice, who knows how small, small is, but when I was in private practice E that was app affordable expense.

So there's good news on that front.

And yeah, I think it's just something for us to continue to look forward to.

Da cone any health department is beginning to use community health work Ors for screening to deliver social determinant health screen realtime or before the patient arrives. I don't see where this CAT tool couldn't be employed the same way

SARAH: Thank you. And our interpreters keep asking you to speak slower.

>>: Oh. Practice. I need to practice.

SARAH:  (laughter) practice, I know.

So we're actually running down on the panelists discussion time, but we don't have any Q & As, but we have some really good comments.

I would like to bring ‑‑ now Priya, I don't know if we can do this, but can we unmute Jim House? Because he had ‑‑ he would like to share with us all what we're missing in the communication access tool sheet. And then he would also like to remind us that access must be consistent throughout the day over shifts et cetera.

And I think both of those are really good points. I don't know how this works, and ‑‑

PRIYA: This is Priya. No worry, I'm I'll bring you other as a panelist and that will allow you to turn your camera on and share, if that is okay with you, Jim.

SARAH: Whatever. You're not talking. You're talking to an 80‑year‑old woman who's failing technology. (chuckling).

PRIYA: It's a team effort, it's a team.

SARAH: I hope you can do this.

PRIYA: We absolutely can.

SARAH: Okay.

PRIYA: Jim is here. One moment as he turns his camera on and we had spotlight. Hi, Jim, we can see you.

>>: Hi, can you see me?

Okay, perfect, great

SARAH: Yes, go ahead. Yes.

INTERPRETER: Hold on for from the interpreter.

>>: Interpreter can you see me?

INTERPRETER: I'm just going to try to make jail little bit bigger. Go ahead.

>>: Okay. So let me get my bearings straight. So the question in regards to accessibility, for example, so you have to design to allow for something that's called function Al equivalencies. So regardless ‑‑ for example if you're working with a deaf person. Equivalence means the technology you use has to be equivalent to how a hearing person would use it for a deaf person so for example in the hospital, in hospital setting the first thing that you can think about is communication access.

Ongoing communication access, regardless where the person might be, whether they're moving between different providers. L you have the responsibility of training all staff to be aware of that.

And in addition to that, you can have different modes of communication, not only for example you know different lanks, but in addition, different devices. You can use gestures, train staff on how to use gestures

SARAH: Jim? Jim? You're way ahead of the translators. You're going to have to slow down. And so can you just focus on what you think needs to be added or taken from the CAT? The communication access tool, you were suggesting? That would be great and then we can go on the next thing. Thank you.

>>: Jim ‑‑ so for example, making calls.

SARAH: You said it didn't save video phone.

>>: So basically ‑‑ communication doesn't mean only providing other sign or spoken language interpreters but training staff on how to gesture.

SARAH: Great.

>>: And basically can be something as simple as that. So when working with a patient, gesturing a syringe for a shot or sort of sign like this for food. There are different methods one word signs, very simple signs you can use to communicate with these patients.

While the interpreter is getting there.

SARAH: Great.

>>: And also a more complex conversations that.

SARAH: Yeah.

>>: Which one necessitates the use of an interpreter.

SARAH: Right. So I'm going to see if other people ‑‑ thank you, Jim ‑‑ appreciate it and I kind of threw that at everybody.

>>: I apologize for that.

SARAH: (chuckling) I've just been reading your comments, and I would encourage others to have a look at tell as well. And the other comments in the chat.

And I would like to invite other questions, so we can go to the next slide.

This is open to anybody. And as I said, I didn't see any questions in the Q & A.

PRIYA: This is Priya.

SARAH: But I can't believe there aren't any. Yes?

PRIYA: (chuckling) you are believing correctly there because we are seeing some questions in the chat. A gentle reminder for folks, we encourage folks to put questions in the Q & A and any comments in chat. But I am seeing some questions here. One from faith asking John, are you referring to a community health worker? Like a mental health aid? Or can it be an aid paid for by insurance for chronic physical conditions as well?

>>: John ‑‑ so yes, faith, I'm not referring to mental health aids. I'm referring to community health worker. These are unlicensed practitioners, unlicensed but certified practitioners that are link between the community and the office.

And they can do things in office but they like the transition their work alternatively to facilitating life in the community for individuals.

There is a certification process. Many schools offer even often community colleges. I work with the local workforce development board, and in addition to the certification, the state of California is working on a standardized credentialed process.

And presently, yes, Medicaid in California covers this service. And Medicare it is my understanding is just beginning to for a certain set of chronic disease patients.

SARAH: Thank you. And we have another question, is there a difference in terms of the buy in success with pediatric vs. adult populations? This is from Jason.

>>: I might they can if that's okay, because I work with both pediatric and adults.

And I see a big difference at my hospital. In fact, I often pilot and test initiatives out on the pediatric population because it's easier to access.

But I think there's a different culture on the pediatric services with the amount of support that's provided socially and inter personally for those parents and families. And we see it even with a child life specialist who's focused on making the child very comfortable during their hospital stay and explaining procedures and developmental language for those patients.

And there's not an equivalent that I know of at least in my hospital, for our adult patients. And so in terms of funding and physician and nurse buy‑in and maintenance of programs, I do see a huge difference between pediatrics and adults.

Jessica, I don't know if you ‑‑ I know you see both at your hospital and now I'm putting you on the spot

>>: Yeah. No I would agree. (Jessica) so I've worked in a few different organizations as well, and I think that it's all about kind of the message that we're framing to groups of providers.

So I think that sometimes it's easier to communicate ‑‑ I get that buy‑in from our pediatric patients. And but I also think that in the adult realm, one way to get started is to find those smaller groups of people who are like those ‑‑ I call them early (air quotes) adopters or people who are trying to like they're in a habit of trying new things all the time.

And those are the people maybe that you want to bounce ideas off of. A lot of times in my hospital sometimes their pediatrics and our surgical ICU team are amazing and are always trying new things. So I think it, yeah, it can be. I've seen it a lot in Peds, but don't count out some of these adult providers and teams, because I've just learned so much from zoom of those early adopters or curious groups who want to see a change and are willing to try new things too.

I don't know if that answers the question, but, yeah, it's worth investigating, really building those relationships in your organization to find your people who are going to be your teammate

SARAH: June has a follow up for you two. Have there anyway to speed up the uptake of some of the other change processes you've described? Magic?

 (laughter)

>>: Oof. That's a good question. You go ahead, Tami, I'm thinking outloud (laughter).

TAMI: This might not speed it up, but I think it might ‑‑ or in the short‑term it might not speed it up, but I think later on it can, with doing more research on showing health economics, why helping people with communication access costwise actually benefits not just the health system but that individual hospital who would invest in the time and resources for this.

A lot of discussions I'm in are, well, what are the outcome measures? And it's not been enough for me to say, well, we're legally required to do this and at this time right thing to do. I'm being asked, how do doing this can reduce the cost for the hospital and how it can impact length of stay, discharge location, reduce readmission rate, I can go on and on.

But I think we need a lot more research out there to support this. So that's not speeding anything up, but right now, but I think it can speed things up later on

>>: Jessica ‑‑ I would agree that. Using a both and approach. So we need to not wait on one side to get the ball rolling. We need research and we need these clinical designs to just feed off of each other.

One thing that I've learned is ‑‑ and I think Tami mentioned ‑‑ is really leaning into what does administration care about and what do those ‑‑ like kind of using that curiosity and looking outside of your typical day to day, but looking at people at all different levels and making the ask.

Like our informational technology people, we need them to help us make these changes. We need administration. And I think just equally having those conversations is going to really help get a pulse *per se* on where we're at.

And some of the other webinars I spoke that the only guarantee in healthcare right now is that it going to change (laughter). So I think we just have to keep up with that and try and get ahead of it as much as we can. And caring for each too. We all speak ‑‑ have different needs, so I think being able to understand those needs and think of how to have some win‑win situations for everyone are going to get us to some common goals and really build momentum over time.

But I don't have a magic potion or anything, but that's just some learnings that I've had. I'm hoping to see in the future.

JUNE: Jessica were are the videos you mentioned? Were you able to measure impact of those in particular? Because that seemed rather compelling to me.

>>: Jessica ‑‑ yeah I think it's hard. There's a lot of different ways to measure things, so I think that sometimes you can measure immediate change by watching, but sometimes that doesn't always translate to the bottom line.

Like as John mentioned, the length of stay and things, you might not capture it all.

So a lot of work I've done is measuring that immediate communication success, but I and my team definitely need more public health, and big data people to help figure out how we can translate that to the bedside to some of these oh variables that mean a lot to the organization and yeah to the system over all.

SARAH: So we are running low on time. And now we have two questions.

 (laughter)

So I want some advice. Should we move ‑‑ should we handle ‑‑ can we handle these questions? Or should we go to the next slide, which is related to archiving

>>: I think we have time for one more. I would respond to Todd's question about his hopeful imagination.

SARAH: Okay.

>>: Not me, but the panelists.

SARAH: So as Jim mentions, individuals communicate in very various cases and having a baseline for technology access and healthcare settings seems like an easier benchmark to get to in 2024. What are your feelings about hi hopeful imagination lol.

One of the questions we didn't address was related to AI, but that is opening like a whole new thing and we're not going there.

So what was your answer? Priya?

PRIYA: Oh, no, that was me, Megan.

>>: I don't have an answer. I was hoping Tami or Jessica or John.

SARAH: , yeah but we're running out of time. So what was your quick answer, Megan.

>>: I don't have one.

SARAH: Oh, okay.

Well speak of Megan, I just want to ‑‑ to have her show herself. And we all want to thank her. Megan Juring who is our glue. Where are you? There you are.

Okay and our manager. And I just think we want to thank for all the help you've given all of us for the webinar series. Thank you, Megan.

And I do think we need to ‑‑ there's one more ‑‑ are there any healthcare insurance billing codes that providers can add on to their billing codes ‑‑ Oh, boy ‑‑ for the time they may send set up accommodation or paying for interpreters and captioners.

Yeah. Sock so that's a whole nother thing for another day (chuckling).

JUNE: There is a billing code I can code it for a longer appointment that sometimes you can use. We're not ready to address it, but I know it exists.

SARAH: Right. Good.

So that's a start.

>>: Yep.

SARAH: Yep, that's a start but can we have the next slide, folks?

This is a great discussion.

All right. So we're going to do a survey. We would ask that you please participate. We really value your opinions, and you can ‑‑ the poll questions have just jumped at you. Please answer them.

Or there's a link in the chat. Or if that doesn't work, you can e‑mail Priya, priya@disasterstrategies.org

And may we have the next slide while you're doing that? Here they are.

We promised from the beginning that the webinars will be available. And this is the link at this point where you can access them.

They're available in both English and Spanish. With obviously ASL.

And we will be announcing and sending out to all of you when the third webinar becomes available as well.

Next slide.

So if you have ‑‑ you now met Megan (chuckling) so please feel free to e‑mail us, and she will get us to e‑mail you back.

And also that's another way to access the patient‑provider communication website. That will get you on to the communication access tool as well as keep and stay tuned. Keep in touch and stay tuned for additional resources and tools and tips that are being organized and will be provided.

Obviously all of this is free of charge. And we just hope you keep giving us good feedback.

Next slide.

>>: Before I move to the next slide, I would just like to say on the archived webinar page, there's also a link to today's wonderful presenter's bios if you would like to learn more about who they are are.

And also the notice on this contact information page for the Patient‑Provider Communication Network, that website is really kind of your go to resource where you can sign up if you aren't already to receive updates from them directly

SARAH: Okay. Great.

Next slide.

And Sheila I do see your hand is raised, so stay on.

But we want to thank you. We want to thank all of you. The panelists for all the webinars. Some of you are also on this one, Susan, I see you, and I think Anita may have been on.

We want to thank all the planning partners.

Our language access team. And what we hope we've been modeling with the way we've done this webinar is communication access.

We've been ‑‑ it took time to explain at the beginning of the webinar how this works. It's not easy. It's complex. And it's important.

And we also of course need to and want to thank our Ability Central funder, and most of all for all of you attending and participating.

And Sheila, I'm going to ‑‑

Patricia put, what about having providers connect and partner with your local independent living center? Good idea.

Sheila, I think I've just allowed you to talk.

PRIYA: This is Priya. I'm so sorry to interrupt. I want to encourage folks to follow up via e‑mail given we are at the bottom half of the hour here together and want to be respectful of folks' time. Want to encourage everyone to reach out to Megan Juring at juring@gmail.com.

And once again thank you all everyone for joining us. Please do finish up with those polls, and let us know of anything in the meantime. Thank you all.

SARAH: Thank you, Priya. Thank you to the Partnership. Thank you to all our subject experts and leadership, and thank you to all of you who are coming and have come more than once and will keep coming so that we can continue to work on this very complex set of problems.

And prevail!

>>: Can I go ahead and ask the question that I had or?

PRIYA: This is Priya. Sheila, we encourage you to e‑mail us and we can follow up there.

SARAH: Yes.

PRIYA: Thanks everybody.

SARAH: Thanks very much.