



L.A. Care
HEALTH PLAN®

For A Healthy Life



Better Communication, Better Care

A Provider Toolkit for Serving Diverse Populations

Table of Contents

What is the Purpose of This Tool Kit? How Can It Help My Practice?	4
Acknowledgement	4
Section A: What You Need to Know	6
Provider Responsibilities – How Can L.A. Care Help You?	6
Employee Language Skills Self-Assessment Tool	8
Language Services Requirements	11
Interpreting Services	12
Translation Services	15
Referrals to Community Services	16
Cultural Competency Training	17
Complaints and Grievances	17
Section B: Interaction with a Diverse Patient Base	18
Working with Diverse Patients: Tips for Successful Patient Encounters	20
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	21
Non-Verbal Communication and Patient Care	22
“Diverse” A Mnemonic for Patient Encounters	24
Tips for Identifying and Addressing Health Literacy Issues	25
Interview Guide for Hiring Office/Clinic Staff with Diverse Awareness	27
American with Disabilities Act (ADA) Requirements	28
Effective Communication	28
Auxiliary Aids and Services	29
Effective Communication Provisions	30
Tips for Communicating with Deaf and Hard of Hearing People	30
Companions	31
Use of Accompanying Adults or Children as Interpreters	31
Who Decides Which Aid or Service is Needed?	32
ADA Requirements for Effective Communication	33
Supporting Patients with 211 and 711 Community Services	34
Section C: Crossing Barriers: Communication Across Language Barriers	35
Language Services: The Key to Patient Engagement	37
Tips for Working with Limited English Proficient Patients	38
Tips for Communicating: Across Language Barriers	39
Tips for Locating Interpreter Services	40
Tips for Working with Interpreters	41
Telephonic Interpreters	41
On-Site (In-Person) Interpreters	42
Common Signs in Multiple Languages	43
Common Sentences in Multiple Languages	44

Table of Contents (Continued)

Section D: Awareness of Cultural Background and Its Impact on Healthcare Delivery	49
Health Equity, Health Equality and Health Disparities	51
Let's Talk About Sex	54
Lesbian, Gay, Bisexual or Transgender (LGBT)	55
Pain Management Across Cultures	56
Cultural Background Information on Special Topics	58
Effectively Communicating with the Elderly	60
Section E: References and Resources	62
45 CFR 92, Non Discrimination Rule	64
Title VI of the Civil Rights Act of 1964	65
Section 1557 of the Affordable Care Act of 2010 (Section 1557)	66
Americans with Disabilities Act of 1990	68
National Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	69
Executive Order 13166, August 2000	70
Race/Ethnicity/Language (REL) Categories Importance of Collecting REL and Appropriate Use	72
Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters	73
Bibliography of Major Sources Used in the Production of the Toolkit	74
Cultural Competence Web Resources	77
Glossary of Terms	78
Acknowledgements – Cultural and Linguistics Work Group	80

What is the purpose of this tool kit? How can it help my practice?

Cultural and linguistic competence is widely recognized as a fundamental aspect of quality health care (including mental health), particularly for the diverse patient population. It serves as an essential strategy for reducing disparities by improving access, utilization, and quality of care. Because of changes in demography, in our awareness of differences in individual behaviors, and new legal mandates, we are constantly presented with new challenges in our attempts to deliver quality health care.

This tool kit was developed to assist you in providing high-quality, effective, and compassionate care to your patients. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient population. It also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The contents of the tool kit are organized into five sections which contain helpful information and tools that can be reproduced and used as needed. Below you will find a list of topics and a small sample of their contents.

What You Need to Know: an overview of provider responsibilities, the language skill selfassessment tool, the language services requirements per Section 1557 of the Affordable Care Act, and the cultural and linguistic programs and services available through L.A. Care Health Plan.

Interaction with a Diverse Patient Base: encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who has an awareness of diversity issues.

Crossing Barriers: Communication Across Language Barriers: tips for working with limited English proficient patients, tips for locating and working with interpreters, and common signs and sentences in the L.A. Care's threshold languages.

Awareness of Cultural Background and Its Impact on Health Care Delivery: tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.

References and Resources: key legal requirements including 45 CFR 92 – Non Discrimination Rule, Title VI of the Civil Rights Act, Section 1557 of the Affordable Care Act, and Americans with Disabilities Act, a summary of the “Culturally and Linguistically Appropriate Service (CLAS) Standards,” which serves as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, Medi-Cal Managed Care All-Plan letters, a bibliography of print and web resources, and a glossary of terms.

We consider this tool kit a work in progress. Patient needs and the tools we use will continue to evolve. We encourage you to use what is helpful, disregard what is not, provide us with any feedback you might have. We hope that the provided tools and resources help you communicate effectively with our diverse patient base, as well as serve as a reference guide for your office.

Acknowledgement

This tool kit was adapted from the materials developed by and used with the permission of the **Industry Collaboration Effort (I.C.E) Cultural and Linguistics Workgroup**, a “volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public.” More information on the I.C.E Workgroup may be found on their website: www.iceforhealth.org.



For A Healthy Life



Section A: What You Need to Know

Section A: What You Need to Know

Under Title VI of the Civil Rights Act of 1964, any agency, program, or activity that receives federal financial funding may not discriminate on the basis of race, color, or national origin. The mission of L.A. Care's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve patients' health status by ensuring equal access to culturally and linguistically appropriate resources and health care, and by providing wellness and disease prevention programs.

Provider Responsibilities – How Can L.A. Care Help You?

L.A. Care Health Plan provides:

- Free aids and services to patients with disabilities to communicate effectively, such as:
 - Qualified sign language interpreters
 - Written information in large print, audio, accessible electronic and other formats
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Documents translated into other languages

Below is more information on what you are required to do and the various ways that can help you better provide equal access to health care for all patients.

Provider Network Linguistic Capabilities

L.A. Care providers are required to have a system in place to identify the language proficiency of all practitioners and staff who are bilingual, and to communicate with patients in a language other than English. This includes maintaining documentation of staff's bilingual qualifications on file, and updating this information at least annually.

The evidence of the language proficiency assessment must include the following:

- Employee name
- Position and department
- Spoken and written language
- Proficiency level for spoken and written language (I.C.E. Employee Language Skills Assessment Tool or any other language proficiency assessment results)
- Assessment date

AND one or more of the following (if any):

- Number of years of employment the individual has as an interpreter (e.g., resume)
- Certification of medical interpreters (e.g., National Board of Certification for Medical Interpreters, Certification Commission for Healthcare Interpreters)
- Documentation of successful completion of education and training in interpreting ethics, conduct and confidentiality that are promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare
- Other reasonable alternative documentation of interpreter capability

Furthermore, providers' offices should submit updates to the Provider Network Management Department (ProviderRelations@lacare.org) regarding any changes. L.A. Care Health Plan (L.A. Care) monitors disclosure forms signed by bilingual providers and/or office staff, attesting to their fluency in languages other than English through the credentialing process and the facility site review process. Submission of the language capabilities of your office staff is important as this information is included in the L.A. Care Health Plan provider directory which is distributed to patients and made available online at www.lacare.org.

Employee Language Skills Self-Assessment Tool

L.A. Care Health Plan along with Plan Partners and the I.C.E. Collaborative Team joined forces to develop an Employee Language Skills Self-Assessment tool that can be used to document bilingual skills of all practitioners and staff members.

The tool serves as the first step to improving communication with a diverse patient base, and provides a basic idea of bilingual capabilities of staff members.

How to Use the Self-Assessment Tool?

- Complete the enclosed survey for each member of your staff:
 - Document each language other than English spoken by your staff.
 - Use the evaluation guidelines on the form to determine the fluency level for each language in the following areas: speaking, reading, and writing.

OR

- Distribute the tool to **all your clinical and non-clinical employees** who use their non-English language skills in the workplace, and ask to complete the survey.
- Attach the qualifications of all bilingual staff to the completed survey, and keep them on file. Please refer to the list of qualifications in the “*Provider Network Linguistic Capabilities*” section.
- Once bilingual staff members are identified, **they should be referred to a professional language assessment agency** to evaluate their level of language proficiency.

This survey will not affect your performance evaluation. It is just a way for us to improve our customer service and to make you part of such efforts.

Employee Language Skills Self-Assessment Tool

Dear Physician,

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. The tool is not meant to serve as an assessment for qualified medical interpreters or meet the California Language Assistance Program law or any other regulatory requirements.

It is important that all bilingual practitioners and their staff who speak with patients in a language other than English complete this form. Those who rate themselves with speaking, reading, or writing at 3 or above, should take a professional language assessment before using their bilingual skills with patients.

No-cost qualified interpreting services are available through patients' health plans. This includes faceto face, telephonic, and American Sign Language interpreting services. To receive immediate assistance or to schedule a face-to-face interpreter, call the patient's health plan.

If a patient belongs to Medi-Cal, please call the number listed next to the patient's health plan to request a face-to-face interpreter:

Anthem Blue Cross	1.888.285.7801	Kaiser Permanente	1.800.464.4000
Blue Shield of California Promise Health Plan (<i>previously known as Care1st</i>)	1.800.605.2556	L.A. Care Health Plan	1.888.839.9909
Health Net	1.800.675.6110	Molina Healthcare	1.888.665.4621

Thank you for your assistance.

The Cultural & Linguistics Collaborative of Los Angeles County



(Modifications from the approved I.C.E. Collaborative document were made for this page only).

Approved on 06/20/2018 by the C&L Collaborative of Los Angeles

Employee Language Prescreening Tool Key

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key	Reading
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and health care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key	Writing
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation

vs.

Translation

Interpretation: Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor.

Translation: Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original.

Source: University of Washington Medical Center

EMPLOYEE LANGUAGE PRESCREENING TOOL (For Clinical and Non-Clinical Employees)



This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ Department/Job Title: _____

Work Days: Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun Work Hours (Please Specify): _____

- Directions:** (1) List any/all language(s) or dialects you know.
 (2) Indicate how fluently you speak, read and/or write each language

Language	Dialect, region, or country	Fluency: see attached key (Circle)			I would like to use my language skills to speak with patients (Circle)	I would like to use my reading language skills to communicate with patients (Circle)	I would like to use my language skills to write patient communications (Circle)
		Speaking	Reading	Writing			
		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

Language Services Requirements

Health plans can provide no-cost qualified interpreters for their members. Members should call their health plan for assistance.

The federal guidance, published as Section 1557 of the Affordable Care Act, provides specific limitations on the use of certain individuals as interpreters as described below. The limitations include the use of:

- Bilingual staff
- Adults and minors that accompany a patient

Health plans appreciate your efforts to comply with these important regulations. Non-compliance may expose providers to the risk of violating consumers' civil rights.

If bilingual staff is used as interpreters, the following Section 1557 guidelines apply:

A qualified interpreter for an individual with limited English proficiency as defined in Section 1557 means an interpreter who via a remote interpreting service or an on-site appearance:

- (1) Adheres to generally accepted code of ethics for interpreters, including client confidentiality;
- (2) Has demonstrated proficiency in speaking and understanding both English and at least one other spoken language;
- (3) Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Section 1557 guidelines on use of accompanying adult or minor:

Restricted use of certain persons to interpret or facilitate communication. A covered entity shall not:

- (1) Require an individual with limited English proficiency to provide his or her own interpreter;
- (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:
 - (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
 - (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interprets or facilitates communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;
- (3) Rely on a child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
- (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.

Interpreting Services

L.A. Care Health Plan provides professional interpreting services, including American Sign Language (ASL), to limited English proficient (LEP) patients at no cost to them. Services are not limited to the threshold languages for Los Angeles County.

The interpreting services include:

- **Face-to-Face Interpreting Services**
 - Face-to-face interpreting services are available for patients' medical appointments in all languages and dialects, and are the preferred method of communication.
- **24-Hour Telephonic Interpreting Services**
 - Telephonic interpreting services are available in over 200 languages 24 hours a day, 7 days a week, including holidays.
- **American Sign Language Interpreting Services (ASL)**
 - American Sign Language interpreting services are available to communicate with deaf and hard-of-hearing patients at their medical appointments.
- **California Relay Service (CRS)**
 - California Relay Service is available to communicate with patients who have a hearing or speech impairment. Both providers and patients can dial **711** to access CRS.

Interpreting services are available to patients at all key points of contact, including primary care physician offices and ancillary sites.

L.A. Care Health Plan developed *an interpreting services poster* to inform patients of their right to free interpreting services and how to properly access them.

It is a requirement that provider sites display the poster at all key points of contact. This includes reception areas, waiting and exam rooms. The interpreting services poster can be ordered on the L.A. Care website:

<https://external.lacare.org/HealthForm/>

L.A. Care Medi-Cal 1.888.879.9909 TTY 711	L.A. Care Cal Medi-Connect 1.888.822.1298 TTY 711	L.A. Care Covered 1.888.822.2327 TTY 711	PASC SEIU 1.844.654.7272 TTY 711	Anthem Blue Cross 1.888.235.7981 TTY 711	Blue Shield of California Promise Health Plan 1.800.695.2556 TTY 711
---	---	--	--	--	---

Patients are mailed a Language Card which include their spoken language and the phone number to request an interpreter when they make a medical appointment or during their doctor visit. Ensure that your front office staff is familiar with this card and knows how to request an interpreter. Below is a sample of the Language Card:



Accessing Interpreting Services

Provider offices are encouraged to access L.A. Care's face-to-face, American Sign Language, and telephonic interpreting services for all L.A. Care direct line of business patients.

Face-to-Face Interpreting Services

Face-to-face interpreting services, including American Sign Language, can be obtained through L.A. Care Health Plan. If you need to request an interpreter on patient's behalf, please call Member Services Department at **1.888.839.9909** when scheduling the next appointment but at least ten (10) business days prior to the appointment date.

Important: If there are any changes to a patient's appointment, please call Member Services Department immediately at **1.888.839.9909**.

Have the following patient information ready:

- Provider name
- Language needed (including American Sign Language)
- L.A. Care patient's name and ID number
- Date of birth
- Requestor name and contact number
- Date, time, and duration of appointment
- Location of appointment (i.e. address, suite #, major cross streets)
- Type of appointment (i.e. consultation, specialist, OB/GYN, etc.)
- Purpose of appointment (i.e. well visit, medical visit, follow-up, lab, etc.)
- Contact person at appointment site
- Other special instructions (i.e. gender of interpreter, patient has disabilities, driving directions, parking, etc.)

It is important that patients have access to after-hours interpreting services. At a minimum, provider sites should ensure that their answering machine informs patients on how to access interpreting services.

If a patient belongs to Medi-Cal, please call the number listed next to the patient's health plan to request a face-to-face interpreter:

Anthem Blue Cross: 1.888.285.7801

Blue Shield of California Promise Health Plan
(previously known as Care1st): **1.800.605.2556**

Kaiser Permanente: 1.800.464.4000

L.A. Care Health Plan: 1.888.839.9909

Required Documentation

It is necessary to document the following patient's information in their medical chart:

- Patient's preferred spoken and written language
- Patient's request for an interpreter
- Patient's refusal of an interpreter, and
 - Patient's request to use family or friends to interpret for them
(*after being informed of their right to a free interpreter*)

Use the below methods to document patients' request or refusal of interpreting services:

- Intake form/registration
- Stamp
- Medical chart (use of colored labels)
- Request/refusal form

L.A. Care has several forms in place that can be used by your office. Please go on the L.A. Care website to download them: www.lacare.org/providers/resources/downloadableforms.

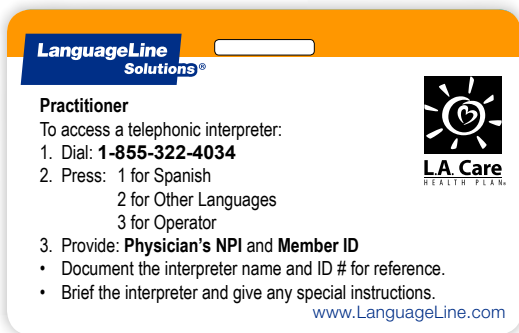
24-Hour Telephonic Interpreting Services

Telephonic interpreting services are available in over 200 languages 24 hours a day, 7 days a week, including holidays, and can serve as a back-up for face-to-face interpreting.

To access telephonic interpreting services, please call the appropriate number:

- Providers (Practitioners): **1.855.322.4034**
- Participating Physician Groups (PPGs): **1.855.322.4022**

L.A. Care has wallet-sized telephonic interpreting cards for providers to keep on hand. Providers can dial the indicated number at any time to request an over-the-phone interpreter by providing the above information.



To request your copy of the telephonic interpreting card, email us at CulturalandLinguisticServices@lacare.org

or call at **1.213.694.1250 ext. 4523**. Please have the following information ready in order to receive these services:

- Language needed
- L.A. Care member ID number
- Physician's NPI (practitioner) **OR** Name of IPA (PPG)

Assistance for The Deaf and Hard of Hearing

L.A. Care Health Plan ensures equal access to health care services for patients with hearing, speech and visual loss through the coordination of interpreting services and the provision of auxiliary aids during business-hours, after-hours, and in emergency situations. This includes:

American Sign Language Interpreting Services (ASL)

- L.A. Care Health Plan provides ASL services at no cost to patients. Simply call Member Services Department at **1.888.8399.909** and follow the directions listed in the *FaceToFace Interpreting Services* section of this tool kit.

California Relay Service (CRS)

- The California Relay Service allows to communicate with patients who have a hearing or speech impairment through a relay operator by calling **711**.

Translation Services

Quality translations provide limited English proficient (LEP) patients with equal access to health information and help providers deliver better health care to improve health outcomes. L.A. Care routinely sends written member informing materials in patient’s preferred language and/or alternative format.

Materials in Threshold Languages

Patient materials are available in the below threshold languages depending on the line of business. Threshold languages are the primary languages spoken by LEP population.

- The Threshold Languages for Medi-Cal Managed Care and Cal MediConnect in Los Angeles County are determined by the Department of Health Care Services (DHCS) and were released in Medi-Cal Managed Care All Plan Letter 17-011. The numeric threshold as defined by the DHCS is 3,000 or five percent (5%), whichever is lower, of mandatory Medi-Cal beneficiaries residing in the service area who speak a language other than English.
- The Threshold Languages for L.A. Care Covered and Personal Assistance Services Council and Service Employees International Union (PASC-SEIU) are determined by the Department of Managed Health Care (DMHC). The numeric threshold as defined by the DMHC is 3,000 or five percent (5%), whichever is lower, of enrollees who speak a language other than English.

The table of the threshold languages by line of business.

Medi-Cal	Cal MediConnect	L.A. Care Covered*	PASC-SEIU
English	English	English	English
Spanish	Spanish	Spanish	Spanish
Arabic	Arabic		Armenian
Armenian	Armenian		Chinese
Chinese	Chinese		Korean
Farsi	Farsi		Russian
Khmer	Khmer		
Korean	Korean		
Russian	Russian		
Tagalog	Tagalog		
Vietnamese	Vietnamese		

*Includes L.A. Care Covered and L.A. Care Covered Direct

Types of materials available to patients include but are not limited to:

- evidence of coverage
- grievance forms
- notice of action letters (i.e., denial, modification, deferral, and termination)
- health education materials
- health plan information *and*
- other patient informing materials

Materials in nonthreshold languages are available upon request.

Materials in Alternative Formats

L.A. Care provides written documents in other formats, such as:

- Large print - 18pt font (all threshold languages)
- Audio (English and Spanish)

Braille can be made available upon request. Some L.A. Care materials are available on the L.A. Care website (www.lacare.org) in a text-only format with the ability to adjust the font size.

To request information in another language or format, please call L.A. Care’s Member Services Department at **1.888.839.9909**.

Referrals to Community Services

L.A. Care Health Plan maintains a closed-loop system to refer and coordinate culturally and linguistically appropriate community services for direct line of business patients. Extending beyond direct health care services, Health Education Cultural & Linguistics Services (HECLS) Department assists patients and providers in coordinating the appropriate service using online databases, such as <https://www.auntbertha.com>.

Health education, cultural and linguistic services referrals have never been easier! Just follow these three easy steps:

1. Go onto the L.A. Care Health Plan website and access the Health Education Provider Resources: www.lacare.org/providers/provider-resources/health-education-tools.
2. Click on the “Refer L.A. Care members to free Health Education, Cultural and Linguistic Services” link to open up the HECLS Referral Form.
3. Complete and fax a hard copy of the HECLS Referral form to the HECLS Department. The fax information is on the form.

Class topics and services are provided by phone and in-person – please limit up to 3 topics.

The **health education** topics include:

Weight Management/Nutrition-Related Topics (MD, PA, PA-C, FNP, NP, DP signature required except for Diabetes)	Wellness and Health Education Topics
<input type="checkbox"/> Diabetes: Type 1	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Type 2	
<input type="checkbox"/> Gestational	
<input type="checkbox"/> Gastrointestinal Disorders	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chronic Disease Self-Management Program
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Hyperlipidemia	
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cold and Flu Prevention
<input type="checkbox"/> Prediabetes (A1C between 5.7-6.4%)	<input type="checkbox"/> COPD
<input type="checkbox"/> Weight: Pediatric Underweight (BMI less than 5 th %)	<input type="checkbox"/> Cultural Resources
<input type="checkbox"/> Weight: Pediatric Overweight (BMI 85 th – 95 th %)	<input type="checkbox"/> Living Well With a Disability
<input type="checkbox"/> Weight: Pediatric Obesity (BMI greater than 95 th %)	<input type="checkbox"/> Health Care Navigation
<input type="checkbox"/> Weight: Adult Underweight (BMI < 18.5)	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Weight: Adult Overweight (BMI 25-29.9)	<input type="checkbox"/> Physical Activity
<input type="checkbox"/> Weight: Adult Obesity (BMI 30+)	<input type="checkbox"/> Stress and Anxiety Management
<input type="checkbox"/> Other (<i>please specify in instructions/comments below</i>)	<input type="checkbox"/> Tobacco Cessation
	<input type="checkbox"/> Other

The **cultural & linguistic topics** include:

- Cultural Competency (including C&L requirements)
- Disability Sensitivity
- Communicating Through Healthcare Interpreters
(Available only for L.A. Care Network Physicians)

You can schedule classroom training sessions or access the online CME course by emailing us at CLStrainings@lacare.org.

Cultural Competency Training

Providers and office staff are encouraged to participate in the cultural competency training. Providers serving the Cal MediConnect patients are required to complete this training annually.

The following trainings are available through L.A. Care:

- **Cultural Competency**
1 hour, classroom or online (<https://lacareuniversity.torchlms.com>) This course is for providers, front and back office staff. Learn how to provide care more effectively to culturally diverse patients. This course explores cultural awareness, communication style, and examines the skills and steps to achieve cultural competency as well as language assistance services and the importance of using qualified interpreters.
- **Communicating through Healthcare Interpreters**
2 hours, online This CME course is for network physicians. Learn how to reduce doctor-patient language barriers and work effectively with in-person and telephonic interpreters. The first 25 physicians to register and complete the course will receive a \$100 stipend.
- **Disability Sensitivity:**
1 hour, classroom or online This course is for providers, front and back office staff. Learn how to meet the unique needs of seniors and people with disabilities and ensure equal access to health care. This course explores “People First” language and examines accommodations to assist them.

To receive information about upcoming trainings or to schedule an on-site training session, check the L.A. Care website: lacare.org, or contact L.A. Care’s Cultural & Linguistic Services Unit at CLStrainings@lacare.org.

Complaints and Grievances

Patients have the right to file a complaint when their cultural or linguistic needs are not met. Provider offices must have a process in place allowing patients to submit such a complaint. They should also inform patients on the reasons why they may file a complaint and the ways they can do it, should patients request it.

Patients may file a complaint in the following cases:

- They feel that they were denied services because they do not speak English.
- They cannot get an interpreter.
- They have a complaint about the interpreter.
- They cannot get information in their language or format.
- Their cultural needs are not met.

There are four ways for a patient to file a complaint. Patients can:

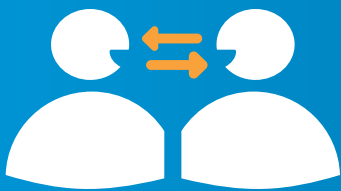
- Call Member Services Department at **1.888.839.9909 (TTY 711)**
- File Online at www.lacare.org/members/member-rights/file-complaint/online-grievance-form
- Write to: L.A. Care Health Plan
Member Services Department
West 7th Street
Los Angeles, CA 90017
- Send a Fax to **1.213.438.5748**

To receive additional information about the above services or resources, please contact Cultural & Linguistic Services Unit at **1.213.694.1250 ext. 4523** or email CulturalandLinguisticServices@lacare.org.



L.A. Care
HEALTH PLAN®

For A Healthy Life



Section B: Interaction with a Diverse Patient Base

Section B: Interaction with a Diverse Patient Base

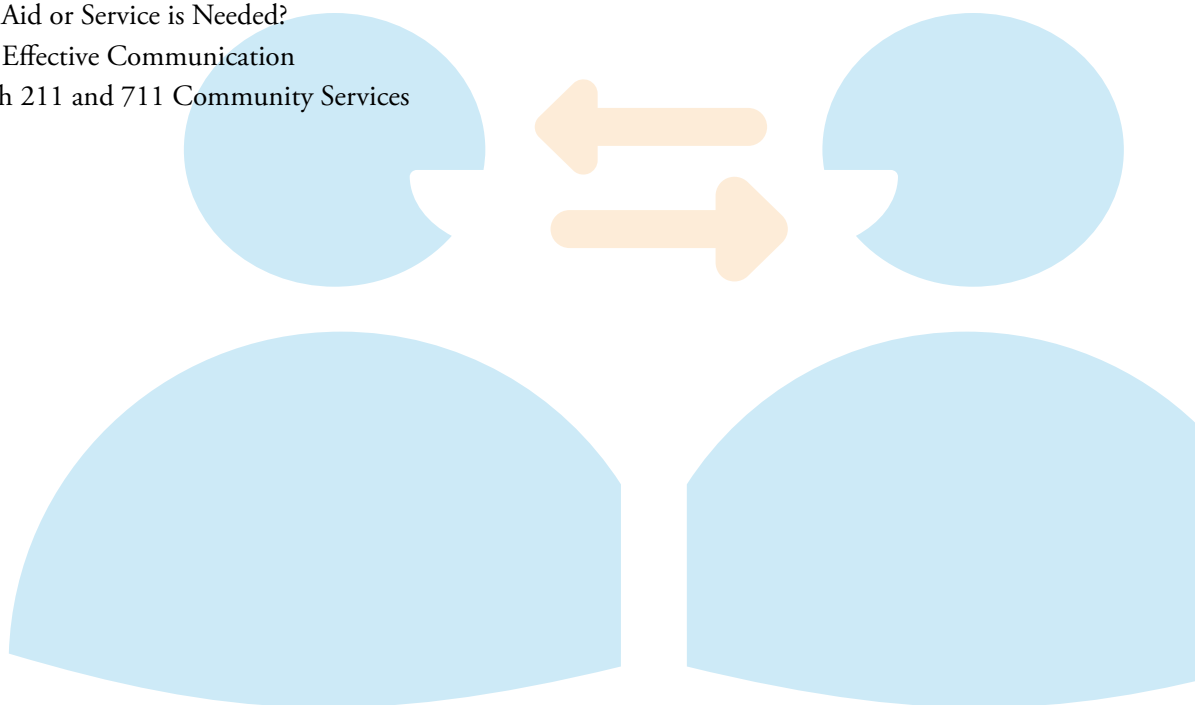
The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable for the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

- Working with Diverse Patients: Tips for Successful Patient Encounters
- Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication
- Non-verbal Communication and Patient Care
- “Diverse” A Mnemonic for Patient Encounters
- Tips for Identifying and Addressing Health Literacy Issues
- Interview Guide for Hiring Office/Clinic Staff with Diverse Awareness
- American with Disabilities Act (ADA) Requirements
 - Effective Communication
 - Auxiliary Aids and Services
 - Effective Communication Provisions
 - Tips for Communicating with Deaf and Hard of Hearing
 - Companions
 - Use of Accompanying Adults or Children as Interpreters
 - Who Decides Which Aid or Service is Needed?
- ADA Requirements for Effective Communication
- Supporting Patients with 211 and 711 Community Services



Working with Diverse Patients: Tips for Successful Patient Encounters

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech

People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact

The way people interpret various types of eye contact is tied to cultural background and life experience.

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language

Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation

English predisposes us to a direct communication style; however other languages and cultures differ.

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (See Employee Language Skills SelfAssessment Tool.)
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

Non-Verbal Communication and Patient Care

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.¹

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

¹ Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication*. Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences*. Yarmouth, ME: Intercultural Press.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: “Nurse, nurse.” Elena came to Mr. Todd’s door and politely asked, “May I help you?” Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, “What do you want?” Mr. Todd was confused. Why had Elena’s manner suddenly changed?²

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd’s innocent hand gesture. In the Philippines (and in Korea) the “come here” hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor’s visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person’s physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn’t get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

²Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.

Hall, E.T. (1985). *Hidden Differences: Studies in International Communication*. Hamburg: Gruner & Jahr.

Hall, E.T. (1990). *Understanding Cultural Differences*. Yarmouth, ME: Intercultural Press.

“Diverse” A Mnemonic for Patient Encounters

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient’s chart or use the mnemonic when gathering the patient’s history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	Demographics- <i>Explore regional background, level of acculturation, age and sex as they influence health care behaviors.</i>	Where were you born? Where was “home” before coming to the U.S.? How long have you lived in the U.S.? What is the patient’s age and sex?	
I	Ideas- <i>ask the patient to explain his/her ideas or concepts of health and illness.</i>	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	Views of health care treatments- <i>ask about treatment preference, use of home remedies, and treatment avoidance practices.</i>	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	Expectations- <i>ask about what your patient expects from his/her doctor?</i>	What do you hope to achieve from today’s visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	Religion- <i>asks about your patient’s religious and spiritual traditions.</i>	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	Speech- <i>identifies your patient’s language needs including health literacy levels. Avoid using a family member as an interpreter.</i>	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	Environment- <i>identify patient’s home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient’s daily schedule, support system and level of independence.</i>	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

Tips for Identifying and Addressing Health Literacy Issues

Low Health Literacy Can Prevent Patients from Understanding Their Health Care Services.

Health Literacy is defined by the National Health Education Standards¹ as “*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*”

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor’s directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I’ll take this home for my family to read.
- What does this say? I don’t understand this.

Your patients’ behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient’s culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person’s ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures, it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

Tips For Dealing With Low Health Literacy³

- Use simple words and avoid jargon.
- Never use acronyms.
- Avoid technical language (if possible).
- Repeat important information – a patient’s logic may be different from yours.
- Ask patients to repeat back to you important information.
- Ask open-ended questions.
- Use medically trained interpreters familiar with cultural nuances.
- Give information in small chunks.
- Articulate words.
- “Read” written instructions out loud. I Speak slowly (don’t shout).
- Use body language to support what you are saying.
- Draw pictures, use posters, models or physical demonstrations.
- Use video and audio media as an alternative to written communications.

Additional Resources

Use **Ask Me 3^{®2}**. Ask Me 3[®] is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3[®] and to view a video on how to use the questions, please visit www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: www.ama-assn.org/ama/pub/about-ama/ama-foundation

³Joint Committee on National Education Standards, 1995

Interview Guide for Hiring Office/Clinic Staff with Diverse Awareness

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. Remember that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

Interview Questions

Q. What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

American with Disabilities Act (ADA) Requirements

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit the website www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for Title II (state and local government services) and Title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

Effective Communication

Overview

People who have vision, hearing, or speech disabilities (“communication disabilities”) use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that Title II entities (state and local governments) and Title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities.

This publication⁴ is designed to help title II and title III entities (“covered entities”) understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person’s normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity’s goods or services as well as with that person’s parent, spouse, or companion in appropriate circumstances.

⁴www.ada.gov/effective-comm.htm

Auxiliary Aids and Services

The ADA uses the term “auxiliary aids and services” (“aids and services”) to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screenreading program; or an audio recording of printed information. A “qualified” reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.
- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A “qualified” interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly), especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including

1. Assistive listening systems and devices

2. Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices

3. Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products

4. Videotext displays

5. Screen reader software, magnification software, and optical readers

6. Video description and secondary auditory programming (SAP) devices that pick up videodescribed audio feeds for television programs

7. Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers)

Effective Communication Provisions

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations.

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:

In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program. In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication is also key.

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

Tips for Communicating with Deaf and Hard of Hearing People

Myths About Deaf or Hard of Hearing Persons

- All hearing losses are the same.
- All deaf people are mutes.
- All deaf people use hearing aids.
- Hearing aids restore hearing.
- All deaf people use sign language.
- Sign language is universal.
- All deaf people can read lips.
- Deaf people are less intelligent.

Issues to be aware of

- Some Deaf individuals have very limited English language skills as it is their second language, and will require an interpreter to ensure comprehension of the message.
- There are literacy levels and language use differences among deaf individuals and groups of deaf individuals.
- Problems with the varying quality, experience and knowledge of interpreters in these critical settings.
- Words like "right" or "silent" have contextual meanings, are abstract, and when signed by different interpreters, could result in completely different meanings.
- Regardless of educational level, many individuals who are deaf have not been exposed to mainstream culture through mass media based on sound. Media exposure is the source for the general public for its information

Tips for Communicating with Deaf or Hard of Hearing Persons

- Face the deaf person and maintain eye contact. Deaf individuals often rely on visual cues to determine your message as much as your words. Give the deaf person as many visual cues as possible.
- Speak directly to the Deaf or Hard of Hearing Person. Focus your attention on the deaf person, not the interpreter. Avoid using phrases such as “Tell him/her” or “Can he/she read lips?”
- Speak clearly and at your normal, natural pace. The interpreter will let you know if you are speaking too fast. Enunciate your words. Do not exaggerate.
- Remember, talking louder does not help the deaf person understand better.
- Avoid asking the interpreter for his/her opinion. You are speaking with the Deaf or Hard of Hearing Person.
- Consider your choice of words. Some words are easier to lip-read than others.
- If the deaf person does not understand, re-phrase instead of repeating the same words.
- Apply “Tips for Working with Interpreters” when using sign language interpreters to communicate with your patients.

Companions

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child’s progress;
- Hospital staff often talks to a patient’s spouse, other relative, or friend about the patient’s condition or prognosis.

The rules refer to such people as “companions” and require covered entities to provide effective communication for companions who have communication disabilities.

The term “companion” includes any family member, friend, or associate of a person seeking or receiving an entity’s goods or services who is an appropriate person with whom the entity should communicate.

Use of Accompanying Adults or Children as Interpreters

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people’s children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

- (1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.
- (2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person’s impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

Who Decides Which Aid or Service is Needed?

When choosing an aid or service, Title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

**For more information about the ADA, please visit the website or call the toll-free number: www.ada.gov
ADA Information Line: 800-514-0301 (Voice) and 800-514-0383 (TTY)**

ADA Requirements for Effective Communication

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.).

Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because ...	These are some options we can provide for you...
<p>I am blind or have vision impairments that keep me from reading</p>	<ul style="list-style-type: none"> • Large print materials • Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped • www.loc.gov/nls/pdf/application.pdf • Physician can complete form for Vision enabled telephone www.californiaphones.org/application • Check with health plans to see what they have available (audio recordings of printed materials, etc.)
<p>I am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell</p>	<ul style="list-style-type: none"> • Amplifier/ Pocket Talker • Written materials • Qualified sign language interpreter • Qualified note taker • Telecommunications Relay Service (TRS) 7-1-1 • Have physician dictate into voice-recognition software and patient can type answers back
<p>I have difficulty speaking clearly and making myself understood</p>	<ul style="list-style-type: none"> • Allow for extra time and attentive listening • Qualified note taker • Telecommunications Relay Services (TRS) 7-1-1 • Communication board or paper and pencil • Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America: aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association: www.asha.org
- Administration for Community Living DHHS: www.acl.gov
- The Look Closer, See Me Generational Diversity and Sensitivity training program nursing.uc.edu/content/dam/nursing/docs/CAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S. Department of Justice – ADA requirements for Effective Communication www.ada.gov/effective-comm.htm

Supporting Patients with 211 and 711 Community Services

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit ddtp.cpuc.ca.gov/homepage.aspx



L.A. Care
HEALTH PLAN®

For A Healthy Life



Section C: Crossing Barriers: Communication Across Language Barriers

Section C: Crossing Barriers: Communication Across Language Barriers

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment.

Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased appropriate utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials are available in this section:

- Language Services: The Key to Patient Engagement
- Tips for Working with Limited English Proficient Patients
- Tips for Communicating Across Language Barriers
- Tips for Locating Interpreter Services
- Tips for Working with Interpreters
 - Telephonic Interpreters
 - On-Site (In-Person) Interpreters
- Common Signs in Multiple Languages
- Common Sentences in Multiple Languages



Language Services: The Key to Patient Engagement

Where do I start?

Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field⁵. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:

- Gather your team
- Make a commitment
- Identify needs

Get Set: identify resources

Go: pull it all together, implement, evaluate, plan for the future

What language service needs should I begin to identify?

Keep it simple and write down:

- What you know about your patient demographics
- What you already do to provide language services
- Where you can grow and strengthen your language services

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!

- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!

- Review resources and identify those most useful for your office

Go!

- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

⁵Wirthlin Worldwide 2002 RWJF Survey

Tips for Working with Limited English Proficient Patients

Who is a LEP patient?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP patient over the phone?

- Patient is quiet or does not respond to questions
- Patient simply says yes or no, or gives inappropriate or inconsistent answers to your questions
- Patient may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
- Patient self identifies as LEP by requesting language assistance

Tips for working with LEP patients and how to offer interpreter services

- Patient speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpreting vendor to identify language needed
- Patient speaks some English:
 - Speak slowly and clearly.
 - Do not speak loudly or shout.
 - Use simple words and short sentences.
- How to offer interpreter services:

“I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?”

OR

“May I put you on hold? I am going to connect us with an interpreter.” (If you are having a difficult time communicating with the patient)

Best practice to capture language preference

For LEP patients it is a best practice to capture the patient’s preferred language and record it in the patient data system.

“In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?”

Tips for Communicating: Across Language Barriers

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and

medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; *and*
- Ask patients to point at the poster to their language of preference.
- Post information relative to the availability of interpreter services.
- Make available and encourage patients to carry "I speak..." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.
(*e.g., Orange =Spanish, Yellow=Vietnamese, Green=Russian*).

Tips to Assessing Which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	<ul style="list-style-type: none">• Avoid jargon and acronyms• Provide educational material in the languages your patients read• Limit/avoid technical language
Speak Slowly	<ul style="list-style-type: none">• Do not shout, articulate words completely• Use pictures, demonstrations, video or audiotapes to increase understanding• Give information in small chunks and verify comprehension before going on
Repeat Information	<ul style="list-style-type: none">• Always confirm patient's understanding of the information - patient's logic may be different from yours

Tips for Locating Interpreter Services

Steps you need to take to locate interpreter services:

1. Identify the languages spoken by your patients, and
2. Identify the language services available to meet these needs.

For example:

Languages spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in-person interpreter

Identify the language capabilities of your staff

(See *Employee Language Skills SelfAssessment* on p. 7)

- Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
- Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
- Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. **IF you use a minor, document the reason a minor was used.**

Identify available services and do Not require an individual with limited English proficiency to provide his/her own interpreter

- Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.
- Identify community based qualified interpreter resources.
- Create and provide to your staff policies and procedures to access interpreter services.
- Keep an updated list of specific telephone numbers and health plan contacts for language services.
- If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.
- 711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.

California law requires that health plans and insurers offer free interpreter services to both limited English proficient (LEP) patients and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

Tips for Working with Interpreters

Telephonic Interpreters^{6,7}

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey.
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., “can’t - cannot.”
- Speak in short sentences, expressing one idea at a time.
- Speak slower than your normal speed of talking, pausing after each phrase.
- Avoid the use of double negatives, e.g., “If you don’t appear in person, you won’t get your benefits”. Instead, “You must come in person in order to get your benefits.”
- Speak in the first person. Avoid the “he said/she said.”
- Avoid using colloquialisms and acronyms, e.g., “MFII.” If you must do so, please explain their meaning.
- Provide brief explanations of technical terms, or terms of art, e.g., “Spend-down” means the client must use up some of his/her monies or assets in order to be eligible for services.”
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client.
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.
- ABOVE ALL, BE PATIENT with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service.
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is “blind” to the visual cues in the room. The following will help the interpreter do a better job.

When the interpreter comes onto the line let the interpreter know the following:

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, “Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez’ annual exam.”

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient.
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.

⁶“Limited English Proficiency Plan,” Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

⁷“Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members,” California Endowment website.

On-Site (In-Person) Interpreters⁸

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For face-to-face interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For American Sign Language (ASL) interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- Be aware of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- Be attentive to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, “yes” may not always mean “yes.” Instead, “yes” might be a polite way of acknowledging a statement or question, a way of politely reserving one’s judgment, or simply a polite way of declining to give a definite answer at that juncture.
- Greet the patient first, not the interpreter.
- During the medical interview, speak directly to the patient, not to the interpreter: “Tell me why you came in today” instead of “Ask her why she came in today.”
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. “My stomach hurts” instead of “She says her stomach hurts.” This allows you to hear the patient’s “voice” most accurately and deal with the patient directly.
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter’s job more difficult.
- Don’t say anything that you don’t want interpreted; it is the interpreter’s job to interpret everything.
 - If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter.
 - Speak in: Standard English (avoid slang)
 - Layman’s terms (avoid medical terminology and jargon)
 - Straightforward sentence structure
 - Complete sentences and ideas
- Ask one question at a time.
 - Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter’s judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter’s help in eliciting the information in a more appropriate way.
- Do not hold the interpreter responsible for what the patient says or doesn’t say. The interpreter is the medium, not the source, of the message.
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech.
- Don’t make assumptions about the patient’s education level. An inability to speak English does not necessarily indicate a lack of education.
- Acknowledge the interpreter as a professional in communication. Respect his or her role.

⁸“Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members,” California Endowment website.

Common Signs in Multiple Languages

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English	Welcome
Arabic	أهلاً وسهلاً
Armenian	Բարի գալուստ
Chinese	歡迎
Farsi	خوش آمدید
Khmer	ស្វាគមន៍
Korean	환영합니다
Russian	Добро пожаловать
Spanish	Bienvenido
Tagalog	Tuloy po kayo
Vietnamese	Chào mừng

English	Enter
Arabic	دخول
Armenian	Մուտք
Chinese	入口
Farsi	ورود
Khmer	ចូល
Korean	입구
Russian	Вход
Spanish	Entrada
Tagalog	Pasukan
Vietnamese	Đi vào

English	Registration
Arabic	التسجيل
Armenian	Գրանցում
Chinese	報到
Farsi	ثبت نام
Khmer	កាន់ចុះឈ្មោះ
Korean	등록
Russian	Регистратура
Spanish	Inscripción
Tagalog	Pagpaparehistro
Vietnamese	Đăng ký

English	Exit
Arabic	خروج
Armenian	Ելք
Chinese	出口
Farsi	خروج
Khmer	ចេញ
Korean	출구
Russian	Выход
Spanish	Salida
Tagalog	Labasan
Vietnamese	Đi ra

English	Cashier
Arabic	المحاسب
Armenian	Գանձապահ
Chinese	收費處
Farsi	صندوقدار
Khmer	បម្រើទឹក
Korean	출납원
Russian	Кассир
Spanish	Cajero
Tagalog	Cashier
Vietnamese	Thu ngân

English	Restroom
Arabic	حمام
Armenian	Սանհանգույց
Chinese	洗手間
Farsi	دستشویی
Khmer	បន្ទប់ទឹក
Korean	화장실
Russian	Туалет
Spanish	Baños
Tagalog	Palikuran
Vietnamese	Phòng vệ sinh

Common Sentences in Multiple Languages

This tool is designed for office staff to assist in basic entry level communication with Limited English Proficient (LEP) patients. Point to the sentences you wish to communicate and your LEP patient may read in his/her language of preference. The patient can then point to the next message.

English	Arabic / يبرع	Armenian / Հայերեն
Point to a sentence <i>Instructions</i>	قلمچال یل رشأ تامی لعتل	Ցույց տվեք նախադասությունը Հրահանգներ
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	هذه مادختسا عیطتسن یلع انتدعاسمل تاقاطبلا یل رشأ. ضعبلا انضعب مهف ریبعتل دیرت یتلأ قلمچال موقنس، ةجاج كانه تنك اذا. انع مجرتم عم لاصتال اب أقحال یروف.	Մենք կարող ենք օգտագործել այս քարտերը, որոնք կօգնեն մեզ հասկանալ միմյանց: Ցույց տվեք նախադասությունը, որը ցանկանում եք հայտնել: Եթե կարիք կա, ապա ավելի ուշ մենք կարող ենք բանավոր թարգմանիչ կանչել:
Courtesy statements	ةف ی ظل تارابع	Սիրալիրության արտահայտումներ
Please wait.	راظنتال ای جری	Խնդրում եմ սպասել:
Thank you.	كئل ارکفش	Շնորհակալություն:
One moment, please.	كئلضف نم، ةدحاو ةظحل	Մեկ րոպե, խնդրում եմ:
Patient may say...	ض ی رمل لوقی نأ نكمی	Հիվանդը կարող է ասել...
My name is...	... ی مسا	Իմ անունն է...
I need an interpreter.	یروف مجرتم دیرأ	Ինձ բանավոր թարգմանիչ է հարկավոր:
I came to see the doctor, because...	ب، یبطلأ ةعجارمل تیتأ ... ببسب	Ես եկել եմ բժշկի այցելության, քանի որ...
I don't understand.	مهفأ مل	Ես չեմ հասկանում:
Please hurry. It is urgent.	قلاج قلا ح انل. ءأجر ةعرسب	Խնդրում եմ արագացնել: Մա շտապ է:
Where is the bathroom?	؟امچال نیأ	Որտե՞ղ է գտնվում սանհանգույցը:
How much do I owe you?	؟ی نم دیرت لاملا نم مك	Ինչքա՞ն պետք է ձեզ վճարեմ:
Is it possible to have an interpreter?	مجرتم ءاعدتسا نكممل له ؟یروف	Հնարավո՞ր է արդյոք բանավոր թարգմանիչ կանչել:
Staff may ask or say...	ض ی رمل لوقی نأ نكمی	Անձնակազմը կարող է հարցնել կամ ասել...
How may I help you?	؟كئدعاسأ نأ یننكمی فیک	Կարո՞ղ եմ օգնել ձեզ:
I don't understand. Please wait.	راظنتال ای جری مهفأ مل	Ես չեմ հասկանում: Խնդրում եմ սպասել:
What language do you prefer?	؟هلضفت یتلأ ةغلل ای ام	Ո՞ր լեզուն եք նախընտրում:
We will call an interpreter.	مجرتم عم لاصتال اب موقنس یروف	Մենք բանավոր թարգմանիչ կկանչենք:
An interpreter is coming.	مداق یروف مجرتم كانه	Բանավոր թարգմանիչ է գալիս:
What is your name?	؟كمسا وه ام	Ի՞նչ է ձեր անունը:
Who is the patient?	؟ض ی رمل وه نم	Ո՞վ է հիվանդը:
Please write the patient's:	ض ی رمل ءتابتك ای جری	Խնդրում եմ գրել <u>հիվանդի</u>
Name	مسا	Անունը
Address	ناونع	Հասցեն
Telephone number	فتاه مقرر	Հեռախոսահամարը
Identification number	فیبرعت مقرر	Ճանաչողական համարը
Birth date:	ةدالو خیرات	Ծննդյան ամսաթիվը
Month/Day/Year	رهل/امویل/ةنسل	Ամիս/օր/տարի
Now, fill out these forms, please.	نأ، ءأجر جزامنل هذه ةیبعتب مقرر	Իսկ այժմ խնդրում եմ լրացնել այս ձևաթղթերը:

English	Chinese /中文	Farsi / یرسراف
Point to a sentence	指向某個句子	دینک دراشا هلمج کی هب
Instructions	說明	لمعلاروتسد
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	我們可利用這些卡片來協助我們彼此互相瞭解。指向某個您想溝通表達的句子。如有需要，等一下我們可以致電與口譯員聯絡。	هدافتسا امتراک نیازا میناوتیم میهفب ار رگیدکی روظنم ات مینک، دیوگب دیه اوخیم مک یا هلمج هب ادعب، موزل تروص رد. دینک دراشا میه اوخ سامت یه افش مجرتم کی اب بتفرگ
Courtesy statements	禮貌用語	هنابدوم تالمج
Please wait.	請稍後。	دینامب رظتنم افطل
Thank you.	感謝您。	مركشتم
One moment, please.	請稍後。	دینک ربص مظل کی افطل
Patient may say...	病人可能會說...	دیوگب تسا نکم رامیب
My name is...	本人名叫...	تسا ... نم مبرا
I need an interpreter.	本人需要使用口譯員。	مراذ زاین یه افش مجرتم هب نم
I came to see the doctor, because...	本人前來看醫生，因為...	... نوچ، مدرک هج ارم رتکد هب نم
I don't understand.	我無法瞭解。	موشیمن هجوتم
Please hurry. It is urgent.	請盡快處理。這十分緊急。	تسا یروررض. دینک هلمج افطل
Where is the bathroom?	請問洗手間在哪裡？	تسا چکی یوش تسد
How much do I owe you?	我需要支付多少錢給您？	مراکدب امش هب ردقچ
Is it possible to have an interpreter?	我可以使用口譯員嗎？	یه افش مجرتم کی هک دراد ناکم ای آ مشاب هتشد
Staff may ask or say...	職員可能會詢問或會說...	...دن سربب تسا نکم نانکراک
How may I help you?	我可以為您提供哪些協助？	مکن ناتکمک مناوتیم روظچ
I don't understand. Please wait.	我無法瞭解。請稍後。	دینک ربص افطل. موشیمن هجوتم
What language do you prefer?	您慣用什麼語言？	دیهدی حیجرت ار ینابز هج
We will call an interpreter.	我們將會致電與口譯員聯絡。	میریگیم سامت یه افش مجرتم اب ام
An interpreter is coming.	口譯員即將前來。	دیایم دراد یه افش مجرتم
What is your name?	您的姓名是什麼？	تسا یچ امش مبرا
Who is the patient?	哪位是病人？	تسا یسک هج رامیب
Please write the <u>patient's</u> :	請寫下病人的：	ار رامیب هب طوبرم تااعالطانیا افطل دیس یونب
Name	姓名	مان
Address	地址	سر دا
Telephone number	電話號碼	نفلت هرامش
Identification number	識別號碼	یاسانش هرامش
Birth date:	出生日期：	دلوت خیرات
Month/Day/Year	月/日/年	لاس/زور/هام
Now, fill out these forms, please.	現在，請填寫這些表格。	الاح، دینک رب ار اهر ف نی افطل

English	Khmer / ខ្មែរ	Korean / 한국어
Point to a sentence <i>Instructions</i>	ចង្អុលទៅកាន់ប្រយោគ កាត់ណែនាំ	문장 가리키기 안내
<p>We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.</p>	<p>យើងអាចប្រើកាត់ទាំងនេះដើម្បីជួយយើងឱ្យយល់គ្នាទៅវិញទៅមក។ ចង្អុលទៅកាន់ប្រយោគដែលអ្នកចង់ទាក់ទង។ ប្រសិនបើចាំបាច់ យើងនឹងហៅអ្នកបកប្រែតាមក្រោយ។</p>	<p>이 카드를 사용해 서로 의사소통을 할 수 있습니다. 말씀하기를 원하는 문장을 가리켜주세요. 필요한 경우, 나중에 통역사에게 연락하겠습니다.</p>
Courtesy statements	សេចក្តីថ្លែងការណ៍គួរសម	의례적 문장
Please wait.	សូមរង់ចាំ។	기다려주세요.
Thank you.	សូមអរគុណ។	감사합니다.
One moment, please.	សូមរង់ចាំបន្តិច។	잠깐만 기다려주세요.
Patient may say...	អ្នកជម្ងឺប្រហែលជានិយាយ...	환자가 할 수 있는 말...
My name is...	ខ្ញុំឈ្មោះ...	제 이름은입니다.
I need an interpreter.	ខ្ញុំត្រូវការអ្នកបកប្រែបន្តិច។	통역사가 필요합니다.
I came to see the doctor, because...	ខ្ញុំបានទៅជួបគូពេទ្យ ព្រោះ...이유로 의사를 만나러 왔습니다.
I don't understand.	ខ្ញុំមិនយល់ទេ។	이해를 못하겠습니다.
Please hurry. It is urgent.	សូមបញ្ជាប់។ វាជារឿងបន្ទាន់។	빨리 해 주십시오. 긴급합니다.
Where is the bathroom?	តើបន្ទប់ទឹកនៅឯណា?	화장실이 어디죠?
How much do I owe you?	តើខ្ញុំជំពាក់អ្នកប៉ុន្មាន?	제가 얼마를 내야 합니까?
Is it possible to have an interpreter?	តើអាចមានអ្នកបកប្រែដរហូរទេ?	통역사의 도움을 받을 수 있을까요?
Staff may ask or say...	បុគ្គលិកអាចសួរ ឬនិយាយ...	직원이 할 수 있는 질문 또는 말...
How may I help you?	តើខ្ញុំអាចជួយអ្នកតាមរបៀបណា?	어떻게 도와드릴까요?
I don't understand. Please wait.	ខ្ញុំមិនយល់ទេ។ សូមរង់ចាំ។	이해를 못하겠습니다. 기다려주세요.
What language do you prefer?	តើអ្នកចូលចិត្តភាសាអ្វី?	어떤 언어를 원하세요?
We will call an interpreter.	យើងនឹងហៅអ្នកបកប្រែបន្តិច។	통역사에게 연락하겠습니다.
An interpreter is coming.	អ្នកបកប្រែកំពុងតមកហើយ។	통역사가 오는 중입니다.
What is your name?	តើអ្នកឈ្មោះអ្វី?	성함이 무엇이죠?
Who is the patient?	តើនរណាជាអ្នកជំងឺ?	환자분이 누구세요?
Please write the <u>patient's</u> :	សូមសរសេរ របស់អ្នកជំងឺ:	환자분에 관해 다음 사항을 적어주세요.
Name	ឈ្មោះ:	이름
Address	អាសយដ្ឋាន	주소
Telephone number	លេខទូរស័ព្ទ	전화번호
Identification number	អត្តលេខ	ID 번호
Birth date:	ថ្ងៃខែឆ្នាំកំណើត:	생년월일:
Month/Day/Year	ខែ/ថ្ងៃ/ឆ្នាំ	월/일/년
Now, fill out these forms, please.	ឥឡូវនេះ: សូមបំពេញទម្រង់ទាំងនេះ។	이제, 이 양식들을 작성해 주세요.

English	Russian / Русский	Spanish / Español
Point to a sentence	Укажите на предложение	Señalar una frase
<i>Instructions</i>	<i>Инструкции</i>	<i>Instrucciones</i>
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	Мы можем использовать эти карточки, чтобы лучше понимать друг друга. Укажите на предложение, которое вы хотите передать. В случае необходимости, позднее мы пригласим устного переводчика.	Podemos usar estas tarjetas que nos ayudarán a entendernos. Señale la frase que quiera comunicar. Si es necesario, llamaremos a un intérprete más tarde.
Courtesy statements	Знаки вежливости	Frases de cortesía
Please wait.	Подождите, пожалуйста.	Por favor, espere.
Thank you.	Благодарим Вас.	Gracias.
One moment, please.	Подождите минутку, пожалуйста.	Un momento, por favor.
Patient may say...	Пациент может сказать...	El paciente puede decir...
My name is...	Меня зовут...	Mi nombre es...
I need an interpreter.	Мне нужен устный переводчик.	Necesito un intérprete.
I came to see the doctor, because...	Я пришел к врачу, потому что...	Vine a ver al médico porque...
I don't understand.	Я не понимаю.	No entiendo.
Please hurry. It is urgent.	Пожалуйста, поторопитесь. Это срочно.	Por favor, dese prisa. Es urgente.
Where is the bathroom?	Где находится туалет?	¿Dónde está el baño?
How much do I owe you?	Сколько я Вам должен?	¿Cuánto le debo?
Is it possible to have an interpreter?	Возможно ли воспользоваться услугами устного переводчика?	¿Es posible tener un intérprete?
Staff may ask or say...	Персонал может спросить или сказать...	El personal puede preguntar o decir...
How may I help you?	Чем я могу Вам помочь?	¿Cómo puedo ayudarle?
I don't understand. Please wait.	Я не понимаю. Подождите, пожалуйста.	No entiendo. Por favor, espere.
What language do you prefer?	Какой язык Вы предпочитаете?	¿Qué idioma prefiere?
We will call an interpreter.	Мы пригласим устного переводчика.	Vamos a llamar a un intérprete.
An interpreter is coming.	Устный переводчик скоро придёт.	Viene un intérprete.
What is your name?	Как Вас зовут?	¿Cuál es su nombre?
Who is the patient?	Кто пациент?	¿Quién es el paciente?
Please write the <u>patient's</u> :	Пожалуйста, напишите следующую информацию о <u>пациенте</u> :	Escriba la información del <u>paciente</u> :
Name	Полное имя	Nombre
Address	Адрес	Dirección
Telephone number	Номер телефона	Número de teléfono
Identification number	Идентификационный номер	Número de identificación
Birth date:	Дата рождения:	Fecha de nacimiento:
Month/Day/Year	Месяц/День/Год	Mes/Día/Año
Now, fill out these forms, please.	Теперь заполните, пожалуйста, эти формы.	Ahora, llene estos formularios.

English	Tagalog / Tagalog	Vietnamese / tiếng Việt
Point to a sentence	Ituro ang isang pangungusap	Chỉ vào một câu
<i>Instructions</i>	<i>Mga Instruksiyon</i>	<i>Hường dẫn</i>
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	Magagamit natin ang mga card na ito para tulungan tayong maintindihan ang isa't isa. Ituro sa pangungusap na gusto mong sabihin. Kung kailangan, tatawag kami ng isang interpreter mamaya.	Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Chỉ vào câu mà quý vị muốn truyền đạt. Nếu cần, chúng tôi sẽ gọi một thông dịch viên sau đó.
Courtesy statements	Mga pahayag nang may paggalang	Câu nói lịch sự
Please wait.	Mangyaring maghintay.	Vui lòng chờ.
Thank you.	Salamat.	Cảm ơn quý vị.
One moment, please.	Sandali lang.	Vui lòng chờ một chút.
Patient may say...	Maaaring sabihin ng pasyente ang...	Bệnh nhân có thể nói...
My name is...	Ang pangalan ko ay...	Tên tôi là...
I need an interpreter.	Kailangan ko ng isang interpreter.	Tôi cần thông dịch viên.
I came to see the doctor, because...	Pumunta ako para magpatingin sa doktor, dahil...	Tôi đến khám với bác sĩ, vì...
I don't understand.	Hindi ko maintindihan.	Tôi không hiểu.
Please hurry. It is urgent.	Pakibilisan. Apurahan ito.	Vui lòng nhanh lên. Việc này khẩn cấp.
Where is the bathroom?	Nasaan ang banyo?	Nhà vệ sinh ở đâu?
How much do I owe you?	Magkano ang dapat kong bayaran sa iyo?	Tôi nợ quý vị bao nhiêu?
Is it possible to have an interpreter?	Maaari ba akong magkaroon ng isang interpreter?	Có thể yêu cầu một thông dịch viên không?
Staff may ask or say...	Maaaring tanungin o sabihin ng kawani ang...	Nhân viên có thể hỏi hoặc nói...
How may I help you?	Paano kita matutulungan?	Tôi có thể giúp quý vị như thế nào?
I don't understand. Please wait.	Hindi ko maintindihan. Mangyaring maghintay.	Tôi không hiểu. Vui lòng chờ.
What language do you prefer?	Anong wika ang gusto mo?	Quý vị muốn dùng ngôn ngữ nào?
We will call an interpreter.	Tatawag kami ng isang interpreter.	Chúng tôi sẽ gọi một thông dịch viên.
An interpreter is coming.	May darating na isang interpreter.	Một thông dịch viên đang đến.
What is your name?	Ano ang pangalan mo?	Tên quý vị là gì?
Who is the patient?	Sino ang pasyente?	Ai là bệnh nhân?
Please write the <u>patient's</u> :	Pakisulat ang :	Vui lòng viết những thông tin sau đây <u>của bệnh nhân</u> :
Name	Pangalan ng pasyente	Tên
Address	Tirahan ng pasyente	Địa chỉ
Telephone number	Numero ng telepono ng pasyente	Số điện thoại
Identification number	Numero ng pagkakakilanlan ng pasyente	Số nhận dạng
Birth date:	Petsa ng kapanganakan ng pasyente:	Ngày sinh:
Month/Day/Year	Buwan/Araw/Taon	Tháng/Ngày/Năm
Now, fill out these forms, please.	Ngayon, pakisagutan ang mga form na ito.	Bây giờ, vui lòng điền những mẫu đơn này.



L.A. Care
HEALTH PLAN®

For A Healthy Life



Section D: Awareness of Cultural Background and Its Impact on Healthcare Delivery

Section D: Awareness of Cultural Background and Its Impact on Healthcare Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on healthcare. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

- Health Equity, Health Equality and Health Disparities
- Let's Talk About Sex
- Lesbian, Gay, Bisexual or Transgender (LGBT)
- Pain Management Across Cultures
- Cultural Background Information on Special Topics
- Effectively Communicating with the Elderly



Health Equity, Health Equality and Health Disparities

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities...

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division.

Source: www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control.

Source: World Health Organization, www.who.int/healthsystems/topics/equity/en/

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled.

Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. J Epidemiol Community Health 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website www.thinkculturalhealth.hhs.gov, sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), www.thinkculturalhealth.hhs.gov

Think Cultural Health is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of Think Cultural Health is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities.

Source: Offices of Minority minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, minorityhealth.hhs.gov
- Think Cultural Health, www.thinkculturalhealth.hhs.gov

Let's Talk About Sex

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	<ul style="list-style-type: none"> • Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support. 	<ul style="list-style-type: none"> • Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	<ul style="list-style-type: none"> • If a sexual history is requested during a nonrelated illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a “weak liver.” • Be aware that young adults may not be collecting sexual history information as part of preventive care, and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials. 	<ul style="list-style-type: none"> • Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same gender as the patient.
Confidentiality Preferences	<ul style="list-style-type: none"> • Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room. 	<ul style="list-style-type: none"> • It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: “To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information.” • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

Lesbian, Gay, Bisexual or Transgender (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)⁹ may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020¹⁰, LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit www.glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit www.glaad.org for additional resources on how to fairly and accurately report on transgender people.

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- GLMA cultural competence webinar series
- Providing Enhanced Resources Cultural Competency Training
- LGBT Health Resources
- Equal Employment Opportunity Commission for your local EEOC field office
- Creating an LGBT Friendly Practice
- LGBT Training Curricula for Behavioral Health and Primary Care Practitioners
- Preventing Discrimination
- Bullying Policies & Laws

⁹The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person whose gender identity or expression does not match their sex assigned at birth.

¹⁰www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Pain Management Across Cultures

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
<p>Reaction to pain and expression of pain</p>	<ul style="list-style-type: none"> • Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned. 	<ul style="list-style-type: none"> • Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, <i>ask</i> the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
<p>Spiritual and religious beliefs about using pain medication</p>	<ul style="list-style-type: none"> • Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM. 	<ul style="list-style-type: none"> • Consulting with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
<p>Beliefs About Drug Addiction</p>	<ul style="list-style-type: none"> • Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the medications and doses have changed. 	<ul style="list-style-type: none"> • Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

Areas of Cultural Variation	Points to Consider	Suggestions
Use of Alternative Pain relief Treatment	<ul style="list-style-type: none"> Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture or breathing exercises. 	<ul style="list-style-type: none"> Respectfully inquire about all of the ways the patient is treating their pain. Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is “safe” to talk about them. Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	<ul style="list-style-type: none"> Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful. 	<ul style="list-style-type: none"> Ask the patient specifically how they can best describe their pain. Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as “like a burn from a stove,” “cutting with a knife,” or “stepping on a stone,” may produce a more accurate description.

Note:

- **Avoid** using family members as interpreters.
- **Minors** are **prohibited** from being used as interpreters.
- Find an interpreter with a health care background.
- **Document** in the patient’s medical chart the request for or refusal of an interpreter.

Cultural Background Information on Special Topics

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.
- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and “medicines” that are considered “folk” medicine or “herbal” medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about **“alternative,” “traditional,” “folk,” or “herbal” medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact, it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.
- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, “chubby” children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby’s general health.
 - Among traditional Hmong, saying a baby is “pretty” or “cute” may be seen as a threat because of fears that spirits will be attracted to the child and take it away
 - Some traditional Latinos will avoid praise to avoid attracting the “evil eye”
 - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother’s care – “the baby looks like you take care of him well.”
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child’s experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient respond to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.
- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable here, and what may cause physical harm.
- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse not because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.
- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.
- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.
- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.
- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case, you should not draw attention to this issue but seek out other methods of communication.

Effectively Communicating with the Elderly

Older Adult Communication from Your Patients Perspective	
I Wish You Knew...	I Wish You Would Do...
<i>I want to be respected and addressed formally. I appreciate empathy.</i>	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as “honey, dear” and baby talk. Be empathetic and try to see through my lens.
<i>I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.</i>	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
<i>I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.</i>	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
<i>I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.</i>	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions*)
<i>Medical jargon and acronyms confuse me.</i>	Use layperson language, not acronyms or popular slang terms.
<i>I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.</i>	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
<i>Nodding my head doesn't always mean I understand,</i>	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
<i>I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.</i>	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
<i>Some topics such as advance directives or a terminal prognosis are very sensitive for me.</i>	<p>Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me.</p> <p>Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.</p>

* Kleinman's 8 Questions

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a long or a short course?
6. What kind of treatment do you think the patient should receive?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

Resources

- The Gerontological Society of America: aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association: www.asha.org
- Administration for Community Living DHHS: www.acl.gov
- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program
nursing.uc.edu/advantage/aging_with_dignity/Look_Closer_See_Me.html.html



L.A. Care
HEALTH PLAN®

For A Healthy Life



Section E: References and Resources

Section E: References and Resources

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report *Unequal Treatment* that intersect to perpetuate health disparities (IOM, 2003).¹¹

Health Equity & Culturally and Linguistically Appropriate Services Are Connected

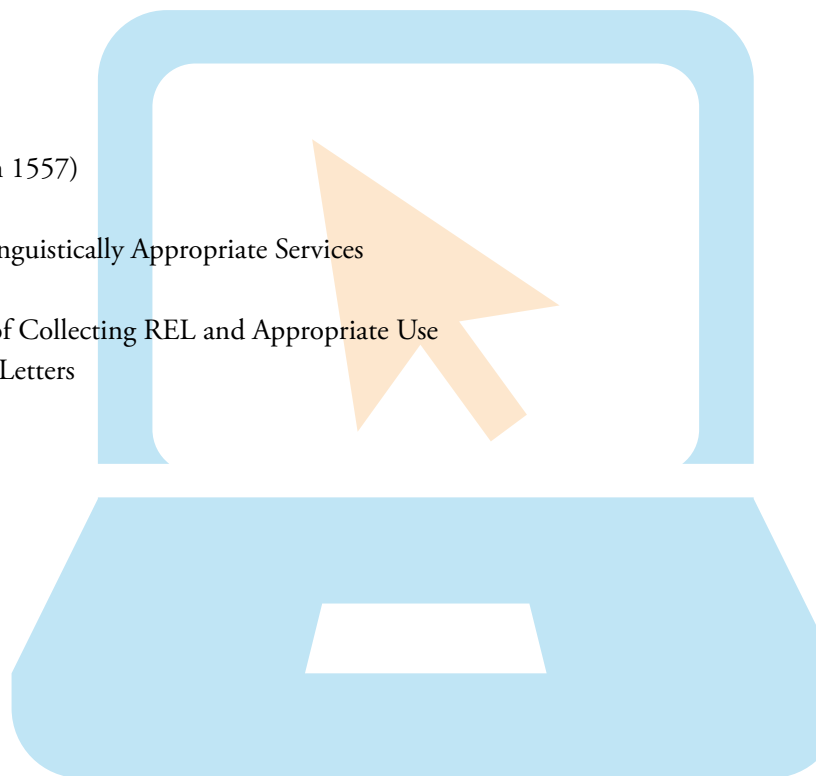
Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.¹

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

The following materials are available in this section:

- 45 CFR 92, Non-Discrimination Rule
- Title VI of the Civil Rights Act of 1964
- Section 1557 of the Affordable Care Act of 2010 (Section 1557)
- Americans with Disabilities Act of 1990
- National Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services
- Executive Order 13166, August 2000
- Race/Ethnicity/Language (REL) Categories Importance of Collecting REL and Appropriate Use
- Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters



¹¹www.thinkculturalhealth.hhs.gov

45 CFR 92, Non Discrimination Rule

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

Title VI of the Civil Rights Act of 1964

“No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”

Under Title VI, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring “meaningful access” to healthcare, and “equal care” for all patients. Other federal and state legislation protecting the right to “equal care” outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued “Policy Guidance on the Prohibition against National Origin Discrimination as it Affects Persons with Limited English Proficiency.” This policy established ‘national origin’ as applying to limited English-speaking recipients of federally funded programs.

Section 1557 of the Affordable Care Act of 2010 (Section 1557)

Ensuring Meaningful Access for Individuals with Limited English Proficiency

Section 1557 is the civil rights provision of the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the grounds of race, color, national origin, sex, age, or disability in certain health programs and activities. The Section 1557 final rule applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments; the Health Insurance Marketplaces and issuers that participate in those Marketplaces; and any health program that HHS itself administers.

Protections for Individuals with Limited English Proficiency

- Consistent with longstanding principles under civil rights laws, the final rule makes clear that the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities' health programs and activities.
 - An individual with limited English proficiency is a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.
 - Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translation.
 - The standards in the final rule are flexible and context-specific, taking into account factors such as the nature and importance of the health program and the communication at issue, as well as other considerations, including whether an entity has developed and implemented an effective language access plan.
- Covered entities are required to post a notice of individuals' rights providing information about communication assistance for individuals with limited English proficiency, among other information.
- In each state, covered entities are required to post taglines* in the top 15 languages spoken by individuals with limited English proficiency in that state that indicate the availability of language assistance.
- Covered entities are prohibited from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.

Covered entities are encouraged to develop and implement a language access plan to ensure they are prepared to take reasonable steps to provide meaningful access to each individual that may require assistance.

Protections for Individuals with Disabilities

- Consistent with existing requirements, Section 1557 requires covered entities to take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others. Section 1557 also requires covered entities to provide appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, where necessary for effective communication.
- Covered entities must post a notice of individuals' rights, providing information about communication assistance among other information.
- Covered entities are required to make all programs and activities provided through electronic and information technology accessible to individuals with disabilities, unless doing so would impose undue financial or administrative burdens or would result in a fundamental alteration in the nature of the covered entity's health program or activity.
- Section 1557 incorporates the 2010 Americans with Disabilities Act Standards for Accessible Design as the standards for physical accessibility of new construction or alteration of buildings and facilities. Almost all covered entities are already required to comply with these standards.
- Covered entities cannot use marketing practices or benefits designs that discriminate on the basis of disability.
- Covered entities must make reasonable changes to policies, practices and procedures where necessary to provide equal access for individuals with disabilities unless the covered entity can demonstrate that making the changes would fundamentally alter the nature of the health program or activity.

*Below is a sample of a tagline in 16 languages, including English, for the Medi-Cal line of business.

English	Free language assistance services are available. You can request interpreting or translation services, information in your language or in another format, or auxiliary aids and services. Call L.A. Care at 1.888.839.9909 (TTY 711), 24 hours a day, 7 days a week, including holidays. The call is free.
Spanish	Los servicios de asistencia de idiomas están disponibles de forma gratuita. Puede solicitar servicios de traducción e interpretación, información en su idioma o en otro formato, o servicios o dispositivos auxiliares. Llame a L.A. Care al 1.888.839.9909 (TTY 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.
Arabic	خدمات المساعدة اللغوية متاحة مجاناً. يمكنك طلب خدمات الترجمة الفورية أو الترجمة التحريرية أو معلومات بلغتك أو بتتسيق آخر أو مساعدات وخدمات إضافية. اتصل بـ L.A. Care على الرقم 1.888.839.9909 (TTY 711) على مدار الساعة وطوال أيام الأسبوع، بما في ذلك أيام العطلات. المكالمات مجانية.
Armenian	Տրամադրելի են լեզվական օգնության անվճար ծառայություններ: Կարող եք խնդրել բանավոր թարգմանչական կամ թարգմանչական ծառայություններ, Ձեր լեզվով կամ տարբեր ձևաչափով տեղեկություն, կամ օժանդակ օգնություններ և ծառայություններ: Զանգահարեք L.A. Care 1.888.839.9909 համարով (TTY 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոնական օրերը: Այս հեռախոսազանգն անվճար է:
Chinese	提供免費語言協助服務。您可申請口譯或翻譯服務，您使用之語言版本或其他格式的資訊，或輔助援助和服務。請致電 L.A. Care 電話 1.888.839.9909 (TTY 711)，服務時間為每週7天，每天24小時（包含假日）。上述電話均為免費。
Farsi	خدمات رایگان امداد زبانی موجود می باشد. می توانید برای خدمات ترجمه شفاهی یا کتبی، اطلاعات به زبان خودتان یا فرمت دیگر، یا امدادها و خدمات اضافی درخواست کنید. با L.A. Care شماره 1.888.839.9909 (TTY 711) در 24 ساعت شبانه روز و 7 روز هفته شامل روزهای تعطیل تماس بگیرید. این تماس رایگان است.
Hindi	मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। आप दुभाषिया या अनुवाद सेवाओं, आपकी भाषा या किसी अन्य प्रारूप में जानकारी, या सहायक उपकरणों और सेवाओं के लिए अनुरोध कर सकते हैं। आप L.A. Care को 1.888.839.9909 (TTY 711) नंबर पर फ़ोन करें, दिन में 24 घंटे, सप्ताह में 7 दिन, छुट्टियों सहित। कॉल मुफ्त है।
Hmong	Muaj kev pab txhais lus pub dawb rau koj. Koj tuaj yeem thov kom muab cov ntaub ntauw txhais ua lus lossis txhais ua ntauw rau koj lossis muab txhai ua lwm yam lossis muab koom pab thiab lwm yam kev pab cuam. Hu rau L.A. Care ntawm tus xov tooj 1.888.839.9909 (TTY 711), tuaj yeem hu tau txhua txhua 24 teev hauv ib hnub, 7 hnub hauv ib vij thiab suab nrog cov hnub so tib si, tus xov tooj no hu dawb xwb.
Japanese	言語支援サービスを無料でご利用いただけます。通訳・翻訳サービス、日本語や他の形式での情報、補助具・サービスをリクエストすることができます。L.A. Careまでフリーダイヤル 1.888.839.9909 (TTY 711)にてご連絡ください。祝休日を含め毎日24時間、年中無休で受け付けています。
Khmer	សេវាជំនួយខាងភាសា គឺមានដោយឥតគិតថ្លៃ។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ ឬការបកប្រែ រឿងរ៉ាវព័ត៌មាន ជាភាសាខ្មែរ ឬជាទម្រង់មួយទៀត ឬជំនួយប្រាំមួយ និងសេវា។ ទូរស័ព្ទទៅ L.A. Care តាមលេខ 1.888.839.9909 (TTY 711) បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃ មួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។ ការហៅនេះគឺឥតគិតថ្លៃឡើយ។
Korean	무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하는 통역 또는 번역 서비스, 귀하가 사용하는 언어 또는 기타 다른 형식으로 된 정보 또는 보조 지원 및 서비스 등을 요청하실 수 있습니다. 공휴일을 포함해 주 7일, 하루 24시간 동안 L.A. Care, 1.888.839.9909 (TTY 711)번으로 문의하십시오. 이 전화는 무료로 이용하실 수 있습니다.
Lao	ພາສາອັງກິດ ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ ຫຼື ຕອບພາສາໄດ້, ສຳລັບຂໍ້ມູນໃນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນ, ຫຼື ເຄື່ອງມືຊ່ວຍເຫຼືອ ດຸ່ວະ ບໍລິການເສີມ. ໃຫ້ໂທຫາ L.A. Care ໄດ້ທີ 1.888.839.9909 (TTY 711), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ, ວອມເຖິງວັນພັກຕ່າງໆ. ການໂທແມ່ນບໍ່ເສຍຄ່າ.
Panjabi	ਪੰਜਾਬੀ: ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਤੁਸੀਂ ਦੁਆਰਾ ਸੇਵਾਵਾਂ, ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਸਹਾਇਕ ਉਪਕਰਣਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। L.A. Care ਨੂੰ 1.888.839.9909 (TTY 711) ਨੰਬਰ ਉੱਤੇ ਕਾਲ ਕਰੋ, ਇੱਕ ਦਿਨ ਵਿੱਚ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚ 7 ਦਿਨ, ਛੁੱਟੀਆਂ ਸਮੇਤ। ਕਾਲ ਮੁਫਤ ਹੈ।
Russian	Мы предоставляем бесплатные услуги перевода. У Вас есть возможность подать запрос о предоставлении устных и письменных услуг перевода, информации на Вашем языке или в другом формате, а также вспомогательных средств и услуг. Звоните в L.A. Care по телефону 1.888.839.9909 (TTY 711) 24 часа в сутки, 7 дней в неделю, включая праздничные дни. Этот звонок является бесплатным.
Tagalog	Available ang mga libreng serbisyo ng tulong sa wika. Maaari kang humiling ng mga serbisyo ng pag-interpret o pagsasalang-wika, impormasyon na nasa iyong wika o nasa ibang format, o mga karagdagang tulong at serbisyo. Tawagan ang L.A. Care sa 1.888.839.9909 (TTY 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga holiday. Libre ang tawag.
Thai	มีบริการช่วยเหลือภาษาฟรี คุณสามารถขอรับบริการการแปลหรือล่าม ข้อมูลในภาษาของคุณหรือในรูปแบบอื่น หรือความช่วยเหลือและบริการเสริมต่าง ๆ ได้ โทร L.A. Care ที่ 1.888.839.9909 (TTY 711) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์รวมทั้งวันหยุด โทรฟรี
Vietnamese	Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Quý vị có thể yêu cầu dịch vụ biên dịch hoặc phiên dịch, thông tin bằng ngôn ngữ của quý vị hoặc bằng các định dạng khác, hay các dịch vụ và thiết bị hỗ trợ ngôn ngữ. Xin vui lòng gọi L.A. Care tại 1.888.839.9909 (TTY 711), 24 giờ một ngày, 7 ngày một tuần, kể cả ngày lễ. Cuộc gọi này miễn phí.

Americans with Disabilities Act of 1990

The Americans with Disabilities Act (ADA) of 1990 is a law that protects people with disabilities from being treated unfairly. A disability is a physical or mental condition that totally or seriously limits a person's ability in at least one major life activity. This law protects people who:

- Are any age, including seniors (65 years of age or older), who have disabilities
- Have disabilities such as hearing, speech or vision loss, developmental disabilities and other types of disabilities
- May not look like they have a disability or had a disability in the past

The ADA law makes sure there are equal chances for people with disabilities in employment and in state and local government services, including healthcare. The ADA requires public entities to take appropriate steps to ensure effective communication with individuals with disabilities, including the provision of auxiliary aids and services.

Here are some telephone numbers that can help you if you have a disability or want more information about the Americans with Disabilities Act (ADA):

ADA Information Line:

1.800.514.0301 (Voice) or

1.800.514.0383 (TTY/TDD)

National Standards to Provide “CLAS” Culturally and Linguistically Appropriate Services

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate **policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Executive Order 13166, August 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Sec. 1 Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON
THE WHITE HOUSE

Office of the Press Secretary
(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: www.justice.gov/crt/executive-order-13166

Race/Ethnicity/Language (REL) Categories Importance of Collecting REL and Appropriate Use

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.

The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other"

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown," "Unable to complete," or "Other."

Source: <https://www.whitehouse.gov/omb/federal-register/>

Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters

Medi-Cal Managed Care communicates with Medi-Cal managed care contractors and Duals Plans participating in the Dual-Eligible Demonstration Project, by means of All Plan, Policy, and Duals Plan Letters.

- All Plan Letters (APLs) are the means by which Medi-Cal Managed Care Division (MMCD) conveys information or interpretation of changes in policy or procedure at the Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis.
- Policy Letters (PLs) provide instruction to contractors about changes in Federal or State law and Regulation that affect the way in which they operate, or deliver services to Medi-Cal beneficiaries.
- The Dual Plan Letters (DPLs) convey information or interpretation of changes in policy or procedure at the Federal or State levels, and about changes in Federal or State law and Regulations. DPLs provide instruction to Dual Plans, if applicable on how to implement these changes on an operational basis, and about how Federal or State law affect the way in which they operate, or deliver services to dual-eligible beneficiaries.

Below is a list of Cultural and Linguistic notices:

- PL 99-001 – Community Advisory Committee (CAC)
- APL 99-005 – Cultural Competency in Health Care - Meeting the Needs of a Culturally and Linguistically Diverse Population
- APL 02-003 – Cultural and Linguistic Contractual Requirements: Threshold and Concentration Standard – Languages Update
- APL 14-008 – Standards for Determining Threshold Languages
- APL 17-011 – Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
- APL 17-002 – Health Education and Cultural and Linguistic Group Needs Assessment (GNA)
- PL 10-012 – Health Education and Cultural and Linguistic Group Needs Assessment (GNA)
- PL 99-002 – Health Education and Cultural and Linguistic Group Needs Assessment (GNA)
- PL 99-003 – Linguistic Services
- PL 99-004 – Translation of Written Informing Materials

These are available for download on the California Department of Health Care Services (DHCS) website: www.dhcs.ca.gov/formsandpubs/Pages/MMCDAPLPLSubjectListing.aspx. If you have questions concerning a specific All Plan, Policy, or Duals Plan Letter, please call **916.449.5000**.

Bibliography of Major Sources Used in the Production of the Toolkit

- Aguirre-Molina, M., et al. (2001). *Health Issues in the Latino Community*. San Francisco: Jossey-Bass.
- Avery, C. (1991). Native American Medicine: Traditional Healing. *JAMA*, 265, 2271-2273.
- Baer, H. (2001). *Biomedicine and Alternative Healing Systems in America*. Madison, WI: University of Wisconsin Press.
- Bonder, B., Martin, L., & Miracle, A. (n.d.) *Culture in Clinical Care*. Thorofare, NJ: SLACK, Inc.
- Carillo, J.A., Green., & J. Betancourt. (1999). Cross-Cultural Primary Care: A patient-based approach. *Annals of Internal Medicine*, 130, 829-834.
- California Healthcare Interpreters Association & CHIA Standards and Certification Committee (Eds.). *California Standards for Healthcare Interpreters: Ethical Principal, Protocols, and Guidance on Roles and Interventions*. Oxnard, CA: The California Endowment.
- Cross, T., Dennis, KW., et al. (1989). *Towards a Culturally Competent System of Care*. Washington, DC: Georgetown University.
- Doak, C., et al. (1996). *Teaching Patients with Low Literacy Skills*. Philadelphia: J.B. Lippincott Co.
- Duran, D., et al. (Eds.). (2001). *A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics*. Washington D.C.: National Alliance for Hispanic Health.
- Fadiman, A. (1997). *The Spirit Catches You and You Fall Down*. New York: Farrar, Strauss & Giroux.
- Galanti, G. (1997). *Caring for Patients from Different Cultures*. Pennsylvania, PA: University of Pennsylvania Press.
- Goodman, A., et al. (2000). *Nutritional Anthropology: Biocultural Perspectives on Food and Nutrition*. Mountainview, CA: Mayfield Publishing Company.
- Hall, E.T. (1985). *Hidden Differences: Studies in International Communication*. Hamburg, Germany: Gruner & Jahr.
- Hall, E.T. (1990). *Understanding Cultural Differences*. Yarmouth, ME: Intercultural Press.
- Harwood, A. (Eds.). (1981). *Ethnicity and Medical Care*. Cambridge, MA: Harvard University Press.
- ddtp.cpuc.ca.gov/homepage.aspx
- definitions.uslegal.com
- en.wikipedia.org/wiki/Limited_English_proficiency
- minorityhealth.hhs.gov
- minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf
- minorityhealth.hhs.gov/npa
- Kaiser Permanente National Diversity Council. (1999). *Provider's Handbook on Culturally Competent Care*. Oakland, CA: Kaiser Permanente.
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.
- Kleinman, A. (1990). *Illness Narratives*. New York: Perseus Publishing.
- Kleinman, A., & Good, B. (Eds.). (1985). *Culture and Depression*. Berkeley, CA: University of California Press.

- Leslie, C., & Young, A. (Eds.). (1992). *Paths to Asian Medical Knowledge*. Berkeley, CA: University of California Press.
- Leigh, JW. (1998). *Communicating for Cultural Competence*. New York: Allyn and Bacon. Lipson, J., Dibble, S., et al. (Eds.). (1996). *Culture and Nursing Care: A Pocket Guide*. San Francisco: UCSF Nursing Press.
- O'Conner, B. (1995). *Healing Traditions: Alternative Medicine and the Health Professions*. Philadelphia: University of Pennsylvania Press.
- Office of Minority Health, Department of Health and Human Services (2000). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes focused research agenda* (Federal Register Volume 65, No. 247, pp. 80865-80879).
- Office of Minority Health, Department of Health and Human Services (2001). *National standards for culturally and linguistically appropriate services in health care: Final Report*.
- Purnell, L.D., & Paulanka, B.J. (1998). *Transcultural Health Care: A Culturally Competent Approach*. Philadelphia, PA: F.A. Davis Company.
- Salimbene, S. (2000). *What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Care*. Northampton, MA: Inter-Face International, Inc.
- Smedley, B., Stith, A., & Nelson, A. (Eds.). (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press.
- Spector, R. (1996). *Cultural Diversity in Health and Illness: a Guide to Heritage Assessment and Health Traditions*. Boston: Appleton & Lange.
- Spector, R. (2000). *Cultural Diversity in Health and Illness*. Upper Saddle, NJ: Prentice Hall Health.
- U.S. Code. (1964). Title VI of the Civil Rights Act of 1964. Title 42 - The Public Health and Welfare. 42 U.S.C. § 2000d et seq.
- Walzer, J. (2002, May 2). *The Health of Hispanic Elders: The Intersection of Nutrition, Culture and Diabetes*. Tufts Nutrition. Centers for Medicare and Medicaid Services. The Medicare Advantage Organization National QAPI Project for 2003. (2004).
- Department of Health and Human Services Centers for Medicare & Medicaid Services. Operational Policy Letter #: OPL 2001.133. July 16, 2001.
- www.ada.gov/effective-comm.htm
- www.ahrq.gov/cpi/about/index.html: Oral, Linguistic, and Culturally Competent Services: Guides for Managed Care Plans. Agency for Healthcare Research and Quality. Rockville, MD. (2003).
- www.ama-assn.org/about/ama-foundation
- www.floridablue.com: Blue Cross and Blue Shield of Florida. Healthy People 2010. (2002).
- www.bphc.org: Culturally and Linguistically Appropriate Standards of Care. As approved by the Boston HIV Health Services Planning Council on January 11, 2001.
- www.differencebetween.net/language/difference-between-equity-and-equality
- www.dictionary.com/browse/teletypewriter?s=t
- www.ecfr.gov/cgi-bin/text-idx?node=sp45.1.92.c#se45.1.921201

www.msh.org: Management Sciences for Health. Culturally Competent Organizations. CLAS Standards. (2003).

www.glma.org

www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

www.lep.gov: Department of Justice, Civil Rights Division, Executive Order 13166. Information and Guidance for Recipients of Federal Funds on Language Access to Federally Assisted Programs and Activities. (2003).

www.ihl.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

www.thinkculturalhealth.hhs.gov/

www.thinkculturalhealth.hhs.gov/clas/standards

www.justice.gov/crt/executive-order-13166: Department of Justice, Civil Rights Division, Executive Order 13166. Improving Access to Services for Persons with Limited English Proficiency. Verbatim as released by the Office of the Press Secretary, The White House (August 11, 2000).

www.whitehouse.gov/omb/federal-register/

www.who.int/healthsystems/topics/equity/en/

Please refer to the “Web Resources” page of this toolkit to find the internet resources that informed the work of the Committee.

Cultural Competence Web Resources

U.S. Department of Health and Human Services - Think Cultural Health
www.thinkculturalhealth.hhs.gov

Diversity RX
diversityrx.org/resources

Institute for Healthcare Improvement
www.ihl.org/Pages/default.aspx

U.S. Department of Health and Human Services - Office of Minority Health
www.minorityhealth.hhs.gov

Cross Cultural Health Care Program
xculture.org

National Institute of Health
www.nih.gov

U.S. Department of Health and Human Services – Health Resources and Services Administration
www.hrsa.gov/culturalcompetence/index.html

Provider's Guide to Quality & Culture
www.msh.org/resources/providers-guide-to-quality-culture

U.S. Department of Justice – Civil Rights Division
www.justice.gov/crt

National Center for Cultural Competence – Georgetown University
nccc.georgetown.edu

Industry Collaboration Effort (ICE)
iceforhealth.org/aboutice.asp

Remember, web pages can expire often. If the web address provided does not work, use a search engine and search under the organization's name.

This information is intended for educational purposes only, and should not be interpreted as medical advice. Please consult your doctor for advice about changes that may affect your health.

Linkage to the websites listed is for educational purposes only and is not intended as a particular endorsement of any organization.

Glossary of Terms

Alternative Format

A format of written materials that includes larger size print, Braille, and audio, for people with low or no vision, cognitive disabilities, or low literacy.

American Sign Language (ASL)

A nonverbal method of communication with deaf and hard-of-hearing patients where hands and fingers are used to indicate words and concepts.

Audio

A type of an alternative format provided as an audio recording.

Bilingual

An individual who is able to use more than one language to communicate directly with patients in a language other than English.

Braille

A type of an alternative format allowing to access information by touch.

California Relay Service (CRS)

A telephonic system that allows to communicate with patients who have a hearing or speech impairment through a relay operator.

Complaint (Grievance)

A patient's verbal or written expression of dissatisfaction about L.A. Care, a provider, or the quality of care or services provided. A complaint is the same as a grievance.

Cultural Competence

Sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. A professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

Shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Department of Health Care Services (DHCS)

The state agency that is responsible for administration of the federal Medicaid (referred to Medi-Cal in California) Program.

Disability

Any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

1. The process of distinguishing or differentiating.
2. An unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

1. of a different kind, form, character, etc.; unlike.
2. Including representatives from more than one social, cultural, or economic group, especially patients of ethnic or religious minority groups.

Ethnicity

A shared culture and way of life, especially reflected in language, religion and material culture products.

Health Literacy

1. The ability to understand the causes, prevention, and treatment of disease.
2. The degree of communication that enhances people's related information.

Interpreter

A qualified professional individual who converts one spoken (or sign) language into another spoken (or sign) language.

Interpreting Services

Coordination of efforts to provide language appropriate services that can encompass telephonic, face-to-face interpreting and utilize various assistive technologies in order to assist patients to communicate effectively with health care providers.

Large Print

A type of an alternative format where a document is printed in larger text than normal.

Limited English Proficient (LEP) Patients

Patients who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

Member Services Department

An L.A. Care department that is responsible for answering patients' questions about membership, benefits, grievances, and appeals.

Teletypewriter (TTY)

An assistive device that enables a patient with hearing or speech loss to contact, or be contacted by an entity with the assistive device in which communication can be typed and read by either party similar to a typewriter or computer.

Threshold Languages

Primary languages spoken by Limited English Proficiency (LEP) populations meeting a numeric threshold.

Translator

A qualified professional individual who converts one written language into another written language.

Acknowledgements – Cultural and Linguistics Work Group

The ICE for Health Cultural and Linguistic Work Group would like to acknowledge the individuals listed below for the knowledge they shared in the creation of the materials for the tool kit. Each member contained in this kit. Each member contributed their time, experience and skills to the process of developing and testing the resources contained in this kit.

<p>Peggy Payne MA, CDE ICE C&L Chair, Editor coordinator/team Director of Diversity & Mbr. Ed. SCAN Health Plan® Long Beach, CA 90801</p>	<p>Margie Akin, PhD Editor team Cultural and Linguistic Specialist Molina Health Care, Colton, CA Associate Research Anthropologist University of California, Riverside</p>	<p>Lee Kervin C&L Program Specialist Blue Cross of California Camarillo, CA 93012</p>	<p>Sunny Pak Project Manager National L&C Programs National Diversity Kaiser Permanente Oakland, CA 94612</p>
<p>Diana Carr, MA Tool Kit Work Group Chair, Editor coordinator/team Cultural and Linguistic Specialist Health Net of California, Inc. Glendale, CA 91106</p>	<p>Claudia Brauer Editor team/layout Senior Quality Compliance Analyst Blue Cross and Blue Shield of Florida Miami, FL 33122</p>	<p>Lisa M. Kregel, MBA, Manager, Geriatric Research & Health Ed. Dep. of Healthcare Informatics SCAN Health Plan Long Beach CA 90801 5616</p>	<p>Susana Razo MPA, Health Education & Cultural and Linguistic Manager Santa Clara Family Health Plan San Jose, CA</p>
<p>Nhu-Hao T. Duong, MBA Tool Kit Team Lead Director, Customer Service CalOptima Orange, CA 92868</p>	<p>Amy Bussian Bennett Director, Medicare/Medicaid Blue Cross and Blue Shield Association Chicago, IL 60601</p>	<p>Elizabeth Le Editor team Manager Customer Service CalOptima Orange, CA 92868</p>	<p>Silvana Ricci RN, BA HSA, CPHQ, Quality Improvement Specialist Santa Clara Family Health Plan San Jose, CA</p>
<p>Janie Tyre MPA Tool Kit Team Lead VP Marketing and Mbr. Services Santa Clara Family Health Plan San Jose, CA</p>	<p>Smita S. Dandekar Clinical Research Manager Blue Cross of California Woodland Hills, CA 91367</p>	<p>Jerilou Livingston Independence Blue Cross, Philadelphia Philadelphia, PA 19103</p>	<p>Nancy Rodriguez, BSN, RN, CPHQ, PAHM – Sr. Quality Mgmt. Compliance Specialist Blue Cross Blue Shield of Georgia Atlanta, GA 30326</p>
<p>Regina Ziashari, MPH, CHES Tool Kit Team Lead Cultural & Linguistics Specialist Care1st Health Plan Alhambra, CA 91803</p>	<p>Sandi Deckinger, MPA, RN Quality Assessment Director Chinese Community Health Plan San Francisco, CA 94133</p>	<p>Gloria Orellana, MPH Manager of Health Ed. and C&L Services Universal Care Signal Hill, CA 90755</p>	<p>Philip Smeltzer HealthNow NY Buffalo, NY 14240</p>
<p>Tina Vu Senior Health Education/C&L Coordinator UHP Healthcare Inglewood, CA 90303</p>	<p>Nancy C. Walker Manager, QI Blue Cross of California Walnut Creek, CA 94596</p>		

The 2016 ICE Cultural and Linguistic Focus Group would like to acknowledge the individuals listed below for the knowledge they shared in the creation of additional materials for the tool kit. Each member contributed their time, experience and skills to the process of developing and testing the additional resources added to this kit.

<p>Peggy Payne MA, CDE ICE C&L Co-Chair, Editor coordinator/team Director, Health Equity Strategy</p> <p>Cigna Irvine, CA 92614</p>	<p>Lali (Eulalia) Witrigo, MPH Tool Kit Team Co-Lead Sr. Cultural and Linguistics Consultant</p> <p>Health Net of California, Inc. Fresno, CA 93711</p>	<p>Valencia Walker CTT+ Tool Kit Team Co-Lead Manager of Language Assistance Services</p> <p>Cigna Glendale, CA 91203</p>
<p>Diana Carr, MA ICE C&L Co-Chair Editor coordinator/team</p> <p>Medical Anthropologist Health Net of California, Inc. Glendale, CA 91203</p>	<p>Amanda Cruz Editor Team Business Project Analyst Language Assistance Program Compliance</p> <p>Cigna Glendale, CA 91203</p>	<p>Virginia Cullop Editor Team Commercial/Marketplace Liaison Multicultural Health Programs</p> <p>Anthem Richmond, VA</p>
<p>Bradley Bonilla, MPH, CHES Patient Experience Supervisor</p> <p>SynerMed Monterey Park, CA 91754</p>	<p>Jodi Cohn, Director Research and Planning, Health Care Services</p> <p>SCAN Health Plan Long Beach, CA, 90806</p>	<p>Kristen Barela Health Education Specialist SCAN</p> <p>Health Plan Long Beach, CA, 90806</p>
<p>Jane Lears Multicultural Health Programs</p> <p>Anthem Inc.</p>	<p>Cassandra Caravello, MPH Program Manager, Population Health</p> <p>San Francisco Health Plan San Francisco, CA 94105</p>	<p>Gloria Orellana-Frankhan, MPH Director, Health Education and Cultural & Linguistic Services</p> <p>CareMore Cerritos, CA 90703</p>
<p>Terri Amano, MPH Director, Multicultural Health Programs</p> <p>Anthem Inc.</p>	<p>Nicole C. Rodriguez, MPH Multicultural Health Programs</p> <p>Anthem Inc.</p>	<p>Angela Seney Multicultural Health Programs</p> <p>Anthem Inc.</p>
<p>Sydney Lee Design/Layout Lead Director, Quality Management</p> <p>LIBERTY Dental Plan Irvine, CA 92602</p>	<p>Crystal Tran Design/Layout Coordinator Health Ed/ Cultural Competency Coordinator</p> <p>LIBERTY Dental Plan Irvine, CA 92602</p>	<p>Sandra M. Bello, MPH Health Equity Sr. Specialist</p> <p>Cigna Glendale, CA 91203</p>