Caring for Diverse Populations

Better communication, better care:
A toolkit for Healthy Blue physicians and health care professionals

BlueCross BlueShield of North Carolina | Healthy **Blue**

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Introduction for Healthy Blue Health Care Professionals

Why was this toolkit created? How can it help my practice?

This set of materials was produced by a team of health care professionals from across the country who, like you, are dedicated to providing quality, effective and compassionate care to their patients. Changes in U.S. demography, in our awareness of differences in individual belief and behavior, and new legal mandates continuously present new challenges to deliver access to health care to a diverse patient population. This toolkit was developed to provide you with resources to help address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates.

The toolkit contents are organized into several sections, each containing helpful background information and tools that can be reproduced and used as needed.

Here is a list of the section topics, including a section overview and a small sample of the contents:

Resources to assist with a diverse patient population 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 nonthreatening and comfortable to 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. This section includes tips for providers and their clinical staff, a mnemonic to assist with diverse patient interviews, help in identifying literacy problems, an interview guide for hiring clinical staff with awareness of cultural competency issues, and *Americans with Disabilities Act* (*ADA*) requirements.

Resources to communicate 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, which can lead to poor health outcomes and longer hospital stays. This section contains tools to help improve the linguistic competence of health care providers, including tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and an employee language prescreening tool.

Resources to increase awareness of how cultural background impacts health care 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 tools in this section are intended to help you review and consider important factors that may have an impact on health care. 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. Section content includes tips for talking with a wide range of people across cultures about a variety of culturally sensitive topics and information about health care beliefs of various cultural backgrounds.

Regulations and standards for cultural and linguistic services

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care. This section includes key legal requirements such *45 CFR 92 – Nondiscrimination Rule*, and a summary of the *Culturally and Linguistically Appropriate Service (CLAS) Standards*, which serve as a guide on how to meet legal requirements, as well as race/ethnicity/language categories.

Resources for cultural and linguistic services

This section contains web-based resources for more information related to diversity, cultural competency and the delivery of cultural and linguistic services, resources for conducting an assessment of the cultural and linguistic needs of your practice's patient population, and links to additional tools in multiple languages and/or written for LEP.

This toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) 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 ICE Workgroup may be obtained at **www.iceforhealth.org**.

Improving Communications with a Diverse Patient Base

Tips for successful encounters with diverse patients

To enable effective 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 him or her more comfortable.

- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended when a patient interrupts you if no offense is intended.

- 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 can be tied to cultural background and life experience.

- Most non-Hispanic whites 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 patients seem uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body language

Experts say that 65% of communication is nonverbal.[1] 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 he or she 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.

Note:
1 Adetunji, Raji & Sze, Koh. (2012). Understanding Non-Verbal Communication across Cultures: A Symbolic Interactionism Approach.

Tips for providers and office staff to enhance communication with diverse patients

Recognize that patients from diverse backgrounds may have different communication needs.

Build rapport with the patient.

- Address patients by their last names. 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* and *thank you*.

- Recognize that patients from diverse backgrounds may have different communication needs.

- Explain to the patient the different roles performed by people who work in the office.

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 provider arranges for care (when the provider is the first point of contact and then refers to specialists).

- Have instructions translated by a professional translator and available in the common language(s) spoken by your patient base.

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 provider, review health materials or view waiting room videos.

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.

Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.

- Have a plan for interpreter access. An interpreter with a medical background is preferred, rather than family or friends of the patient.

- Assess your bilingual staff for interpreter abilities. (See *Employee Language*.)

- Resources for interpreter services are available from health plans, the state health department and the internet.

Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base.

- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss.

Make sure patients know what to do.

- Review any follow-up procedures with the patient and family 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 preprinted simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base.

  Note: See commonly used sentences and signs provided in this toolkit.

Nonverbal communication and patient care

Nonverbal communication is a subtle form of communication that takes place in the initial three seconds upon meeting someone for the first time and continues through the entire interaction. Research indicates that nonverbal communication accounts for approximately 65% of a communication episode. Nonverbal 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 may perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of nonverbal miscommunication that may 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 Navajo 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.

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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 also be 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.

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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 patient's 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.

Gestures

A non-Hispanic white 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?

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 provider 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 his or her 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 nonverbal 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 loudly or too softly 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 nonverbal cues to determine how your voice is affecting your patient.

D-I-V-E-R-S-E — 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.

	Assessment	Sample questions	Assessment information/ recommendations
D	**Demographics** — Explore regional background, level of acculturation, age and sex as they influence health care behaviors.	• Where were you born? • Where was home before coming to the U.S.? • How long have you lived in the U.S.? • How old are you?	
I	**Ideas** — Ask the patient to explain his/her ideas or concepts of health and illness.	• 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** — Ask about treatment preference, use of home remedies and treatment avoidance practices.	• 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** — Ask about what your patient expects from his/her provider.	• 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** — Ask about your patient's religious and spiritual traditions.	• 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** — Identify your patient's language needs, including health literacy levels. Avoid using a family member as an interpreter.	• 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** — 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.	• 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 to identify and address health literacy issues

Low health literacy can prevent patients from understanding their health care services.

Health literacy is defined by the National Health Education Standards 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, providers' directions, 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 years of education. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment.

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 an 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 to 12 years to develop.

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' behavior 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.

Tips for dealing with low health literacy

- 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.
- 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®. 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.

For more information or resources on Ask Me 3®
Visit:
http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Ask Me 3® is a registered trademark licensed to the Institute of Healthcare Improvement.

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.

Planning effective written patient communications

All medical offices should have written communication campaigns for their diverse patient base, whether it is to announce business operation changes, or health improvement reminders about routine vaccinations or the importance of preventive health screenings.

Here are some tips to help increase the effectiveness of your office's written communication campaign. When developing your message, think through what you expect the outcome to be. Ask:

- Who is your target audience?

- What is the objective of the communication?

- What does a patient need to know to get the result you want?

- What is the call to action or the desired behavior?

- How will you best clarify the benefit of taking this action?

If yours is a more targeted mailing campaign, think about gender, age, stage of life (single, family and empty nesters), geography, the type of insurance coverage and even race/ethnicity, where appropriate.

Extensive research was conducted with racial and ethnic minority group patients. The results demonstrated that the most effective communication materials that engaged patients and induced action shared several key elements. These themes are integral components of culturally relevant communication initiatives.

We call these themes the *Five Fs*: Food, Family, Faith, Fear and Finances

1. **Food:** affinity to cultural foods and difficulties in changing dietary habits

2. **Family:** particularly being there for children and grandchildren

3. **Faith and spirituality:** respecting life as a gift; recognizing faith-based entities as trusted sources of health information

4. **Fear:** disease complications, especially amputations, blindness and kidney disease, or myths regarding adverse outcomes from treatments

5. **Finances:** affordability of health care and healthy lifestyles (in other words, food, gym membership, testing strips and copays)

While all these themes may not always be relevant to a specific communication topic, framing the benefits to the patient — from defining a call to action to weaving in culturally appropriate and sensitive discussions of the relevant *Five Fs* themes — may help your message resonate more effectively with your diverse patient base.

Tools and Training for Your Office in Caring for a Diverse Patient Base

Interview guide for hiring office/clinic staff with diversity 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.

Sample 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 preferences, sexual orientations, religions, cultures, genders and immigration status, etc. all with different needs. What skills from your past customer service or community/health care work do you think are relevant to this job?

This question should allow a better understanding of the interviewee's approach to customer service across the spectrum of diversity, his or her previous experience, and if his or her 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.

Americans 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, visit **http://www.ada.gov/effective-comm.htm**.

The Department of Justice published revised final regulations implementing the *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 publication 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.

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 screen-reading 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 (in other words, understanding what the person with the disability is saying) and expressively (in other words, 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, such as:

- Assistive listening systems and devices.

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

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

- Videotext displays.

- Screen reader software, magnification software and optical readers.

- Video description and secondary auditory programming devices that pick up video-described audio feeds for television programs.

- 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. For example:

- 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.
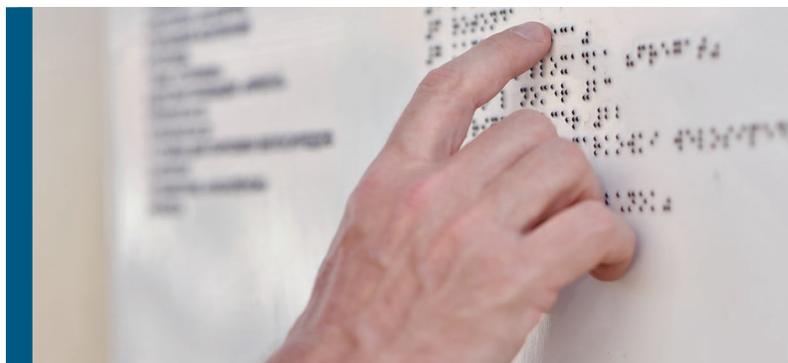
A person's method(s) of communication are also key. For example:

- 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.

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*:

Visit	Call
www.ada.gov	*ADA* Information Line: **1-800-514-0301** (voice) **1-800-514-0383** (TTY)

Examples of 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 of…	These are some options you can offer...
Visual impairments or blindness that keep them from reading	• Large print materials • Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped: **https:// www.loc.gov/nls/pdf/application.pdf** • Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Hearing impairments that impact ability to understand directions	• Amplifier/pocket talker • Written materials • Qualified sign language interpreter • Qualified note taker • Telecommunications Relay Services (TRS) — **711** • Have physician dictate into voice-recognition software and patient can type answers back
Difficulty speaking clearly and making themselves understood	• Allow for extra time and attentive listening • Qualified note taker • TRS — **711** • 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.

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 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, go to **www.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 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 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 **https:// www.fcc.gov/consumers/guides/711-telecommunications-relay-service**.

Resources to Communicate Across Language Barriers

Developing a language service plan

Language services can be the key to patient engagement. Unaddressed language barriers can negatively impact patient satisfaction, quality of care and health outcomes. To ensure your office is effectively meeting the needs of your limited English proficient (LEP) patients, your office can develop a language service plan.

Where to start

Get ready!

- Identify a designee or small team and commit to improve your capacity to serve individuals with 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 available language resources and identify those most useful for your office.

Go!

- Create, implement and evaluate your plan.

- Provide staff training on the language service plan and cultural competency.

This section of the toolkit contains information you can use to help develop your plan, such as identifying preferred languages of your patients, tips for communicating across language barriers and tips for locating and working with interpreters. Additional resources are available at the end of this toolkit to help you complete your language service plan.

Tips for working with LEP patients

Who is a LEP member?

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 LEP.

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions.

- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions.

- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.

- Member self identifies as LEP by requesting language assistance.

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

- Member speaks no English and you are unable to discern the language.

- Connect with contracted telephonic interpretation vendor to identify language needed.

- Member 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 member)

Best practice to capture language preference

For LEP members, it is a best practice to capture the members preferred language and record it in the plan's member data system.

"In order for me (or Blue Cross and Blue Shield of North Carolina) 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

LEP patients are faced with language barriers that undermine their ability to understand information given by health care providers, as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, provider 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 his or her preferred spoken and written language.

- Display a poster of common languages spoken by patients; ask them to point 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 LEP patients, document preferred language on paper and/or in electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed (for example, orange for Spanish, yellow for Vietnamese and green for Russian).

Tips to assess 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; avoid jargon and acronyms.

- Limit or avoid technical language.

- Speak slowly (don't shout).

- Articulate words completely.

- Repeat important information.

- Use pictures, demonstrations, video or audiotapes to increase understanding.

- Give information in small chunks and verify comprehension before going on.

- Always confirm that the patient understands the information — the patient's logic may be different from yours.

- Provide educational material in the languages your patients read.

Tips for working with interpreters

Telephonic interpreters

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey.

- Reassure the patient that the information will be kept confidential.

- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning (for example, *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, for example, "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, such as MFIP. If you must do so, please explain their meaning.

- Provide brief explanations of technical terms, or terms of art, for example, *spend-down* means the client must use up some of his/her monies or assets in order to be eligible for services.
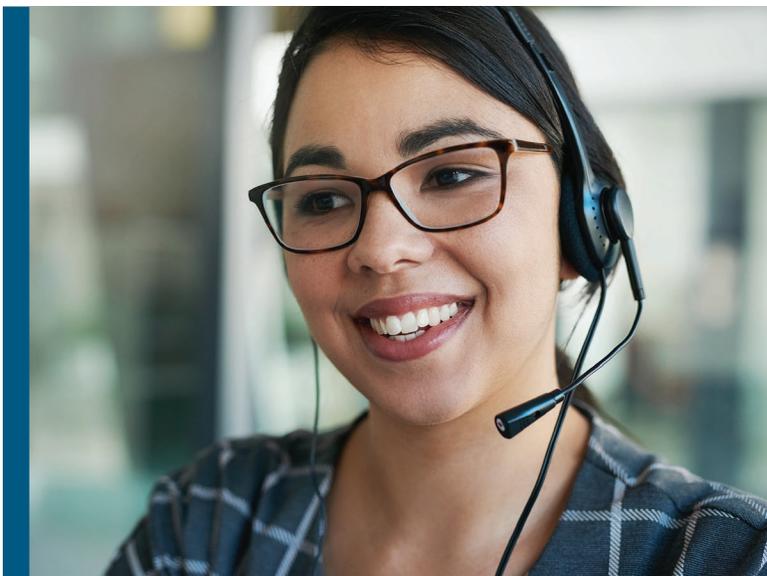
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client.

- 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.

On-site interpreters

- 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 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 person who is deaf or hard of hearing. This makes it easy for the person with the hearing impairment 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, for example, "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) using:

    - 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.

Tips for locating interpreter services

First, identify the languages spoken by your patients. Second, assess the services available to meet these needs.

Assess the language capability of your staff

(See *Employee Language Prescreening Tool*.)

- Keep a list of available certified bilingual staff that can assist with LEP patients onsite.
- 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.

Identify available language services.

- **Do not** require an individual with LEP 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.
  - If face-to-face interpreters are covered, have the following information ready before requesting the interpreter: gender, age, language needed, date/time of appointment, type of visit and office specialty.

- If telephone interpreters are covered, relay the pertinent patient information which will help the interpreter better serve the needs of the patient and the provider.
- 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 patients who are deaf or hard of hearing. In some areas services to communicate with speech impaired individuals may also be available.

Note: Remember to follow all *HIPAA* regulations when transmitting any patient-identifiable information to parties outside your office.

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.

U.S. Census Bureau language identification flashcards

The sheets on the following pages can be used to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to the patient to read the other languages, and point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in his or her medical record.

The language identification flashcards were developed by the U.S. Census Bureau and can be used to identify most languages that are spoken in the United States.
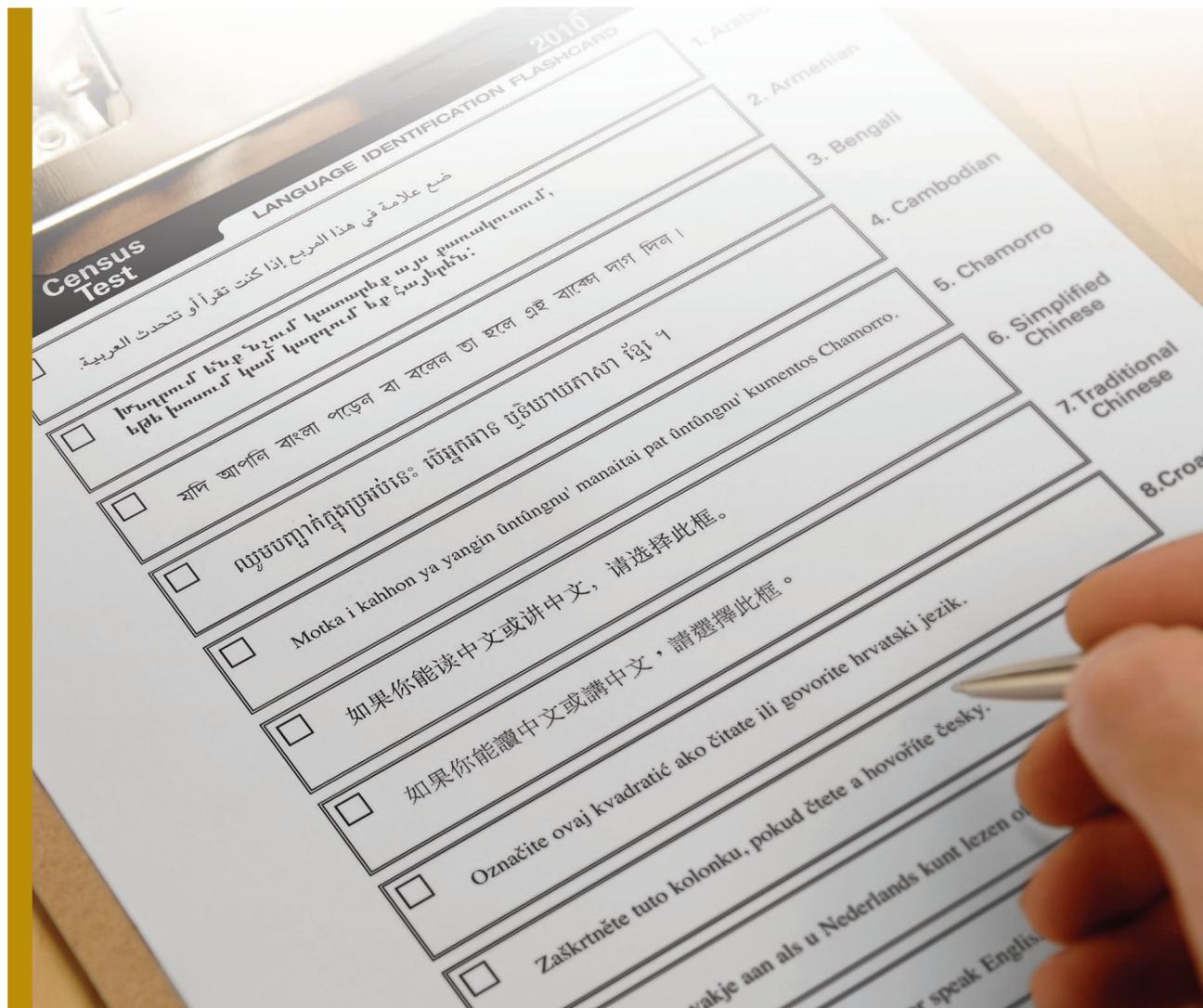
United States census 2010 language identification flashcards

<table>
<tr><td>**2004 Census Test**</td><td colspan="2">**United States Census 2010**</td></tr>
<tr><td></td><td>**LANGUAGE IDENTIFICATION FLASHCARD**</td></tr>
</table>

☐ ضع علامة في هذا المربع إذا كنت تقرأ أو تتحدث العربية.
1. Arabic

☐ Նշեք այս քառակուսին, եթե խոսում կամ կարդում եք հայերեն։
(Մակրում եք դուք նշում կատարեք այս քառակուսում,)
2. Armenian

☐ যদি আপনি বাংলা পড়েন বা বলেন তা হলে এই বাক্সে দাগ দিন।
3. Bengali

☐ ឈ្មបបញ្ជាក់ក្នុងប្រអប់នេះ បើអ្នកអាន ឬនិយាយភាសា ខ្មែរ ។
4. Cambodian

☐ Motka i kahhon ya yangin ûntûngnu' manaitai pat ûntûngnu' kumentos Chamorro.
5. Chamorro

☐ 如果你能读中文或讲中文，请选择此框。
6. Simplified Chinese

☐ 如果你能讀中文或講中文，請選擇此框。
7. Traditional Chinese

☐ Označite ovaj kvadratić ako čitate ili govorite hrvatski jezik.
8. Croatian

☐ Zaškrtněte tuto kolonku, pokud čtete a hovoříte česky.
9. Czech

☐ Kruis dit vakje aan als u Nederlands kunt lezen of spreken.
10. Dutch

☐ Mark this box if you read or speak English.
11. English

☐ اگر خواندن و نوشتن فارسي بلد هستيد، اين مربع را علامت بزنيد.
12. Farsi

DB-3309

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

| □ | Cocher ici si vous lisez ou parlez le français. | 13. French |

| □ | Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen. | 14. German |

| □ | Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά. | 15. Greek |

| □ | Make kazye sa a si ou li oswa ou pale kreyòl ayisyen. | 16. Haitian Creole |

| □ | अगर आप हिन्दी बोलते या पढ़ सकते हों तो इस बक्स पर चिह्न लगाएँ। | 17. Hindi |

| □ | Kos lub voj no yog koj paub twm thiab hais lus Hmoob. | 18. Hmong |

| □ | Jelölje meg ezt a kockát, ha megérti vagy beszéli a magyar nyelvet. | 19. Hungarian |

| □ | Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano. | 20. Ilocano |

| □ | Marchi questa casella se legge o parla italiano. | 21. Italian |

| □ | 日本語を読んだり、話せる場合はここに印を付けてください。 | 22. Japanese |

| □ | 한국어를 읽거나 말할 수 있으면 이 칸에 표시하십시오. | 23. Korean |

| □ | ໃຫ້ໝາຍໃສ່ຊ່ອງນີ້ ຖ້າທ່ານອ່ານຫຼືປາກພາສາລາວ. | 24. Laotian |

| □ | Prosimy o zaznaczenie tego kwadratu, jeżeli posługuje się Pan/Pani językiem polskim. | 25. Polish |

DB-3309

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

☐	Assinale este quadrado se você lê ou fala português.	26. Portuguese
☐	Însemnaţi această căsuţă dacă citiţi sau vorbiţi româneşte.	27. Romanian
☐	Пометьте этот квадратик, если вы читаете или говорите по-русски.	28. Russian
☐	Обележите овај квадратић уколико читате или говорите српски језик.	29. Serbian
☐	Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	30. Slovak
☐	Marque esta casilla si lee o habla español.	31. Spanish
☐	Markahan itong kuwadrado kung kayo ay marunong magbasa o magsalita ng Tagalog.	32. Tagalog
☐	ให้กาเครื่องหมายลงในช่องถ้าท่านอ่านหรือพูดภาษาไทย.	33. Thai
☐	Maaka 'i he puha ni kapau 'oku ke lau pe lea fakatonga.	34. Tongan
☐	Відмітьте цю клітинку, якщо ви читаєте або говорите українською мовою.	35. Ukranian
☐	اگر آپ اردو پڑھتے یا بولتے ہیں تو اس خانے میں نشان لگا ئیں ۔	36. Urdu
☐	Xin đánh dấu vào ô này nếu quý vị biết đọc và nói được Việt Ngữ.	37. Vietnamese
☐	באצייכנט דעם קעסטל אויב איר לייענט אדער רעדט אידיש.	38. Yiddish

Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

Common signs in multiple languages

English, Spanish, Vietnamese and Chinese

You may wish to use this tool to mark special areas in your office to help your LEP patients. It is suggested you laminate each sign and post it.

Welcome		
English		Welcome
Español	Spanish	Bienvenido/a
Tiếng Việt	Vietnamese	Hân hạnh tiếp đón quý vị
中文	Chinese	歡 迎

Enter		
English		Enter
Español	Spanish	Entrada
Tiếng Việt	Vietnamese	Lối vào
中文	Chinese	入 口

Registration		
English		Registration
Español	Spanish	Oficina de Registro
Tiếng Việt	Vietnamese	Quầy tiếp khách
中文	Chinese	登 記 處

Exit		
English		Exit
Español	Spanish	Salida
Tiếng Việt	Vietnamese	Lối ra
中文	Chinese	出 口

Cashier		
English		Cashier
Español	Spanish	Cajera
Tiếng Việt	Vietnamese	Quầy trả tiền
中文	Chinese	收 銀 部

Restroom		
English		Restroom
Español	Spanish	Baños
Tiếng Việt	Vietnamese	Phòng vệ sinh
中文	Chinese	洗 手 間

Common sentences in multiple languages

English-Spanish-Vietnamese-Chinese

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

English	Spanish/Español	Vietnamese/Tieáng Vieät	Chinese/中文
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**
Instructions	**Instrucciones**	**Chỉ Dẫn**	**指示**
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.	Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.	Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.	這卡可以幫助大家更明白對方。請指向您想溝通的句子，如有需要，稍後我們可以為您安排傳譯員。
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**
Courtesy statements	**Frases de cortesía**	**Từ ngữ lịch sử**	**禮貌敘述**
Please wait.	Por favor espere (un momento).	*Xin vui lòng chờ.*	請等等
Thank you.	Gracias.	*Cám ơn.*	多謝
One moment, please.	Un momento, por favor.	*Xin đợi một chút.*	請等一會
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**
Patient may say…	**El paciente puede decir…**	**Bệnh nhân có thể nói…**	**病人可能會說…**
My name is…	Mi nombre es...	Tôi tên là...	我的名字是…
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位傳譯員…
I came to see the provider, because…	Vine a ver al provider porque…	Tôi muốn gặp bác sĩ vì...	我來見醫生是因為…
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	¿Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏?
How much do I owe you?	¿Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	¿ Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員?

English	Spanish/Español	Vietnamese/Tiếng Việt	Chinese/中文
Point to a sentence 👇	**Señale una frase** 👇	**Xin chỉ vào câu** 👇	指向句子 👇
Staff may ask or say…	**El personal del médico le puede decir…**	**Nhân viên có thể hỏi hoặc nói...**	職員可能會問或說…
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể gíup được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Tôi không hiểu. Xin đợi một chút.	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Quí vị thích dùng ngôn ngữ nào?	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Chúng tôi sẽ gọi thông dịch viên	傳譯員就快到。
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼名字？
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人？
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病人的：
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號碼
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期：
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	月/日/年
Now, fill out these forms, please.	Ahora, por favor conteste estas formas.	Bây giờ xin điền những đơn này.	現在，請填寫這表格

English-Spanish-French Creole

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

English	Spanish/Español	Creole/Kreyòl
Point to a sentence 👆	**Señale una frase** 👆	**Lonje dwèt ou sou yon fraz** 👆
Instructions	**Instrucciones**	**Esplikasyon**
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.	Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.	Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.
Point to a sentence 👆	**Señale una frase** 👆	**Lonje dwèt ou sou yon fraz** 👆
Courtesy statements	**Frases de cortesía**	**Pawòl pou Koutwazi**
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman).
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Point to a sentence 👆	**Señale una frase** 👆	**Lonje dwèt ou sou yon fraz** 👆
Patient may say…	**El paciente puede decir…**	**Pasyan an kapab di…**
My name is…	Mi nombre es...	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt.
I came to see the doctor because…	Vine a ver al doctor porque…	Mwen vin wè doktè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	¿Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	¿Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	¿Es posible tener un intérprete?	Èske mwen ka gen yon entèprèt?

English	Spanish/Español	Creole/Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Staff may ask or say…	**El personal del médico le puede decir…**	**Anplwaye medikal la kapab di oubyen mande…**
Please hold. I will be right back.	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka fè pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon entèprèt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon entèprèt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?
Please write the patient's:	Por favor escriba, acerca del paciente:	Tanpri, ekri enfòmasyon sa yo pou pasyan an:
Name	Nombre	Non
Address	Dirección	Adrès
Telephone number	Número de teléfono	Nimewo telefòn
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month/Day/Year	Mes/Día/Año	Mwa / Jou / Ane
Now, fill out these forms, please.	Ahora, por favor conteste estas formas.	Kounye a, ekri enfòmasyon yo mande nan papye sa yo.

Employee language prescreening tool

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment. The screening tool is not meant to serve as an assessment for qualified medical interpreters or meet legal or regulatory requirements.

Once bilingual staff has been identified, they should be referred to professional assessment agencies to evaluate the level of proficiency. There are many sources that will help you assess the bilingual capacity of staff. Depending on their level of confirmed fluency, your practice would be able to make use of this added value to help your practice better communicate with your patients in the client's language of preference. As a recommendation, staff providing interpreter support should receive training on and adhere to the National Standards of Practice for Interpreters in Health Care.

We recommend that you distribute the tool to all of your clinical and nonclinical employees using their non-English language skills in the workplace. The information collected may be used as a first step to improve communication with your diverse patient base. You may wish to write an introductory note along the following lines:

We are committed to maintaining our readiness to serve the needs of our patients. Many of our employees could use their skills in languages other than English. We are compiling information about resources available within our work force.

Please complete and return this prescreening tool to <department/contact> no later than <date>. The responses will not affect your performance evaluation. It is just a way for us to improve our customer service, and to make you a part of such efforts.

Thank you for your assistance.

Employee language prescreening tool (for clinical and nonclinical employees)

Thank you for participating in this survey process. This prescreening tool is intended for clinical and nonclinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee name:	
Department/job title:	
Work days: Mon / Tues / Wed / Thurs / Fri / Sat / Sun	
Work hours (please specify):	

Directions:

- Write all language(s) or dialects you know.
- Indicate how fluently you speak, read and / or write each language (see attached key).

Example

Language	Dialect, region…	Speaking	Reading	Writing	Do you speak…	Do you read…	Do you write…
Spanish	Mexico	①2 3 4 5	1②3 4 5	①2 3 4 5	Yes (No)	(Yes) No	Yes (No)

Language	Dialect, region or country	Fluency: see attached key (Circle)			As part of your job, do you use this language to speak with patients? (Circle)	As part of your job, do you read this language? (Circle)	As part of your job, do you write this language? (Circle)
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		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: _____

Employee language prescreening tool key

Key for spoken language capability	
1	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to two to three word entry-1 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 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 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 for reading capability	
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, nontechnical terms and health care terms.
4	Understands materials that contain idioms and specialized terminology; understands a broad range of literature.
5	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key for writing capability	
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, health care, academic and technical vocabulary.

Interpretation versus 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.

Resources to Increase Awareness of How Cultural Background Impacts Health Care Delivery

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.

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

Health disparities matter to all of us. Here are just two 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 with equal sharing and exact division. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness.

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.

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.

Health equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of 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 **https://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 **https://www.thinkculturalhealth. hhs.gov**, sponsored by the Office of Minority Health (OMH), 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.

Health equity, health equality and health disparities (cont.)

Who else is addressing health disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, health plans and government organizations. The *Affordable Care Act* required the establishment of OMHs within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality
- CDC
- CMS
- Food and Drug Administration
- Health Resources and Services Administration
- Substance Abuse and Mental Health Services Administration

These offices join the HHS OMH 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.

Key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, **https://www.minorityhealth.hhs.gov/npa**

- Office of Minority Health at HHS, **https://www.minorityhealth.hhs.gov**

- Think Cultural Health, **https://www.thinkculturalhealth.hhs.gov**

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 provider 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 woman, 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 Latina women believe that colostrum (a fluid in the breasts that nourishes the baby until the breast milk becomes available) is not good for a baby. An explanation from the provider 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 thinness has in our culture — treat it as a cultural issue 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 (for example, "The baby looks like you take care of him well.")

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.

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 checkups as a kind of extension of the immunization process.

Substance use

- When asking questions 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 responds 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 providers, 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 anyone is being deceptive — just seeing things differently. This may cause special difficulties for teens that 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.

- Be 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.

- Be aware that many people believe 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.

Cultural background — information on special topics (cont.)

Older adult communication needs from your patients' perspective	
I wish you knew…	**I wish you would do…**
I want to be respected and addressed formally. I appreciate empathy.	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 want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to me, if I have a hearing impairment. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible.
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan.
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	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.
Nodding my head doesn't always mean I understand.	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 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.	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.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	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. 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.

Talking 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 are:

Gender roles

- Gender roles vary and change as the person ages (for example, 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 (for example, 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.

- Before entering the exam room, tell the patient and his or her 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 reassure the companion or guardian that the person will be in the room at all times.

- Use same-sex nonfamily members as interpreters.

Sexual health and patient cultural background

- If a sexual history is requested during a nonrelated illness appointment, patients may conclude 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. For example, Chinese males may discuss sexual performance problems in terms of a weak liver.

- Printed materials on topics of sexual health may be considered inappropriate reading materials.

- 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

- Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals of discomfort, or ask directly how they would like to proceed.

- A patient may be required to bring family members to his or her 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 he or she is uncomfortable discussing sexual health with a companion or guardian in the room.

- It may help to apologize for the need to ask sexual or personal questions, and explain the necessity.

- Try to offer the patient a culturally acceptable way to have a confidential conversation. 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

Communities are made up of many diverse cultures, sexual orientations and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT) 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 2020, LGBT health disparities include:

- Youth are two to three times more likely to attempt suicide and are more likely to be homeless.

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.

- LGBT populations have the highest rates of tobacco, alcohol and other drug use.

- Gay men are at higher risk of HIV and other STDs, especially among communities of color.

- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

- 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 **glma.org** for more information about:

- Creating a welcoming environment.

- General guidelines (including referral resources).

- Confidentiality.

- Sensitivity training.

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

Additional resources to help you support the needs of your LGBT patients:

- Providing Enhanced LGBT Courses — Cultural Competency Training (**https://www.hhs.gov/programs/topic-sites/lgbt/enhanced-resources/competency-training/index.html**)

- Creating an LGBT Friendly Practice (**https://mydiversepatients.com/le-lgbt.html**)

- LGBT Training Curricula for Behavioral Health and Primary Care Practitioners (**https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula**)

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

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.**

Reaction to pain and expression of pain

- 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.

- Do not mistake lack of verbal or facial expression for lack of pain. Undertreatment of pain is a problem in populations where stoicism is a cultural norm.

- Because the expression of pain varies, ask patients 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.

Spiritual and religious beliefs about using pain medication

- 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, intravenous or intramuscular.

- Consultation 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.

Do not mistake lack of verbal or facial expression for lack of pain. Undertreatment of pain is a problem in populations where stoicism is a cultural norm.

Beliefs about drug addiction

- 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.

- Be aware of potential differences in the way medication acts in different populations. A patient's belief that he or she is 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.

- Assure your patient you are watching his or her particular case.

Use of alternative pain relief treatment

- Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture, or breathing exercises.

- Respectfully inquire about all of the ways the patient is treating his or her 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 he or she feels it is *safe* to talk about them.

- Accommodate or integrate your treatments with alternative treatments when possible.
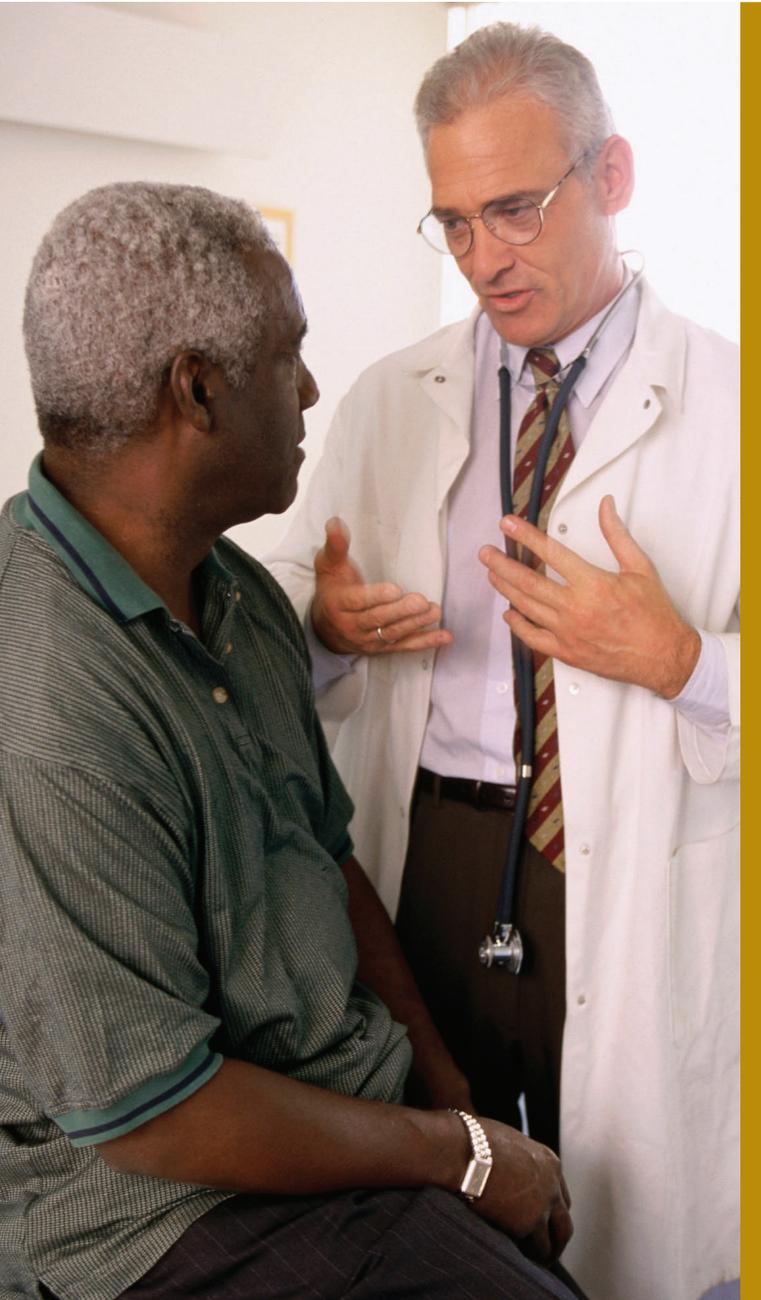
Methods needed to assess pain

- 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.

- Ask the patient specifically how he or she can best describe his or her pain.

- Use multiple methods of assessing pain, such as 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.

Accommodate or integrate your treatments with alternative treatments when possible.

Regulations and Standards for Cultural and Linguistic Services

45 CFR 92, Nondiscrimination 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 LEP 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 LEP; 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 LEP. (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 LEP when oral interpretation is a reasonable step to provide meaningful access for that individual with LEP; 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 LEP to provide his or her own interpreter; (2) rely on an adult accompanying an individual with LEP 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 LEP 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 LEP immediately available; or (4) rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.

(f) Video remote interpreting services: A covered entity that provides a qualified interpreter for an individual with LEP 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 LEP to accept language assistance service.

Standards to provide culturally and linguistically appropriate services (CLAS)

The purpose of the enhanced OMH 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 LEP 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, orally 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 organizations' planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment 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.

Title VI of the *Civil Rights Act of 1964*

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 health care 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 OMH 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.

"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."

Executive Order 13166: improving access to services for persons with limited English proficiency (August 2000, 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:

Section one: 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.

Section two: 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.

Section three: 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

Executive Order 13166: improving access to services for persons with limited English proficiency (August 2000, verbatim) (cont.)

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.

Section four: 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.

Section five: 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 categories

Importance of collecting race/ethnicity/language (REL) data and appropriate the 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*.

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.

- **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 complete. May call this field *Unknown*.

Resources for Cultural and Linguistic Services

Cultural competence web resources

General cultural competence	
U.S. Department of Health and Human Services — Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
U.S. Department of Health and Human Services — OMH	http://www.minorityhealth.hhs.gov
National Institute of Health	https://www.nih.gov
HHS Health Resources and Services Administration Culture, Language and Health Literacy	http://www.hrsa.gov/culturalcompetence/index.html
U.S. Department of Justice — Civil Rights Division	https://www.justice.gov/crt
HHS Office of Civil Rights	www.hhs.gov/ocr
Industry Collaboration Effort	http://iceforhealth.org/aboutice.asp
National Center for Cultural Competence — Georgetown University	https://nccc.georgetown.edu
Office of Disease Prevention and Health Promotion Quick Guide to Health Literacy	https://health.gov/communication/literacy/quickguide/default.htm
My Diverse Patients	https://www.mydiversepatients.com
National Council on Interpreting in Health Care	www.ncihc.org
Resources for cross-cultural health care	www.diversityrx.org
Institute of Medicine: Unequal Treatment	http://iom.nationalacademies.org/reports/2002/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.aspx
Robert Woods Johnson Foundation: Aligning Forces for Quality	www.rwjf.org/en/library/collections/af4q.html
National Partnership for Action to End Health Disparities	https://minorityhealth.hhs.gov/npa
Limited English Proficiency: A Federal Interagency Website	https://www.lep.gov

Cultural competence web resources (cont.)

Aging

Center on an Aging Society	**http://hpi.georgetown.edu/agingsociety**

African American

National Association of Black Cardiologists	**www.abcardio.org**
National Black Nurses Association	**www.nbna.org**

American Indian/Alaskan Native

Association of American Indian Physicians	**www.aaip.org**
Native American Cancer Research	**http://natamcancer.org**
National Indian Council on Aging	**http://nicoa.org**
National Indian Health Board	**www.nihb.org**
National Resource Center on Native American Aging	**https://ruralhealth.und.edu/projects/nrcnaa**

Asian American/Pacific Islander American

Asian & Pacific Islander American Health Forum	**www.apiahf.org**
Chinese American Medical Society	**www.camsociety.org**
National Asian Pacific Center on Aging	**http://napca.org**

Hispanic/Latino American	
National Alliance for Hispanic Health	**https://www.healthyamericas.org**
National Hispanic Council on Aging	**www.nhcoa.org**
National Hispanic Medical Association	**www.nhmamd.org**

Disabilities	
U.S. Department of Justice — **ADA Requirements for Effective Communication**	**https://www.ada.gov/effective-comm.htm**
Administration for Community Living DHHS	**https://www.acl.gov/about-community-living**

Free patient health education materials – low literacy and other languages	
National Institutes of Health — **health information in English/Spanish**	**www.health.nih.gov**
National Network of Libraries of Medicine — **easy-to-read health brochures in other languages**	**http://nnlm.gov/outreach/consumer/multi.html**

Remember, web pages can expire. 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 provider for advice about changes that may affect your health.

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

If you have any questions or comments about this toolkit, contact your provider representative.

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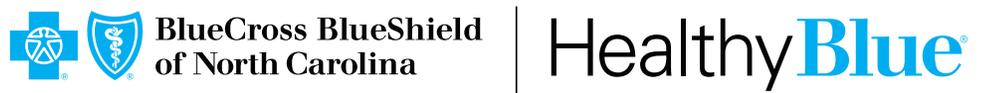**www.thinkculturalhealth.hhs.gov**

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