Cultural Sensitivity Training
Alameda Alliance for Health
March 2019

ALAMEDA Alliance FOR HEALTH

Training Objectives

- By the end of this training you will be able to:
- Understand current laws and regulations on cultural and linguistics services at the federal and state levels.
- State reasons why cultural sensitivity is important for providing quality health care.
- Use strategies to improve communication with key sub-populations:
  - Seniors and persons with disabilities (SPDs)
  - Immigrants and refugees
  - LGBTQ+
- Know how to access cultural and linguistic resources available to Alameda Alliance for Health (Alliance) members.

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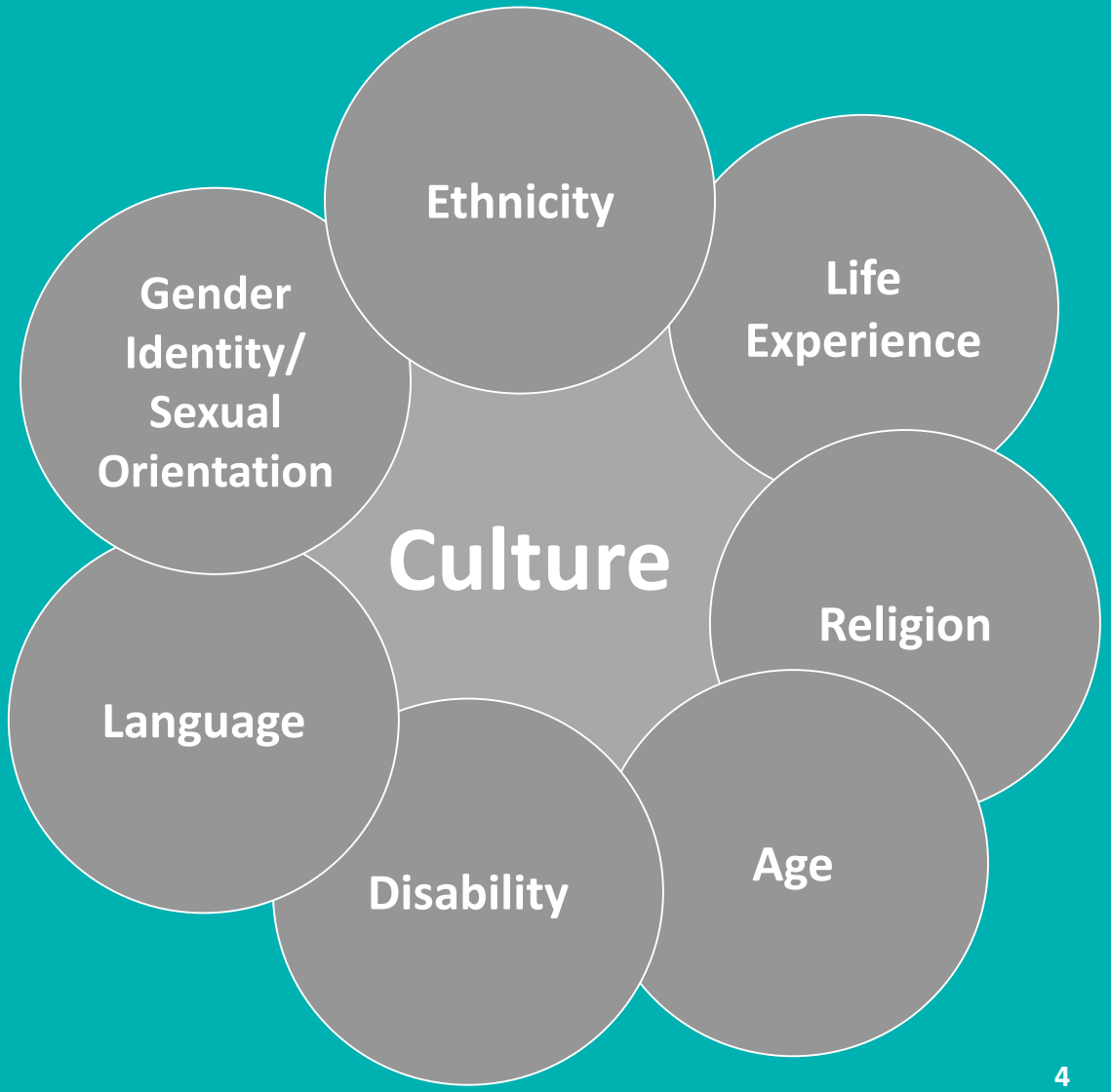
***Culture** refers to integrated patterns of human behavior that includes languages, actions, customs, beliefs, values and institutions that unite a group of people.*

–U.S. Department of Health and Human Services - Office of Minority Health

What Cultures Make Up Who You Are?

Consider these aspects of culture.

1. Consider each aspect of culture. How do you define yourself?
2. Think about how your cultures act as lenses through which you view the world.



Cultural and Linguistic Regulations for Medi-Cal Managed Care

Federal and State

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Department of Managed Health Care (DMHC)

28 CCR 1300.67.04(c)(3)

The ***training*** shall include instruction on:

- Knowledge of the plan's policies and procedures for language assistance;
- Working effectively with Limited English Proficiency (LEP) enrollees;
- Working effectively with interpreters in-person and through video, telephone and other media, as applicable; and
- Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

California Department of Health Care Services (DHCS)

Contractual Requirements

Exhibit A, Attachment 1 – Organization and Administration of the Plan

10. ***Sensitivity training***: Contractor shall ensure that all personnel who interact with SPD (***Seniors & Persons With Disabilities***) beneficiaries, as well as those who may potentially interact with SPD beneficiaries, and any other staff deemed appropriate by Contractor or DHCS, shall receive sensitivity training.

Exhibit A, Attachment 9, Section 13 – Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876.

Contractor shall ***monitor, evaluate, and take effective action to address any needed improvement*** in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements stipulated below.

Federal Regulations

Title 42, Code of Federal regulations, Section 440.262

The State must have methods to promote ***access and delivery of services in a culturally competent manner*** to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meet their unique needs.

Affordable Care Act of 2010, Section 1557

Prohibits discrimination on the grounds of race, color, national origin, sex, age, or disability in certain health programs and activities.

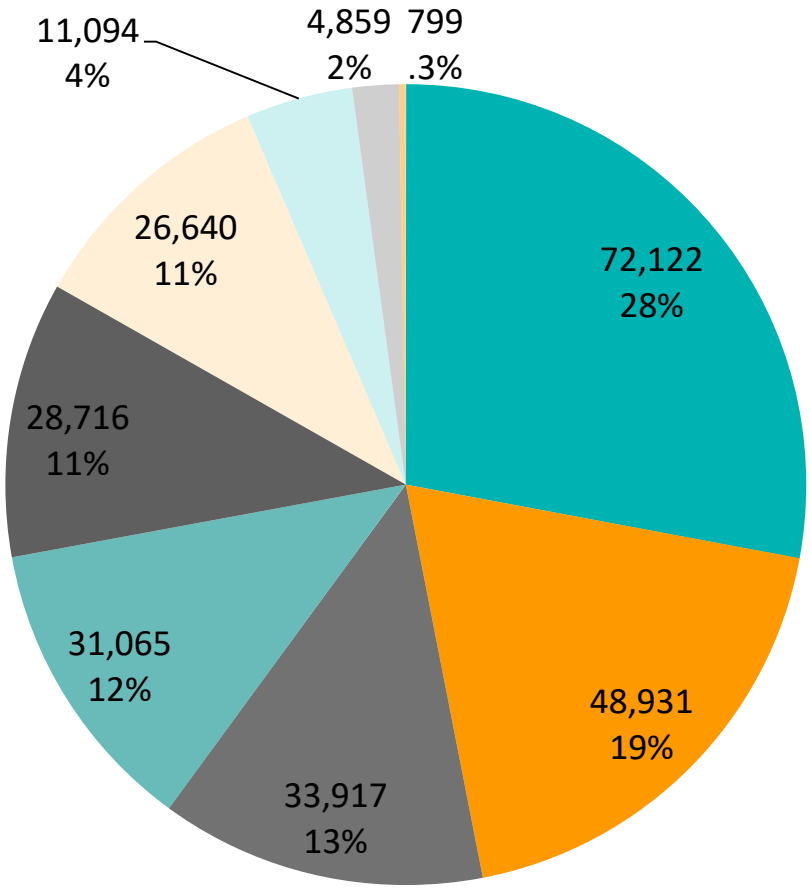
Covered entities are required to post notice of individuals' rights to language assistance, post taglines in the top 15 languages spoken by individuals in the state, prohibited from using low-quality video remote interpreting or unqualified staff, and must implement a language access plan.

Our Commitment

- The Alliance is committed to serving all of its members with respect and dignity regardless of race, color, national origin, gender, gender identity, sexual orientation, age, or disability.
- Our goal is to ensure the communications, health care, physical spaces, services and programs are accessible to all members, including those with visual, hearing, cognitive, and physical disabilities.

Alliance Membership

Alliance Membership by Race/Ethnicity



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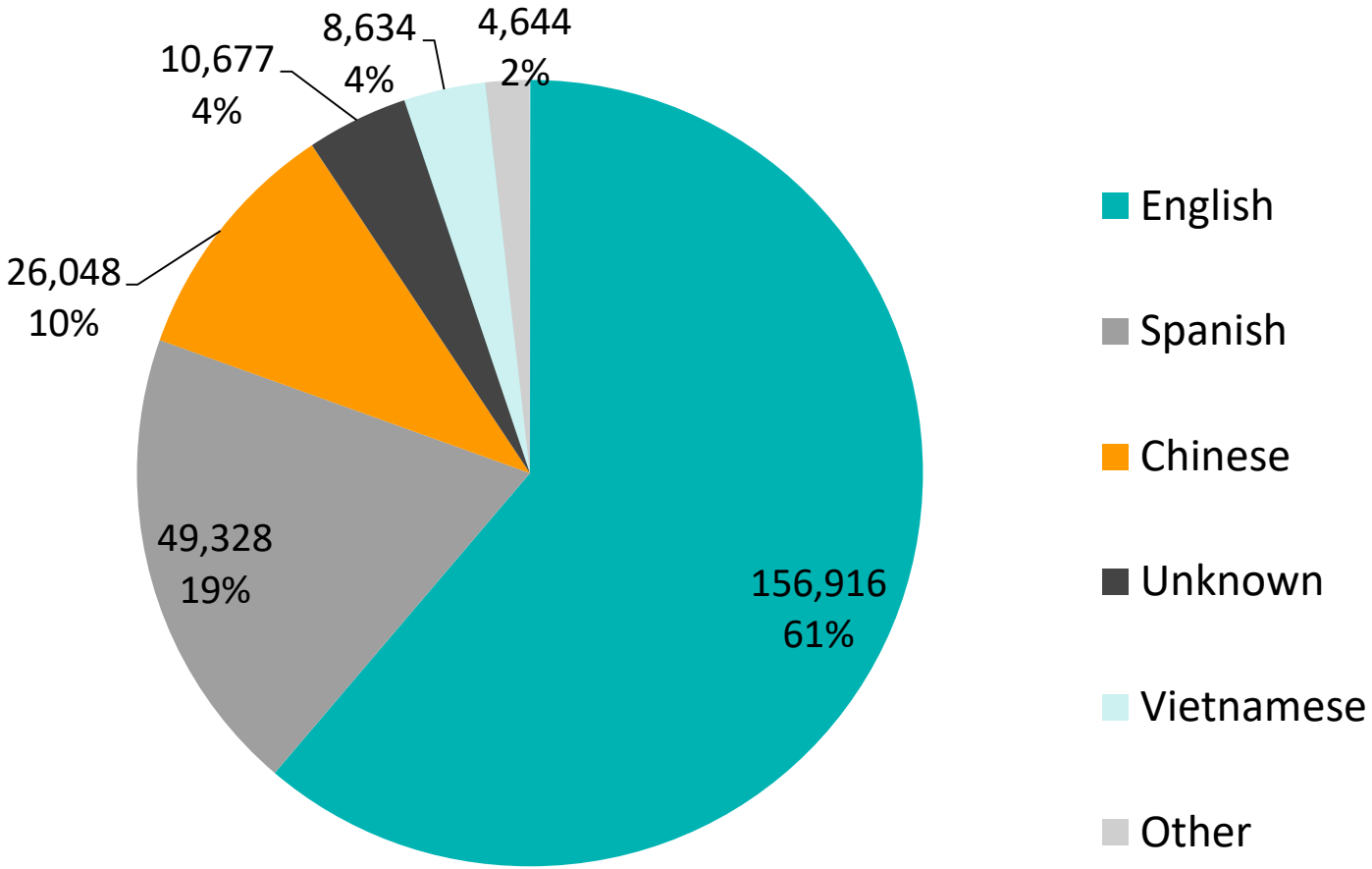
Alliance Membership by Language



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Alliance Threshold Languages

- **Threshold Language**: Either 5% of membership or 3,000 members, 1,500 in two (2) contiguous zip codes, or 1,000 in one (1) zip code.
- By law, the Alliance and its delegates must translate all vital member documents and letters into our most common member languages:

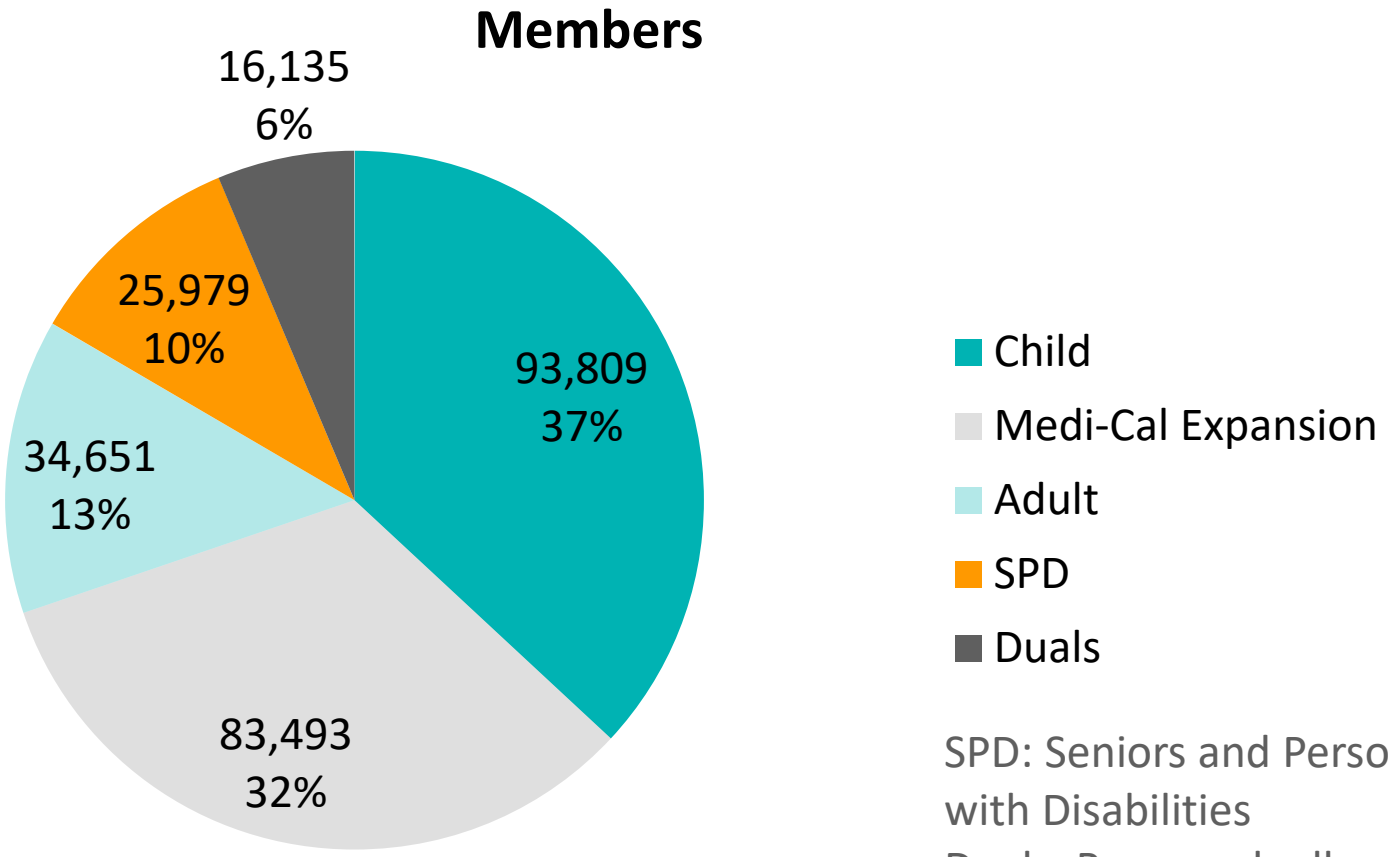
Medi-Cal:

- English
- Spanish
- Chinese
- Vietnamese

Group Care (IHSS):

- English
- Chinese
- Spanish

Medi-Cal Membership by Aid Code



SPD: Seniors and Persons with Disabilities
Duals: Persons dually eligible for Medicare and Medi-Cal

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Embracing Culture and Differences

Cultural Humility

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Why is Culture Important?

Culture impacts every health care encounter:

- Who provides treatment
- What is considered a health problem
- What type of treatment
- Where is care sought
- How symptoms are expressed
- How rights and protections are understood

Cultural Competency in Health Care

Effectively dealing with people from different cultures

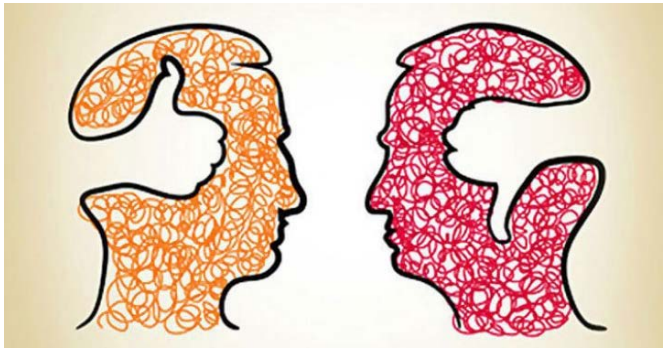
Elements of Cultural Competency:

- Awareness of one's own culture
- Understanding the dynamics of differences
- Awareness and acceptance of differences
- Development and application of cultural knowledge
- Appreciation of diversity

Consider: *Some experts prefer not to use the term "culturally competent." Each person's unique mix of cultures and experiences makes it hard to achieve "competency." Perhaps better terms are "cultural sensitivity" or "cultural humility."*

Looking at Biases

- We all have ***unique experiences*** with people of different cultures.
- This can lead to attitudes or stereotypes that ***unconsciously*** affect how we think and act.
- These unconscious ***biases*** may not be the same as our declared beliefs.
- Yet, unconscious biases ***can be unlearned***. Our brains are complex. New experiences and recognizing our biases can lead to new beliefs.



Case Study #1: Mr. Jackson

Scenario:

Mr. Jackson, a 62 year old black male, came to his doctor complaining that his pain medications were not giving him enough relief and asked if he could increase them. He said his back pain was about 7 out of 10 and he had trouble sleeping. His white doctor said that he wouldn't increase the medication but he could prescribe a different one and decrease his current medication. Mr. Jackson wondered if his doctor believed him and if he changed his medication because he was suspecting drug abuse.

Questions to Consider:

- How might the patient's and the doctor's ethnicity affect this interaction?
- What unconscious bias might the doctor need to consider to ensure the patient gets equitable treatment?
- What might the doctor have done to avoid giving Mr. Jackson this impression?

Case Study #1 Discussion: Mr. Jackson

How might the patient's ethnicity affect this interaction?

- Patients of color may be less likely to assume they will be respected because of past experiences of discrimination.

What unconscious bias might the doctor need to consider to ensure the patient gets equitable treatment?

- Providers have been found to often discount pain when report high levels. When they are uncertain if self-reported pain is valid, stereotypes can be activated. This can affect how aggressive of pain treatment they recommend.

What might the doctor have done to avoid giving Mr. Jackson this impression?

- The doctor could ask more about the patient's symptoms and experience with pain to show empathy, increase understanding and make Mr. Jackson feel heard.
- The doctor could also educate the patient about different treatment options and risks and make the decision collaborative.

For more information: Tait, RC & Chibnall JT. Racial/Ethnic Disparities in the Assessment and Treatment of Pain: Psychosocial Perspectives. *Am Psychol*. 2014 Feb-Mar;69(2):131-41. www.apa.org/pubs/journals/releases/amp-a0035204.pdf

Golden & Platinum Rules of Service

Golden Rule

Treat someone like ***you*** want to be treated – if your culture is similar to that of the member/patient.

Platinum Rule

Treat a person how ***they*** want to be treated – if your culture differs from the member/patient.

Service Score Segmentation of Diverse Populations,
The Permanante Journal/Fall 2009/Volume 13 No. 4

Health Literacy

Health Literacy is the ability to obtain, process, and understand basic health information. It is critical for making good health decisions.

Ways to lower literacy level:

- Use plain language; define complex terms.
- Keep text at a 6th grade reading level or lower, required for health education content.
- To lower the reading level, use shorter sentences and fewer words of three syllables or more.
- Use bullets, bolding and graphics or pictures to help explain health messages.
- Need tips for low literacy writing? Finding a low literacy resource? Please contact Alliance Health Education at livehealthy@alamedaalliance.org!

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"The Dietary Guidelines for Americans recommends a half hour or more of moderate physical activity on most days, preferably every day. The activity can include brisk walking, calisthenics, home care, gardening, moderate sports exercise, and dancing.

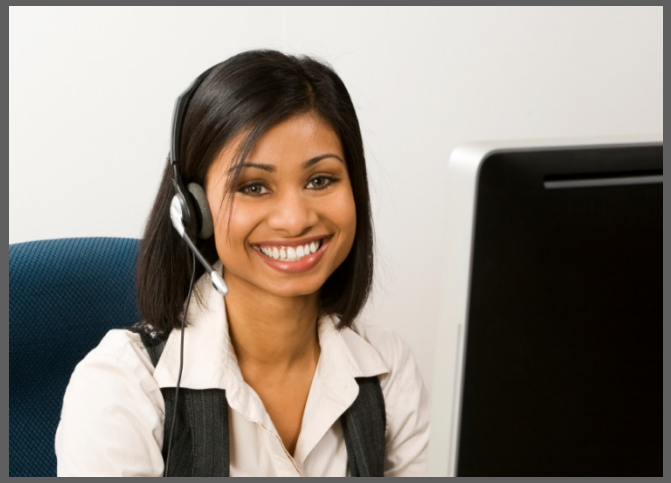
- College level readability

"Do at least 30 minutes of exercise, like brisk walking, most days of the week.

- Sixth grade readability

Benefits to Clear Communication

- **Improve Safety and Adherence**
- Physician and Patient Satisfaction
- **Improve Office Process, Time and Save Money**
- Reduce Malpractice Risk



Multi-Cultural Communication

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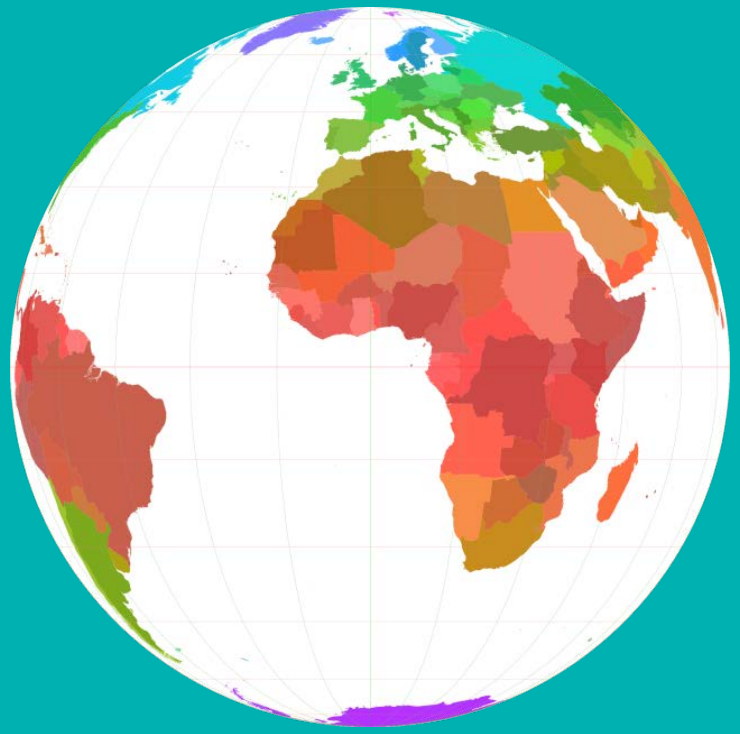
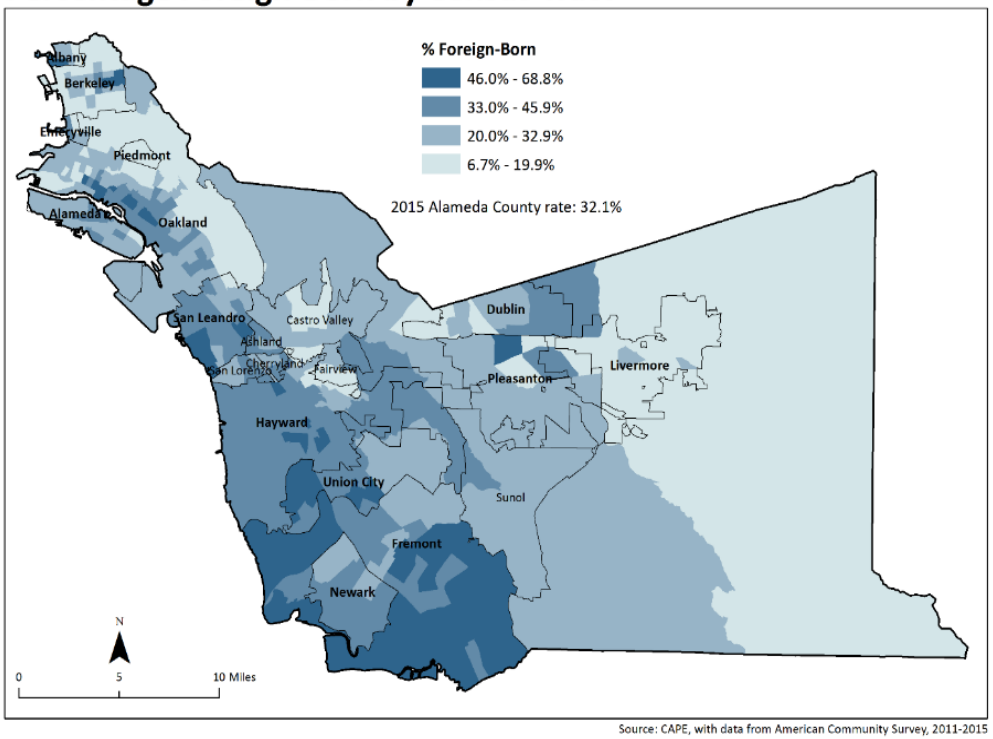
Communicating with Refugee and Immigrant Members



Immigrants in Alameda County

- 1 in 3 Alameda County residents is an immigrant (over 525,000)
- Immigrants come to Alameda County largely from Asia (62%) followed by Latin America (26%)

Percentage Foreign-Born by Census Tract



Source: CAPE, with data from American Community Survey, 2011-2015

- Immigrants live all over Alameda County
- They make up almost half of Union City (46% of population) and Fremont (45%) and more than one-third of Hayward (39%), San Leandro (35%)
- More than half the children in Alameda County have at least one (1) parent born outside of the U.S.

Source: Immigration and Public Health: An Issue Brief, July 2017, Alameda County Public Health Department, www.acphd.org/media/470384/immigration.pdf

Health Care for Refugees & Immigrants

Refugees and Immigrants may:

- Be concerned about their personal information being shared with government agencies, and especially Immigration and Customs Enforcement (ICE).
- Delay seeking healthcare for fear of deportation (especially for undocumented parents of children who are U.S. citizens), or fear it will hurt their path to citizenship.
- Not be familiar with the U.S. health care system:
  - → What is managed care?
  - → Why would I need prenatal care or well visits?
- Experience illness due to stress.
- Practice spiritual, botanic or alternative healing before seeking U.S. medical advice.
- Have economic or social concerns that influence health decisions.

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Community health and wellness rely on people feeling safe when accessing care and services. When residents feel safe, they proactively engage in all efforts to keep their families and communities healthy.

- Op Ed by Alameda County Board of Supervisors Wilma Chan & Keith Carson

East Bay Express, May 2017

Communicating with Refugees and Immigrants

- Assure patients or parents of patients that their health information is confidential.
- Familiarize members with managed care. Explain what Medi-Cal can cover, and what treatments aren't covered.
- Show respect for role of traditional practices, herbal remedies and traditional healers that may be used.
- Offer referrals to culturally appropriate clinics or providers.
- Level of acculturation* and individual experience makes each person unique.

***Acculturation:** The process of adopting the cultural traits or social patterns of another group.

Case Study #2: Mr. N.*

Scenario:

Mr. N. is a 71 year old Vietnamese former lieutenant colonel who was imprisoned for 12 years by the Socialist Republic of Vietnam. Mr. N. feels lucky to be alive, but he experienced post traumatic stress disorder (PTSD) from his long imprisonment and abuse. Now he has nightmares only when he is stressed. He deals with his stress by smoking 4 packs of cigarettes a day and drinking beer. He has a hoarse cough. His family brought him to see a physician because his herbal medicines did not work on his cough anymore and he cannot get to sleep at night.

Questions to Consider:

- What might be the health problems the doctor would consider addressing?
- How could an understanding of the cultural health beliefs and/or cohort experiences assist in giving effective care?
- What resources and referrals might be beneficial?

* Case study is based on Stanford School of Medicine, Ethnogeriatrics Instructional Case Study 1: https://geriatrics.stanford.edu/ethnomed/vietnamese/instructional_strategies.html

Case Study #2 Discussion: Mr. N.

1. **What might be the health problems the doctor would consider addressing?**
    - Hoarse cough, insomnia, smoking & drinking, trauma and stress
2. **How could an understanding of the cultural health beliefs and/or cohort experiences assist in giving effective care?**
    - The doctor could use a Trauma Informed Care approach with Mr. N. This approach is based on understanding the effects of trauma and offering a person-centered response focused on improving an individuals' all around wellness rather than simply treating symptoms.*
    - Mr. N. has used herbal medicines, so the doctor would want to consider how these might complement, or potentially conflict with other strategies to assist with the cough and insomnia.
3. **What resources and referrals might be beneficial?**
    - Explore interest in connecting with social supports where there are individuals with similar experiences
    - Connect patient with specialists who have cultural knowledge and experience with Vietnamese members
    - Other referrals depending on patient's interest: Asian Smoker's Quitline, behavioral health referrals for trauma and alcohol use

*Definition adapted from: https://alamedacountytraumainformedcare.org

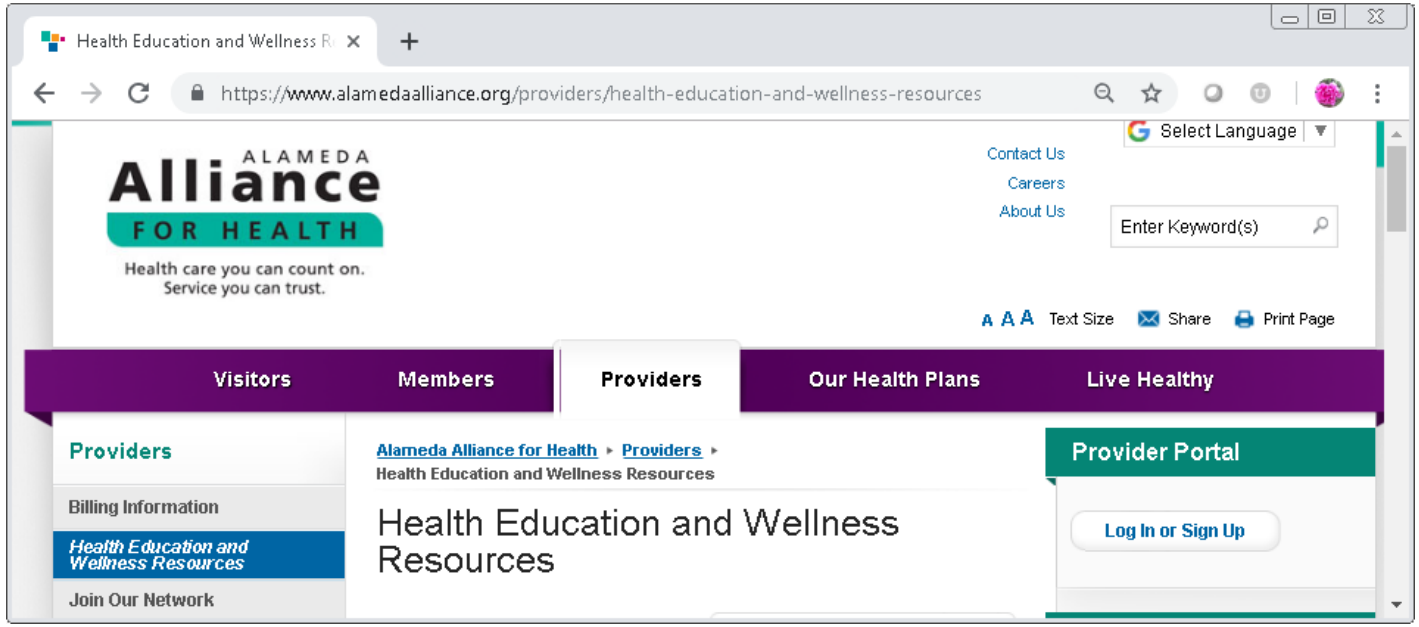
Communication with Members When English Is a Second Language*

- Use plain words; avoid jargon, technical words and acronyms
- Speak at a normal pace
- Repeat important information
- Provide educational handouts in member's language
- Use pictures, demonstrations or video
- Give information in small chunks
- Check for understanding

*Adapted from Industry Collaboration Effort, C&L Provider Toolkit. 1/2017 www.iceforhealth.org

Notes on Language

- There are a diversity of languages spoken, even within a country
- Use “Point to Your Language” signs to help identify language when possible
- Provide translated health education materials and instructions
  - See www.alamedaalliance.org/livehealthy or www.medlineplus.gov for translated materials.



Spanish-Speaking Members

- Spanish-speaking members originate from a wide range of countries and cultures
  - Mexico, Central America, South America, and the Caribbean
  - Spanish may be a second language to an indigenous language.
  - Different regions may use words differently.

Source: www.cia.gov/library/publications/the-world-factbook

Chinese-Speaking Members

- **Cantonese:** Most common Chinese language in Alameda County.
- **Mandarin:** National language of China, growing numbers in Alameda County.
- All spoken Chinese languages are written the same.
- The Alliance translates documents into Traditional Chinese (not Simplified).

Source: www.cia.gov/library/publications/resources/cia-maps-publications

Religion and Healthcare

Alameda County's Ten Largest Faith Groups (2010)

1.	Roman Catholic	15.3%
2.	Nondenominational	4.1%
3.	Muslim	2.0%
4.	Church of Jesus Christ of LDS	1.7%
5.	Southern Baptist Convention	1.5%
6.	Assemblies of God	0.8%
7.	Buddhism, Mahayana	0.6%
8.	United Methodist	0.6%
9.	Presbyterian USA	0.5%
10.	Reform Judaism	0.4%

(Indigenous or native religious practices were not in survey.)

Scheduling a class or event?

Consider the primary sacred times for world religions: **www.interfaith-calendar.org**

Source: University of Southern California **crcc.usc.edu/alameda**

Religion and Healthcare

Consider:

- Diet
- Religious objects/clothing
- Modesty
- Role of prayer
- Beliefs about end of life and death

Religion and Healthcare

Consider	Examples of Religious Beliefs and Practices
Diet	• Certain foods may be healing or cause harm • Catholics may refrain from eating meat during Lent (near Easter) • Muslims may fast from sunup to sundown during Ramadan • Jewish people may observe Kosher diets, and Muslims may observe a Halal diet • Some Buddhists are strict vegetarians
Religious objects/clothing	• Catholics may keep a rosary or carry a religious object during procedures • Muslim woman may wear a head scarf (hijab) in public and have restrictions on when it can be removed
Modesty	• Muslim woman may request a family member present during exam and stay as covered as possible; men may prefer a male doctor; no casual contact such as shaking hands with non-family of opposite sex
Role of prayer	• Christians may use prayer for healing or believe in miraculous healing • Catholics may see sacraments or blessings by a priest as highly important • Daily prayer and prayer at certain times is important in many religions
Beliefs about end-of life and death	• Religious patients may want to consult with a priest, imam, monk or Rabbi prior to deciding about treatments. • Beliefs may influence whether or not to withhold life-sustaining treatment

Sources: www.uphs.upenn.edu/pastoral/resed/diversity_points.htm; ethnomed.org/cross-cultural-health/religion

Best Practices

- **Show respect for patients' health beliefs, religion and practices.** Practice non-judgement.
- **Extend respect to family members**, and find out what role the member wants them to play in their healthcare.
- **Traditional medicine may be trusted and preferred**, such as acupuncture, herbs, botanicals and massage.
- **Western and traditional medicine may be used** for treating different illnesses or used at the same time.
- **Connect patients** with providers who can meet members' cultural needs when possible.

Communicating with LGBTQ+ Members

*Lesbian, Gay, Bisexual, Transgender, Questioning/Queer

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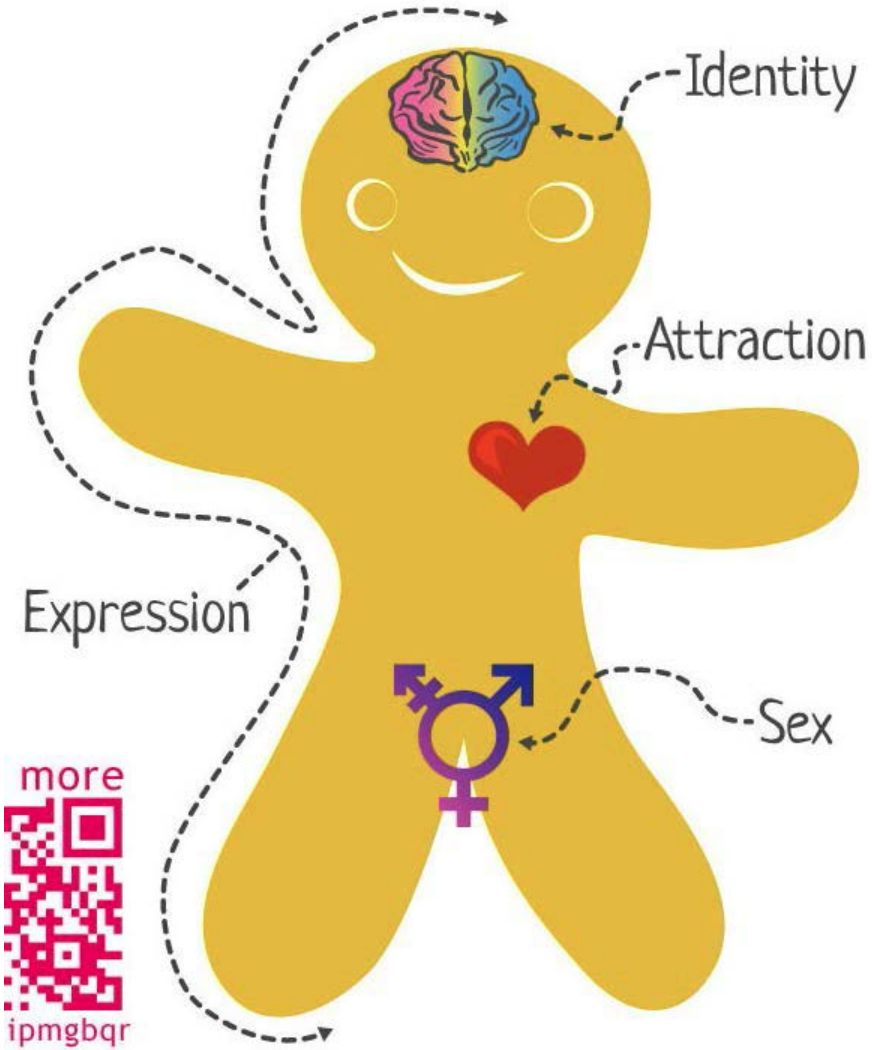
Genderbread Person

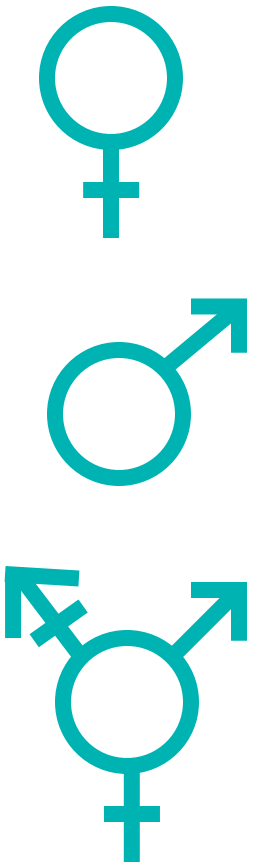


- **Identity** – How we perceive ourselves on a man-ness to woman-ness to continuum
- **Attraction** – Sexual orientation both physical and romantic attraction
- **Gender Expression** – How we present our gender through actions, dress and demeanor
- **Biological Sex** – Physical characteristics we are born with and develop. Our Birth Sex is assignment as male or female at birth based on anatomy.

Source: itspronouncedmetrosexual.com

Gender Terminology

- **Gender Identity**
  - An individual's internal sense of being male, female, both, neither or something else.
  - **Transgender**
    - → People whose gender identity does not match the biological sex they were assigned at birth.
  - **Cisgender (pronounced sis-gender)**
    - → People whose gender identity matches the biological sex they were assigned at birth.
  - **Gender Non-Conforming**
    - → People who express their gender differently than what is culturally expected of them regardless of their gender identity.
- **Gender Expression**
  - How someone presents their gender identity, such as behavior, clothing, haircut or voice, and which may or may not conform to what is typically considered either masculine or feminine.



Sexual Orientation Terminology

Sexual Orientation: A person's emotional, sexual, and/or relational attraction to others.

- **Heterosexual**: One whose attraction and behaviors are directed at the opposite sex **M ⇔ F / F ⇔ M**
- **Lesbian**: Women whose attraction and behaviors are directed at women **F⇔F**
- **Gay**: Men whose attractions and behaviors are directed at men **M⇔M**
- **Bisexual**: One whose attractions and behaviors are directed at both sexes to a significant degree.
  M ⇔ F or M / F ⇔ M or F
- **Queer**: May be seen as a put down, yet some people have reclaimed it as a general term for people who are not heterosexual or cisgender.
- **Other**: Celibate, non-sexual, other.

Communicating with LGBTQ Members

We wish our health care team knew . . .	Here's what your team can do . . .
We come to you with an extra layer of anxiety. We are more likely than cisgender or heterosexual people to have been: • Verbally or physically abused • Rejected by our families due to our sexual and gender identity • Discriminated against within the health care setting	A little warmth can make all the difference! • Signage or intake form verbiage that is safe, judgment-free, and non-discriminatory • Policies indicating nondiscrimination for sexual and gender identity displayed in common areas • Ask if prefer to be accompanied in the exam room • Ask permission to touch before an exam
Assuming that heterosexual or cisgender is the norm prevents us from seeking care.	Expect not all patients to be heterosexual or cisgender • Example: Do not assume a male patient's spouse is a wife, or vice-versa. • Change options on forms to include option other than female/male and using images that are inclusive.

Communicating with LGBTQ Members

We wish our health care team knew . . .	Here's what your team can do . . .
Consider how to avoid showing surprise or embarrassment through your body language or tone of voice: • We may not talk about our sexual orientation or gender identity due to fear or discomfort • We don't fit stereotypes – so don't assume	Identify your own LGBTQ perceptions and biases Practice some helpful phrases: • "What pronoun do you prefer I use when referring to you?" • "I'm glad you shared that with me. I know that might have been difficult to tell me. Is there anything else regarding your health care that I should know about?" • If you misspeak, be honest and apologize

Case Study #3: Assumed Gender

Scenario:

A front office staff member picks up a ringing phone: “Town Clinic, how may I help you?” The caller says, “This is Sam Green, I’d like to schedule an appointment.” The staff member replies, “I can help you with that. Mr. Green, what is your date of birth?” Sam says, “I’m not Mr. Green”. The staff member corrects, “I apologize. How would you like me to address you?” Sam replies, “Just call me Sam, thank you.”

Questions to Consider:

- What are some reasons Sam might not want to be called Mr. Green?
- Without knowing how they want to be addressed, how would you address callers?
- When would it make sense to ask someone how they want to be addressed?

Case Study #3 Discussion: Assumed Gender

- What are some reasons Sam might not want to be called Mr. Green?
  - Perhaps Sam does not identify as a male or just doesn't like being called Mr. Green.
    - → Don't assume gender of caller.
    - → Use neutral and gender-inclusive language.
- Without knowing how they want to be addressed, how would you address callers? When would it make sense to ask someone how they want to be addressed?
  - Facilitate patient self-reporting of gender information while respecting their decision to disclose their gender identity.
    - → Over the phone, it may be possible to avoid addressing someone directly at all.
    - → When meeting in person, it is easy to ask "What may I call you?" after introducing oneself.
    - → In the office setting, patients can be advised on their intake forms that they can choose whether to have preferred honorifics, names, and pronouns added to their medical record.

For more information: Katherine Steuer & Kaleigh Davis. Respecting Gender Identity in Healthcare: Regulatory Requirements and Recommendations for Treating Transgender Patients. American Bar Association. August 25, 2017. www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2017/march_2017/respecting_gender_identity_healthcare_regulatory_requirements_recommendations_treating_transgender_patients/

Communicating with SPD Members

Seniors and Persons with Disabilities

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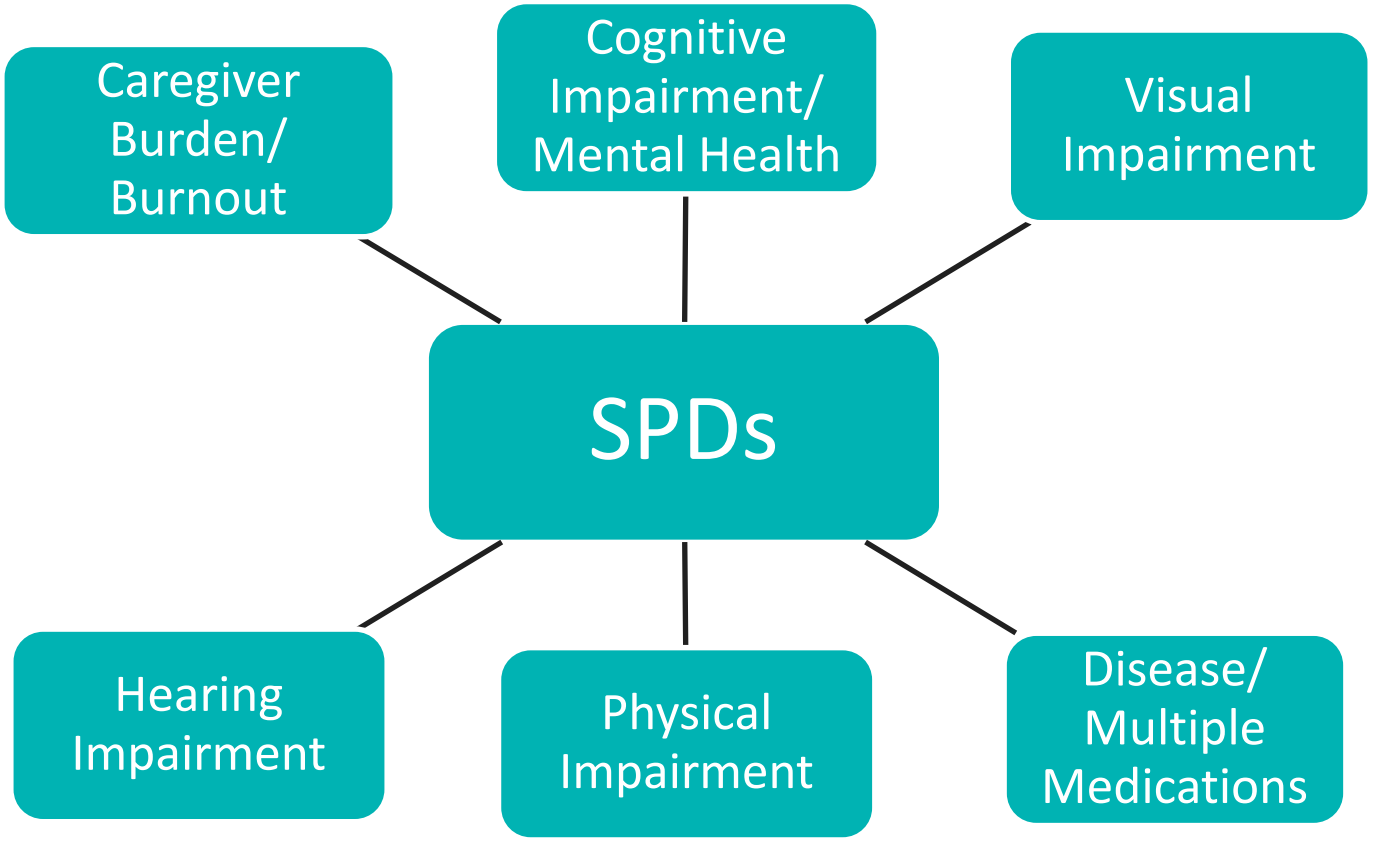
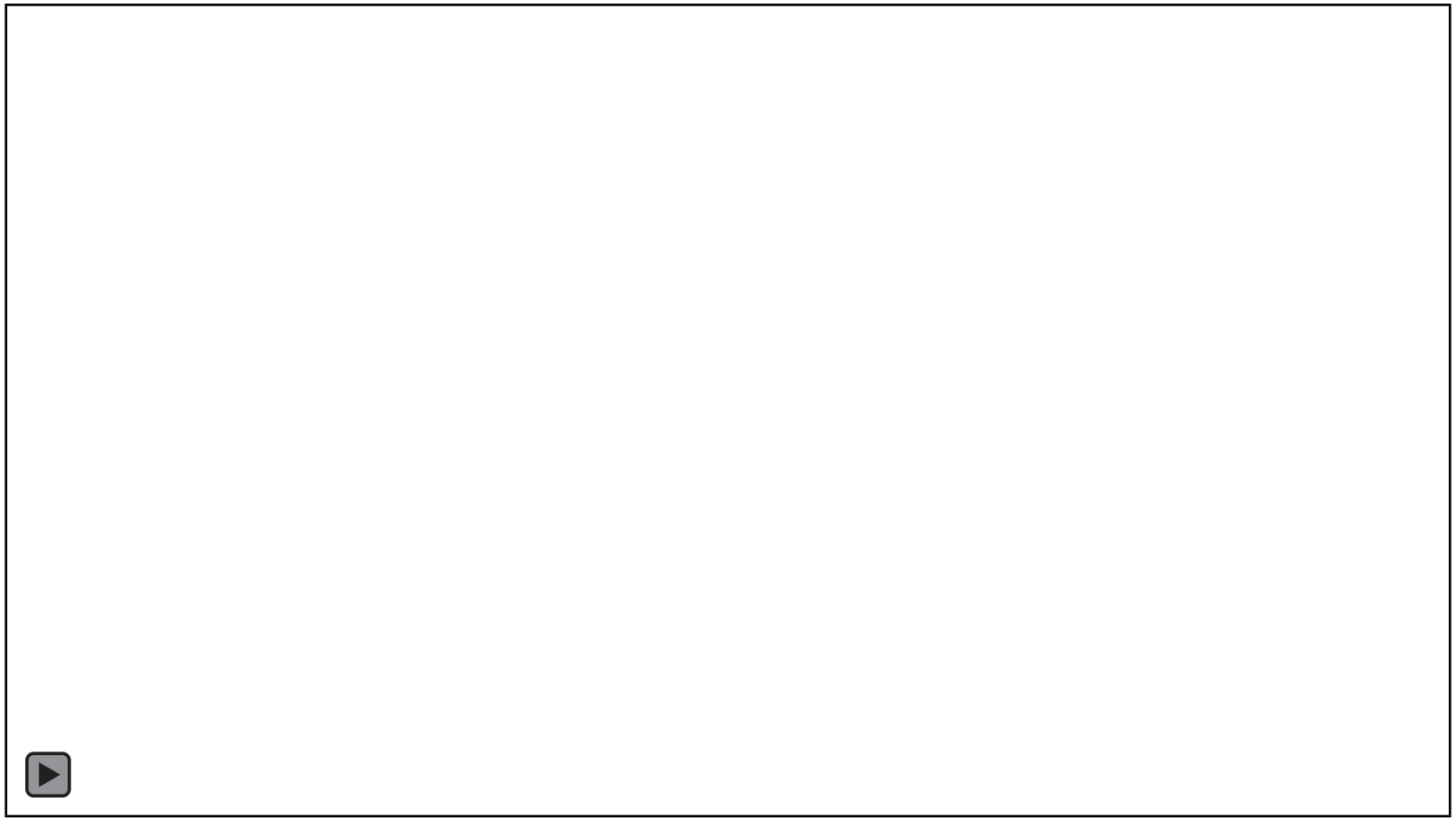
Working with Seniors and Person with Disabilities

SPDs may deal with multiple challenges to accessing quality healthcare.



Communication with Persons with Disabilities

Click on picture to view play button, or copy link into your browser



www.youtube.com/watch?v=Gv1aDEFlXq8

Disability Sensitivity Video (3:41 min)

Disability Etiquette

Person-First Language

- Show respect by putting the person before the disability
- The disability or the equipment they use is a descriptor
- People with a disability are more like people without disabilities than different

People First Examples

BEST	AVOID
People or persons with disabilities.	The handicapped or disabled.
He has a cognitive disability.	He is mentally retarded.
She has autism.	She is autistic.
He has a physical disability.	He is a quadriplegic.
She uses a wheelchair.	She is wheelchair bound.
Children without disabilities.	Comparing children with disabilities to normal or healthy children.
Accessible parking, doctor's office, transportation, etc.	Handicapped parking, doctor's office, transportation, etc.

Members who have Mobility Impairments

- Don’t push or touch someone’s wheelchair.
- Don’t lean on the chair.
- Bring yourself to their level to speak.
- Invisible mobility disabilities are common – don’t assume you can tell by watching someone move.
- Ask before giving assistance.

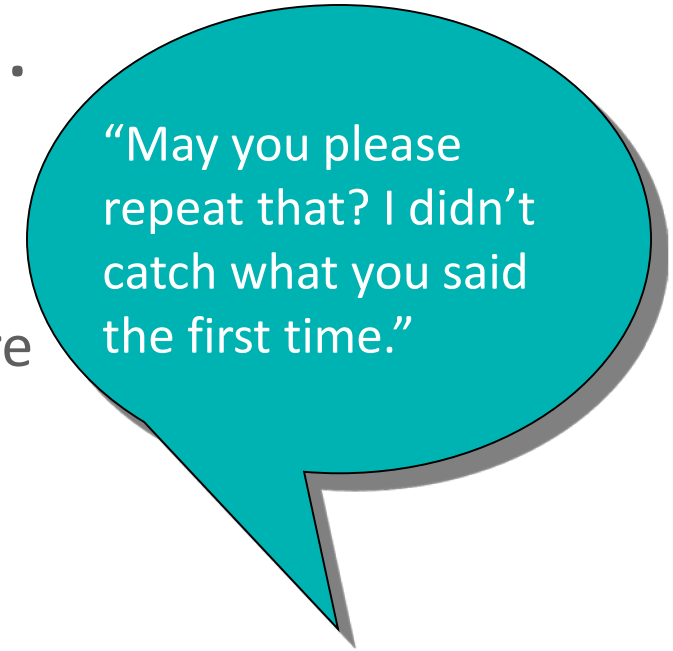
Members with Learning Disabilities

- **There are many forms of learning disabilities. Examples may include:**
  - Dyslexia
  - Auditory or Language Processing Disorders
  - Attention Deficit Hyperactive Disorder
- **Do:**
  - Break ideas or processes into small steps
  - Check for understanding
  - Present things both verbally and visually
  - Offer to read things aloud
  - Allow time; be patient
- **Don't:**
  - Ask to "hurry up!"

Members with Speech Disorders

If you don't understand someone . . .

- **Do**
  - Ask the person to repeat
  - Repeat what you heard to make sure you understood correctly
  - Offer pen and paper if an option
  - Be patient
- **Don't**
  - Speak loudly or shout
  - Finish a person's sentence or thought



Members who are Deaf or Hard of Hearing

- Talk by **phone** with members with hearing and speaking impairments using the California Relay Service (CRS) at **711**.
- Learn about how **video phones** help Deaf and hard-of-hearing people who use sign language to communicate.
- **Create trust** - Face the person you are speaking with. Avoid side conversations.
- Offer to arrange for qualified **American Sign Language (ASL)** interpreters for health care communications and appointments.
  - Remember to speak to the person, not the interpreter!
  - Consider that foreign-born deaf may not use ASL or be fluent in ASL, but use another culture specific sign language. A specialist may be required to communicate.
- Use **lip reading** with caution. Do not assume members can read lips. Lip/speech reading can lead to communication errors. Lighting, accents, even facial hair can make it hard.
- **Writing** may or may not be a good way to communicate. ASL is not the same as written or spoken English. Ask members what works best for them.

Members who have Visual Impairments

- **Communication strategies**
  - Identify yourself
  - Offer to read text or documents
  - Create documents in large font
    - → 14 pt. minimum
  - Translate key materials into braille upon request

Service Animals

- **Do**
  - If not sure, ask if the animal provides assistance for a disability
  - Recognize that service animals assist people with many different types of disabilities
  - Ask your supervisor for help if you are allergic to dogs or are fearful of being near a service animal
- **Don't**
  - Deny a member with a service animal entrance inside the clinics or Alliance offices
  - Pet any service animal or give it a treat without asking first.

Language Assistance Resources

ALAMEDA Alliance FOR HEALTH

Language Assistance Program

The Alliance has a Language Assistance Program that:

- Asks the **Consumer Advisory Committee (CAC)** for input on ways to better serve our members both culturally and linguistically
- Holds quarterly **Language Assistance Program Sub-Committee** meetings to monitor C & L services and address any concerns
- Monitors **provider language capacity**
- Ensures **bilingual staff** are assessed and monitored for quality
- Tracks our **member language preferences** and ethnicities
- Monitors our cultural and linguistic services through **grievance and appeals review**

Interpreter Services: What's Covered

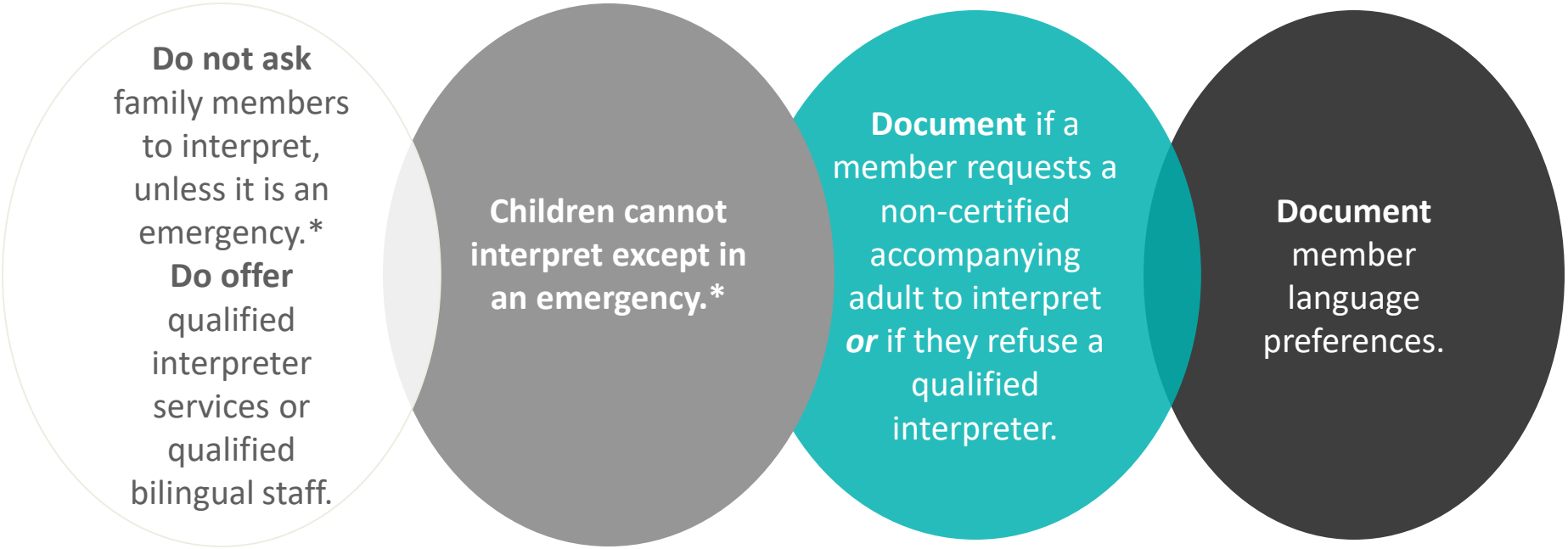
- All members are entitled to an interpreter at all points of contact for covered benefits.
- Points of contact include but not limited to:
  - hospitals
  - provider offices
  - member services settings
  - covered case management & health education
  - administrative offices and facilities

- Offer interpreter services at the time of appointment scheduling.
- Note language preferences in member record

Interpreter Services: How to Access

- The Alliance uses **International Effectiveness Center (IEC)** and **Hanna Interpreting** for interpreter services
  - For 24/7 telephonic interpreter services, providers may call **1.510.809.8939**.
  - Member requests for in-person interpreters may go through the Alliance Member Services Department **1.510.747.4567**.
  - Providers requesting interpreter services for members should fax the Alliance the **Interpreter Services Appointment Request Form** found at **www.alamedaalliance.org**. Please submit a request at least five (5) working days prior to appointment.
- Many contracted clinics also have qualified interpreters or bilingual staff on-site. Sites must keep proof of bilingual staff proficiency.
- Hospitals are required by state law to provide interpreter services to patients (AB 389 Chapter-327).

Family & Friends as Interpreters?



* Emergency is defined as an immediate threat to the safety or welfare of an individual or the public. – Affordable Care Act, Section 1557

Tips for Working with Interpreters

- Hold a brief introductory discussion
  - Your name, organization and nature of the call/visit
  - Reassure the patient about confidentiality
- Allow enough time
- Avoid interrupting
- Speak in a normal voice; not too fast or too loudly
- Speak in short sentences
- Avoid acronyms, medical jargon

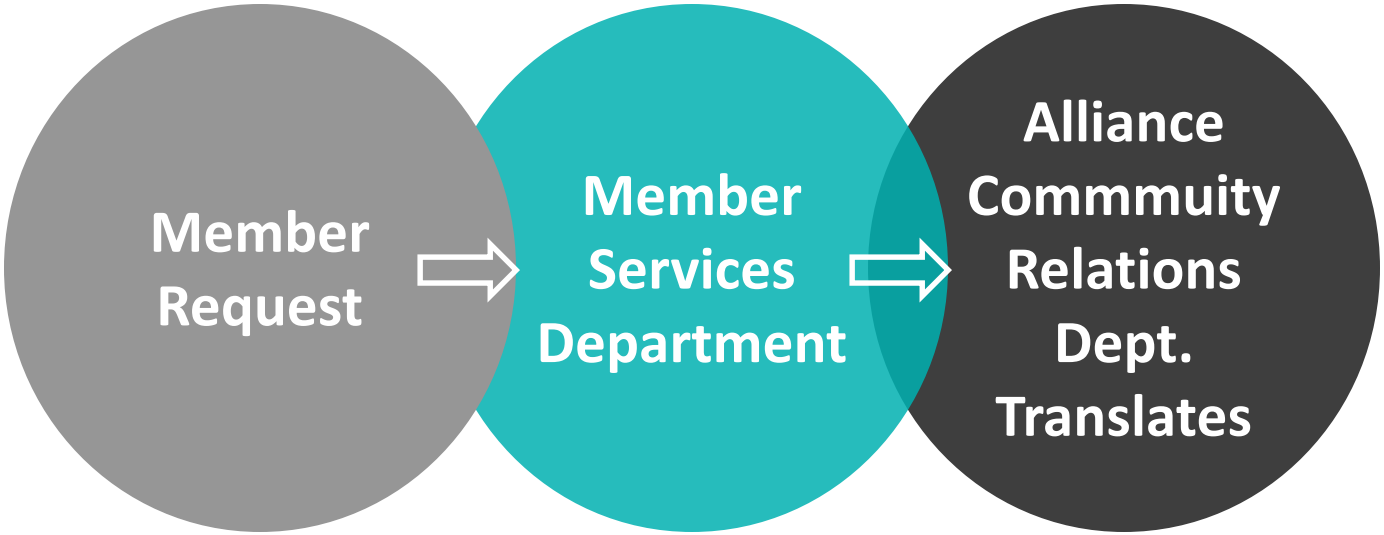
Tips for Working with Interpreters

- **If in-person:**
  - Face and talk to the member directly
  - Be aware of the cultural context of your body language
  - Mirror the body language, position, eye contact
  - Ask the patient if they look unclear

Would you like to see an example? Check out this video:
www.tisnational.gov.au/About-TIS-National/Videos/Hints-and-tips-for-working-with-interpreters-video.aspx

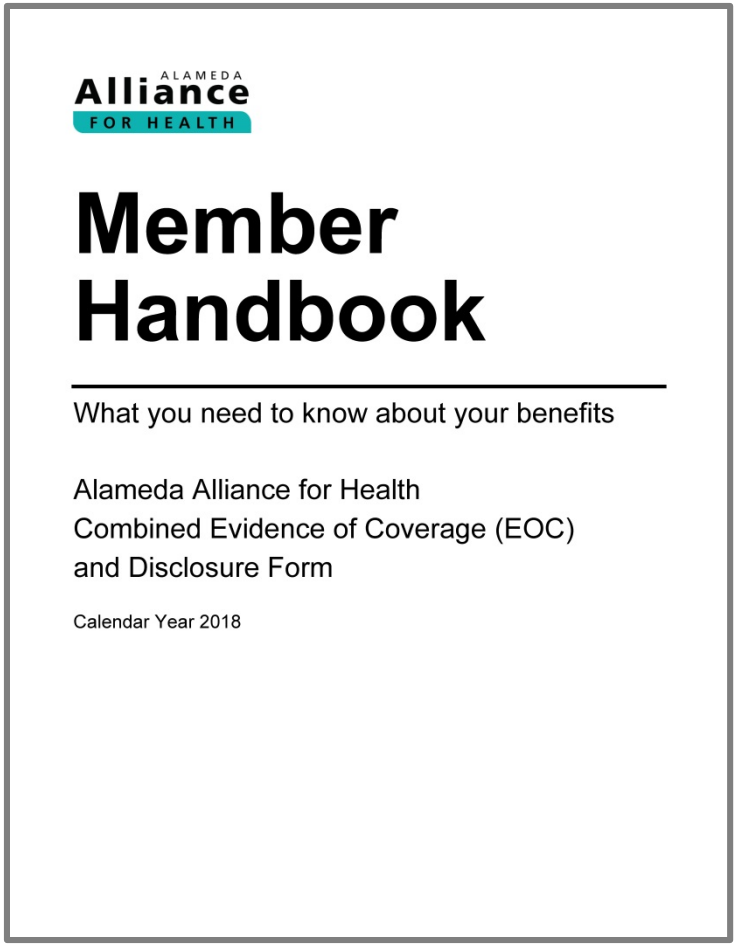
Member Facing Material Translations

- Alliance members have the right to have member material translated into their preferred reading language or a preferred alternative format such as braille, large font, or audio.
- The Alliance has **21 days** to fill the request.
- To make a request, Alliance members may call the Alliance Member Services Department at **1.510.747.4567**.



Provider Directory & EOC

- The **Provider Directory** helps members to find providers that fit their preferences (language, gender, location, accessibility, etc.)
- The **Alliance Evidence of Coverage** (EOC) describes how to access language assistance and how to file grievances.
- The EOC and Provider Directory are available in print form, on our website and in all our threshold languages.



Cultural Sensitivity Requires Lifelong Learning

Ask respectful questions, and question assumptions.

Learn more at:

- Think Culture Health: **www.thinkculturalhealth.hhs.gov**
- Stanford University, Ethnogeriatics: **geriatrics.stanford.edu/culturemed.html**
- EthnoMed: **ethnomed.org/culture**
- University of Pennsylvania Health Services – Religion and Healthcare: **www.uphs.upenn.edu/pastoral/resed**
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations by the Industry Collaboration Effort, ICE. **www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**

Thank You!

For questions about the presentation and the Alliance Cultural and Linguistics Services Program, please contact:

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