Dear Provider:

At Children's Physician's Medical Group/Rady Children's Health Network (CPMG/RCHN) our focus is on the health and wellness of our pediatric members. Our mission is to support and enhance the physician-patient relationship through ensuring excellence in clinical care, quality and service. One way to achieve our mission is to partner with outstanding providers who share our vision of transforming the way pediatric care is delivered.

CPMG/RCHN is providing this manual as a resource for you to use in working with us. We have included business, clinical and contact information in the manual, so that you will be able to find answers to daily process questions. As always, if you do not find the answer you are seeking, or have additional questions, please call the appropriate contact staff person. Name and contact information are located in Section B.

CPMG/RCHN appreciates your partnership and we look forward to collaborating with you to provide outstanding patient care.

Sincerely,

Your Provider Relations Team at CPMG/RCHN

Provider Manual

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January 2022

MISSION STATEMENT

At Children's Physicians Medical Group our only focus is on the health and wellness of our pediatric members. Our mission is to support and enhance the physician-patient relationship through ensuring excellence in clinical care, quality and service.

VISION STATEMENT

Children's Physician's Medical Group is a unique network of dedicated pediatric physicians providing care for children. Our vision is to delight our customers and transform the way pediatric care is provided.

CPMG/RCHN KEY CONTACT LIST

- **Business**
  - **Wanda Koreski** – Executive Director
    (858) 309-6274
    wkoreski@rchsd.org
  - **Katie Coleman** – Director, UM Operations & Customer Service
    (858) 634-4963
    kcoleman@rchsd.org
  - **Nancy Evans** – Claims Director
    (858) 966-8118
    nevans@rchsd.org
  - **Loni Chun** – Claims Manager
    (858) 966-8119
    lnchun@rchsd.org
  - **Amanda Coffey** – Manager of EDI Operations
    (858) 966-8072
    acoffey@rchsd.org
- **Provider Relations**
  - **providerrelations@rchsd.org**
  - **AnnaMarie Agreda** – Sr. Provider Relations Representative
    (858) 634-4954
    amagreda@rchsd.org
  - **Denise Aguirre** – Sr. Provider Relations Representative
    (858) 634-4970
    daguirre@rchsd.org
  - **Noelle Duong** – Provider Relations Representative
    (858) 309-6270 x219013
    nduong@rchsd.org

- **Clinical/Quality Improvement**
  - **RN Case Managers**
    1-877-276-4543

- **Customer Service**
  - Website – network.radychildrens.org
    www.CPMGSanDiego.com User
    Name – cpmgdocs
    Password – Cpmgdocs2010
  - Customer Service and Authorizations
    (1-877-276-4543)

INITIAL CREDENTIALING REQUIREMENTS

One of CPMG/RCHN's goals is to recruit, establish and maintain a high quality network of physicians, allied health professionals and ancillary service providers. To achieve this goal, CPMG/RCHN follows the National Committee for Quality Assurance (NCQA) guidelines for our business processes, including credentialing. NCQA is a private not-for-profit organization dedicated to improving health care quality and is a widely recognized symbol of quality.

The following is a list of CPMG/RCHN credentialing requirements:

- Interview
- Primary specialty is Pediatrics (PCP only)
- Three peer references
- Pediatric leadership in his/her practice area
- Perceived ability to practice high quality, managed care pediatric medicine effectively
- Rapport with pediatric physician colleagues, patients and staff
- Commitment to mission to contribute to the health of the community
- Complete Application
    1. Current license verification
    2. Clinical privileges in good standing at CPMG/RCHN hospitals
    3. Current malpractice coverage verification
    4. Current Board Certification (or Board Eligible with current possible date for testing)
    5. Current DEA Certificate
    6. Query to professional liability insurance carrier and acceptable history
    7. Reports from the National Practitioner Data Bank and Medical Board of California and Medicare and Medicaid sanction reports
- Credentialing fee $250.00 (PCP only)

Fair Hearing Plan:
Part of CPMG/RCHN's credentialing process is to provide a process for a fair review of decisions that adversely affect practitioners and to protect the peer review participants from liability. A detailed description of this process is included in this manual.

RE-CREDENTIALING REQUIREMENTS

NCQA guidelines require a formal re-credentialing of providers every three years. By re-credentialing providers, CPMGRCHN maintains our high-quality network. CPMG/RCHN provider panel participation shall be maintained only for those practitioners who demonstrate that they continuously meet the qualifications, standards and requirements established by CPMG/RCHN.

- Re-credentialing Requirements

    1. Current license verification
    2. All hospital privileges must be in good standing
    3. Current malpractice coverage verification
    4. Current Board Certification
    5. Current DEA certificate
    6. Query to professional liability insurance carrier and acceptable history
    7. Reports from the National Practitioner Data Bank and Medical Board of California and Medicare and Medicaid sanction reports

- May include review of relevant data from:

    1. Member complaints and satisfaction surveys
    2. Findings from CPMG/RCHN's utilization review and quality assurance programs, including but not limited to patterns of care, patient complaints/grievances and adherence to clinic standards.

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CHILDREN'S PHYSICIANS MEDICAL GROUP, INC.
A California Professional Corporation

FAIR HEARING PLAN

1. PREAMBLE AND DEFINITIONS

1.1 Review Philosophy. The goal of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (physicians employed by or otherwise under contract with Children's Physicians Medical Group ("CPMG") and to protect the peer review participants from liability.

1.2 Exhaustion of Remedies. A practitioner must exhaust the remedies afforded by this Fair Hearing Plan before resorting to formal legal action (a) challenging any decision made pursuant to this Plan, or the procedures used to arrive at such decision, or (b) asserting any claim against Children's Physicians Medical Group ("CPMG") or any participants in the decision making process.

1.3 Authority of Committees. The hearing committees established pursuant to this Fair Hearing Plan have no authority to adopt or modify rules and standards, or to decide questions about the merits or substantive validity of bylaws, the Fair Hearing Plan, rules, regulations or policies. Only the CPMG Board of Directors may entertain challenges to the merits or substantive validity of bylaws, rules, regulations or policies or this Fair Hearing Plan and decide those questions.

1.4 Privileges and Immunities. The hearing committees established pursuant to this Fair Hearing Plan, the CPMG Peer Review Committee, and all committees and individuals assigned peer review functions, shall have all privileges and immunities to the fullest extent provided by law

2. GROUNDS OF FAIR HEARING

2.1 Grounds for Hearing. Except as otherwise specified in this document, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

2.1.1 Denial, suspension or revocation of employment or other provider status for medical disciplinary cause or reason;

2.1.2 Employment or other contract termination for medical disciplinary cause or reason; and/or

2.1.3 Involuntary imposition of significant consultation or monitoring requirements status for medical disciplinary cause or reason;

2.2 Definition of "Medical Disciplinary Cause or Reason". For purposes of this Fair Hearing Plan, the phrase "medical disciplinary cause or reason" means that aspect of a physician's competence or professional conduct which is reasonably likely to be detrimental to

patient safety or to the delivery of patient care. In the event the definition of "medical disciplinary cause or reason" as set forth in Section 805(a)(6) of the California Business and Professions Code is changed or modified, the definition set forth in this Section 2.2 shall be likewise changed or modified as of the effective date of such change to the Business and Professions Code.

3. NOTICE OF ACTION OR PROPOSED ACTION

3.1 Notice of Adverse Action. In all cases in which action adverse to a physician has been taken for medical disciplinary cause or reason, or a recommendation to take such adverse action has been made by a CPMG committee to the CPMG Board and will be accepted by the Board subject to the affected physician's fair hearing rights, and that such action, if adopted, shall is reportable to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code, then CPMG shall give the physician prompt written notice ("Notice of Adverse Action") of the recommendation or final proposed action. The notice shall inform the physician of the right to request a hearing pursuant to Section 4, and that such hearing must be requested within thirty (30) days.

3.2 Recommendation of Adverse Action. CPMG's Peer Review Committee, Quality and Risk Management Committee, or other committee created by the Board, or any of their designees, may be the committee making a recommendation of adverse action to the Board. Such adverse recommendation may be made in the context of a corrective action in connection with quality assessment and improvement activities, in response to a specific complaint or in response to the receipt of other information regarding a physician's conduct. Any such committee making a recommendation of adverse action to the Board shall be hereafter referred to as the "Peer Review Committee". In the event the physician against whom such adverse action is recommended requests a hearing under this Fair Hearing Plan, a representative of the Peer Review Committee will present evidence which supports the basis of the proposed recommendation. Such representative is generically referenced in this Fair Hearing Plan as the CPMG Representative.

4. REQUEST FOR HEARING

4.1 The physician shall have thirty (30) days following receipt of the Notice of Adverse Action to request a hearing. The request for hearing shall be in writing addressed to the Chairperson of the Peer Review Committee with a copy to the CPMG President. In the event the physician does not request a hearing within the time and in the manner described, the physician shall be deemed to have waived any right to a hearing and to any appellate review and to have accepted the recommendation, decision or action involved which shall become effective immediately. In such case, the recommendation, decision, or action involved shall become the final recommendation of the body making it.

5. TIME AND PLACE FOR HEARING

5.1 Notice of Hearing. Upon receipt of a request for hearing, CPMG shall schedule a hearing not earlier than thirty (30) days and within sixty (60) days following receipt of the request for hearing and shall give notice to the physician of the time, place and date of the hearing as soon as practical but in no event less than ten (10) days prior to the actual hearing

date; provided, however, that when the request is received from a physician who is under summary suspension or restriction, or whose contractual relationship with CPMG has been terminated, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for hearing.

5.2 Notice of Reasons for Adverse Action. Together with the notice stating the place time and date of the hearing, CPMG shall state clearly and concisely in writing the reasons for the adverse final proposed action taken or recommended, including the acts or omissions with which the physician is charged and a list of the charts in question, where applicable.

6. JUDICIAL REVIEW COMMITTEE

6.1 When a hearing is requested, CPMG shall appoint a Judicial Review Committee composed of not less than three (3) physicians, who may but need not be CPMG employees, who shall gain no direct financial benefit from the outcome, and who have not acted as an accuser, investigator, fact-finder, initial decision maker or otherwise actively participated in the consideration of the matter leading up to the recommendation of adverse action. Whenever feasible, at least one (1) Judicial Review Committee member should practice the same specialty as the affected practitioner. CPMG will also appoint a Chairman of this committee. CPMG may, at its discretion, appoint up to two (2) alternates for the Judicial Review Committee. The alternates shall not be entitled to vote on or otherwise participate in the deliberations or decision of the Judicial Review Committee unless the alternate has replaced one of the three (3) (or more) members of the Judicial Review Committee. CPMG shall have the exclusive right to dismiss the alternates at anytime during hearing process prior to an alternate having replaced one of the three (3) members of the Judicial Review Committee. Knowledge of the matter involved shall not preclude a physician from serving as a member of the Judicial Review Committee. All members of the Judicial Review Committee, and any alternates, shall have M.D. or D.O. degrees and be licensed to practice medicine in the State of California.

7. FAILURE TO APPEAR AND PROCEED

7.1 Failure without good cause of the physician to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become the final recommendation of the Peer Review Committee. Such final recommendation immediately shall be referred to and considered by the Board. Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted may be permitted by CPMG on a showing of good cause, or upon agreement of the parties.

8. PREHEARING PROCEDURES

8.1 Witness Lists. If either side of the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing.

8.2 Physicians Right to Inspect Documents. The physician shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall

also have the right to receive at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the physician to prepare a defense, including all evidence which was considered by the Peer Review Committee.

8.3 CPMG's Right to Inspect Documents. CPMG shall have the right to inspect and copy any documents or other evidence relevant to the charges which the physician has in his or her possession or control as soon as practicable after receiving the request for hearing.

8.4 No Right to Confidential Information. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians, other than the physician under review.

8.5 Costs of Copying. The costs of inspection and copying of documents and other evidence shall be born by the party requesting such inspection and copying.

8.6 Failure to Provide Access. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance.

8.7 Ruling on Information Requests. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards that protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

8.7.1 Whether the information sought may be introduced to support or defend the charges;

8.7.2 The exculpatory or inculpatory nature of the information sought, if any;

8.7.3 The burden imposed on the party in possession of the information sought, if access is granted; and

8.7.4 Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

8.8 Voir Dire. CPMG and the physician shall each be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. The hearing officer shall rule upon challenges to the impartiality of any Judicial Review Committee member or the hearing officer. The Judicial Review Committee shall rule upon challenges to the impartiality of the hearing officer. Failure to challenge the impartiality of Judicial Review Committee members or the hearing officer at the outset of the hearing shall be deemed acceptance of the members and/or the hearing officer.

8.9 Notice of Procedural Disputes. It shall be the duty of the physician and the CPMG Representative to exercise reasonable diligence in notifying the hearing officer, or the chairman of the Judicial Review Committee if no hearing officer has been appointed, of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible,

in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

9. REPRESENTATION

9.1 The purpose of the hearing is to provide a forum for an impartial evaluation of the evidence bearing on professional conduct, professional competency, character or other factors on which an adverse decision affecting the physician are based. The hearing is not a courtroom trial but a process whereby a physician's conduct, competence, character or other professional attributes are evaluated by his or her peers.

10. THE HEARING OFFICER

10.1 CPMG can appoint a hearing officer to preside at the hearing. The hearing officer shall gain no direct financial benefit from the outcome. The hearing officer may be an attorney so long as the attorney is not regularly utilized by CPMG for legal advice regarding its affairs and activities. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and arguments during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but shall not act as a prosecuting officer or advocate and shall not be entitled to vote.

11. RECORD OF THE HEARING

11.1 A shorthand reporter shall be present to make a record of the hearing proceedings. A shorthand reporter shall be present to make a record of the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CPMG, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on an oath administered by any person lawfully authorized to administer such oath.

12. RIGHTS OF THE PARTIES

12.1 Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The physician may be called by the CPMG Representative and examined as if under cross-examination.

13. MISCELLANEOUS RULES

13.1 Judicial rules of evidence and procedure relating to the conduct of a court proceeding, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Fair Hearing Plan. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may question the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

14. BURDENS OF PRESENTING EVIDENCE AND PROOF

14.1 Initial duty to Present Evidence. The CPMG Representative shall have the initial duty to present evidence that supports the charge(s) or recommended action.

14.1.1 Burden of Persuasion. The CPMG Representative shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence that the adverse action or recommendation is reasonable and warranted.

15. ADJOURNMENT AND CONCLUSION

15.1 After consultation with the chairman of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the CPMG Representative and the physician may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

16. BASIS FOR DECISION

16.1 The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable interferences from the evidence and the testimony. The decision of Judicial Review Committee shall be subject to such rights of appeal as described in these procedures.

17. DECISION OF THE JUDICIAL REVIEW COMMITTEE

17.1 Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision that shall be accompanied by a report in writing. If the physician is under summary suspension or restriction at the conclusion of the hearing, the time for the issuance of the decision and report shall be fifteen (15) days. A copy of said decision shall be forwarded to the physician. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision of the Judicial Review Committee shall be subject to such rights of appeal for review as described in these procedures.

18. APPEAL

18.1 Time For Appeal. Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the physician or the CPMG Representative may request an appellate review. A written request for such review shall be delivered to the CPMG President, and the other party to the hearing within the ten (10) day period. If a request for appellate review is not made within such period, the decision of the Judicial Review Committee shall become final. Physicians are notified of the appeal process through the Fair Hearing Plan document distributed to them at the time of joining CPMG.

18.2 Grounds For Appeal.

18.2.1 Identification of Grounds for Appeal. A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

18.2.1.1 substantial non-compliance with the procedures required by this Fair Hearing Plan or applicable law which has created demonstrable prejudice; or

18.2.1.2 the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 18.5.1, below.

18.2.2 Statement of Facts. The statement of facts in support of the appeal shall demonstrate error based on the transcript from the Judicial Review Committee hearing, and based upon such additional evidence as may be submitted to the appeal board in accordance with this Fair Hearing Plan. In the event the transcript from the Judicial Review Committee hearing is not available to the appealing party within three (3) days prior to the date upon which the written request for appeal is due, the statement of facts in support of the appeal may be filed up to ten (10) days after the written request for appeal is filed. Any such delay shall not excuse the appealing party from their obligation to demonstrate error based on the transcript from the Judicial Review Committee hearing.

18.3 Notice Setting Appeal Hearing. If an appellate review is to be conducted, the Board of Directors of CPMG shall, within fifteen (15) days after receipt of notice of appeal, schedule an appeal hearing date and cause each side to be given notice of the time, place and date of the appellate review ("Notice Setting Appeal Hearing"). The date of the appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of the Notice Setting Appeal Hearing, provided however, that when a request for appellate review concerns a physician who is under summary suspension or restriction, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the Notice Setting Appeal Hearing. The appeal board for good cause may extend the time for appellate review.

18.4 Appeal Board. CPMG shall appoint an appeal board that shall be composed of not less than three (3) physicians. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person was not previously involved with the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

CPMG shall have the right to approve or disapprove of the legal fee arrangements with the attorney selected by the appeal board, provided that CPMG shall not unreasonably withhold its approval.

18.5 Appeal Procedure.

18.5.1 Appellate Hearing. The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination and confrontation provided at the Judicial Review Committee hearing. The appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for further decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the parties.

18.5.2 Transcript on Appeal. The party requesting appellate review shall order the complete transcript from the Judicial Review Committee hearing and shall make such transcript available to the appeal board in its entirety.

18.5.3 Obligation to Show Error. It shall be the appellant's obligation on appeal to affirmatively show error based upon the record of the hearing before the Judicial Review Committee, or based upon such additional evidence as may be allowed pursuant to Section 18.5.1 above. The Decision of the Judicial Review Committee shall be presumed correct.

18.5.4 Substantial Evidence Rule. The appeal board shall review challenges to the sufficiency of the evidence under the Substantial Evidence Rule.

18.5.5 Briefing Schedule. The appeal board may establish a briefing schedule to be met by the parties.

18.6 Decision.

18.6.1 Delivery of Decision. Except as provided in Section 18.6.2 below, within thirty (30) days after the conclusion of the appellate review proceedings, the appeal board shall present to the CPMG Board of Directors and to the physician its decision as to whether the Judicial Review Committee's decision should be affirmed, modified, reserved; or remanded to the Judicial Review Committee for further review and decision.

18.6.2 Modification or Remand. Should the appeal board determine that the Judicial Review Committee decision is not supported by substantial evidence, the appeal board may modify or reverse the decision of the Judicial Review Committee. Alternatively, the appeal board may, or shall, where a fair procedure has not been afforded, remand the matter back to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded back to the Judicial Review Committee for further review and decision, the

Judicial Review Committee shall promptly conduct its review and deliver its decision to the appeal board. This further review and the time required to report back shall not exceed forty-five (45) days in duration except as the parties may otherwise agree or for good cause as determined by the appeal board.

18.6.3 Written Decision. The decision of the appeal board shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the CPMG Board of Directors and the physician.

18.7 Finality of Decision and Right to One Hearing Only. The decision of the Board of Directors, following the appeal procedure, shall be final and effective immediately. No party is entitled as a matter of right to more than one appellate review hearing on any single matter.

19. AMENDMENT

19.1 Board Action. The CPMG Board of Directors may amend this Fair Hearing Plan at any time, and from time to time, as it shall in its sole discretion deem appropriate. The Board of Directors shall also have the power to revoke this Fair Hearing Plan, in whole or in part, at any time, with or without the substitution of any other policy.

APPROVED BY THE CPMG PEER REVIEW COMMITTEE:

Date: February 2011 By: ____________________

APPROVED BY THE BOARD OF CPMG:

Date: February 2011 By: ____________________

USE OF THE CPMG/RCHN NETWORK

Section 2.9 of your contract explains that referrals should be made to in-network, contracted providers. These providers can be found using the rosters available on the CPMG/RCHN website (see the Contacts list in this manual for information on how to log in to the website). Laboratories are included in the "in-network" requirement for referrals. CPMG/RCHN has developed forms to help in referring members to approved lab draw sites. (See Lab Waiver forms on the next page or in the "Forms" section of this manual). Failure to utilize in-network (physicians or laboratories) may result in financial sanctions.

- The following rosters are available on the CPMG web site:
    - Primary Care Physicians
    - Specialist Physicians
    - Ancillary Providers
        - Radiology
        - Rehabilitation Therapies
        - Radiation Therapy
        - Sleep Studies
        - Durable Medical Equipment
        - Orthotics/Prosthetics
        - Home Health
    - Lab Draw Sites
        - San Diego County
        - Riverside County
    - Health Plan Rosters
        - DME Rosters for each health plan
        - Orthotics/Prosthetics Rosters for each health plan

- Should a member ask to self-pay rather than access insurance benefits, please have the patient complete a Non-Covered Services Waiver found in the "Forms" section of this manual, or on our website, www.cpmgsandiego.com.

Timely Access Regulations

This notification summarizes the timely access to care standards, to include appointment availability and after-hours protocols. Each provider office is required to abide by these standards. As well, the CPMG PR team will conduct annual audits to ensure compliance. Please read and familiarize yourself with the following standards.

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent appointments that require prior authorization (PCP and SCP)	Must offer the appointment within 96 hours of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent appointments for Primary Care (PCP, excludes physicals and wellness checks)	Must offer the appointment within 10 business days of request
Non-urgent appointments with Specialist physicians (SCP)	Must offer the appointment within 15 business days of request
Urgent appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	Must offer the appointment within 48 hours of request
Urgent appointments that require prior authorization (PCP & SCP)	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment

Access Measure	Time-Elapsed Standard
	within 5 business days of request
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (enrollees age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (enrollees age 18 months and younger)	Must be completed within 60 calendar days of enrollment

Exceptions

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Advanced Access: The primary care appointment availability standard listed above may be met if the primary care physician office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

Triage/After Hours Care Standards

- ✓ Triage or screening by telephone 24 hours a day, 7 days a week.
- ✓ After hours and weekends, provider medical advice and triage lines shall instruct patients to call 911 if there is a life or limb threatening emergency.

- ✓ Must provide the patient with: a phone/pager number, an on-call provider or nurse triage for appropriate screening/referral, an answering service or voicemail ability to leave a message.
- ✓ Answering service or recorded message must state a 30 minute time range for when the patient should expect to hear from the provider.

Phone Message Examples

You have reached the office of _________. If this is a medical emergency, hang up and dial 911 or go to the nearest emergency room. The office is now closed, but if you need to speak to a physician,

Option 1: Please stay on the line and you will be connected to Dr./Nurse _____.
Option 2: You may page Dr. ______at _______and you will receive a call back within 30 minutes.
Option 3: Please leave your name and a call back number. Dr. _____will call you back within 30 minutes.

TIMELY ACCESS REGULATIONS
FREQUENTLY ASKED QUESTIONS (FAQs)

QUESTION	ANSWER
1. What is the effective date of the Timely Access Regulations?	The effective date of the Timely Access Regulations is 1/17/11.
2. To which provider types do the Timely Access Regulations apply?	The Timely Access Regulations establish appointment availability standards for primary care physicians, specialist physicians, ancillary providers (physical therapy, radiology, laboratory, etc.), and mental health providers.
3. To which types of insurance products do the Timely Access Regulations apply?	The Timely Access Regulations apply to those plans that are regulated by the Department of Managed Health Care (DMHC), including commercial HMOs, Medi-Cal HMOs, certain PPOs, including some offered by Anthem Blue Cross and Blue Shield of California, Healthy Families, Healthy Kids, and Access for Infants & Mothers (AIM). The Timely Access Regulations DO NOT apply to PPOs that are not regulated by the DMHC, fee-for-service Medi-Cal, fee-for-service Medicare, or Medicare Advantage plans.
4. Do the appointment availability standards in the Timely Access Regulations apply to all types of patient visits?	No. The Timely Access Regulations do not apply to: • Preventive care (including routine physicals and well-child care); • Periodic follow-up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits for pregnancy, cardiac care, and mental health care; • Laboratory and radiological monitoring for recurrence of disease. All of these types of care are not subject to the Timely Access Regulations and may be scheduled consistent with professionally recognized standards of practice.
5. What if a physician believes that a patient does not need to be seen with the timeframes set forth in the	The applicable waiting time for a particular appointment may be extended only if the referring or treating licensed health care

TIMELY ACCESS REGULATIONS
FREQUENTLY ASKED QUESTIONS (FAQs)

QUESTION	ANSWER
appointment availability standards?	provider, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
6. Can the appointment scheduler in a physician office determine when the appointment availability standards may be extended?	No. This determination may be made only by the referring or treating licensed health care provider, acting within the scope of his or her practice and consistent with professionally recognized standards of practice. See question #5 above.
7. Do the Timely Access Regulations set forth any specific requirements as it relates to medical record documentation when a physician determines that a longer waiting time for an appointment will not be detrimental to the patient?	No. The Timely Access Regulations do not set forth specific chart documentation standards, other than to say that this decision must be documented in the relevant record.
8. What is "advanced access" and how does it relate to compliance with the appointment availability standards?	"Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day). If a primary care physician offers "advanced access," it is considered to be in compliance with the appointment availability standards in the Timely Access Regulations.
9. Does the 30-minute standard for triage and screening apply to physician offices?	Health plans are responsible for ensuring that the triage and screening requirements required by the Timely Access Regulations are met. However, health plans are permitted to delegate the triage and screening function to providers if such delegation is negotiated and agreed to by the provider in writing.
10. How will health plans monitor compliance with the Timely Access Regulations?	The Timely Access Regulations require health plans to use at least the following to assess access in their provider networks: 1) provider satisfaction surveys; 2) appointment availability surveys; 3)

TIMELY ACCESS REGULATIONS
FREQUENTLY ASKED QUESTIONS (FAQs)

QUESTION	ANSWER
	enrollee grievances and appeals; 4) information obtained through their triage and screening services.
11. How will health plans conduct the required provider satisfaction survey?	Health plans will conduct the provider satisfaction surveys via a web-based tool. The link to this tool will be distributed between March and August of 2011 to a random sampling of providers via email, FAX and/or U.S. mail. If your office receives a request to participate in the survey, please complete the survey promptly. You may participate in this survey, regardless of whether you've received a request to do so from a health plan, by going to the following Web site: www.iceforhealth.org/providersurvey. The identities of individual survey respondents will remain anonymous. Health plans are required to conduct this survey on an annual basis and report the survey results to the Department of Managed Health Care.
12. How will health plans conduct the required appointment availability survey?	Health plans will conduct appointment availability surveys with a random sampling of providers between March and August 2011. This telephonic survey, which is expected to take approximately 10 minutes or less, will ask provider offices how quickly they can schedule appointments for various types of non-emergency care. Provider offices are encouraged to participate in this survey. Health plans are required to conduct this survey on an annual basis and report the survey results to the Department of Managed Health Care.
13. What happens if a physician office does not meet the appointment availability standards?	Health plans are required to measure and monitor the performance of their provider networks against the appointment availability standards. As part of this measurement and monitoring process, health plans will focus on overall performance trends and patterns at the IPA/medical group level.

MEMBER ELIGIBILITY AND DISENROLLMENT

Eligibility:

- Providers are responsible for verifying eligibility prior to services being rendered, which is a requirement of your CPMG/RCHN contract.
- Eligibility should be verified as close to the appointment date as possible, by contacting the health plan directly, either by phone or via the health plan website. (CPMG/RCHN cannot provide eligibility verification.)
- Refer to the CPMG/RCHN Key Contact List for health plan phone numbers and websites.

Retroactive Eligibility Termination

Health plans *may* occasionally issue retroactive terminations of eligibility for CPMG/RCHN members, which are reported to CPMG/RCHN on a monthly basis only.
California legislation has been enacted, by an amendment to the CA Health & Safety Code (**AB1324** of 2007), which requires that providers be paid for claims for services rendered in good faith when:

- A specific authorization has been granted prior to rendering service; and,
- the provider has verified member eligibility prior to the date of service, and,
- the member is subsequently terminated from the policy

Documentation and/or proof of eligibility verification may be required for some health plans. Providers should follow up with CPMG/RCHN and the health plans if payment is not received for any such qualifying claim

Member Disenrollment:

Any participating physician may request that a CPMG/RCHN assigned member be reassigned to a different physician in the event that there are persistent issues that prevent an effective physician-patient relationship. Such a request cannot be based solely upon the filing of a grievance, an appeal, a request for external review or any other action by the member related to coverage, high utilization of services by the member or any reason that is not permitted under applicable law. Each of our contracted health plans has specific language for the member disenrollment process. Please call Customer Service for assistance with this process.

CLAIM SUBMISSION & INQUIRY

SUBMISSION:
Provider may submit claims electronically through a clearinghouse, or by paper.

- Per AB 1455 regulations, Provider must submit claims within 90 days after the Date of Service as a condition for payment, unless the Agreement provides for a longer time frame and except as otherwise required or permitted by any state or federal law or regulation.
- Provider may use a clearinghouse that may be associated with a billing service or through their practice software.
- CPMG/RCHN does have a business relationship with Office Ally (866-575-4120 or info@officeally.com) who will submit electronic claims at no charge to CPMG/RCHN's contracted Providers. For contact information, please call Provider Services.
- The payor ID for CPMG/RCHN with Office Ally is RCHN1.
- For paper claims please send to:

  Children's Physicians Medical Group/Rady Children's Health Network
  Attn: Claims Department
  P.O. Box 23076
  San Diego, CA 92193

INQUIRY:
Provider may check claim status:

- At EZ Net.rchsd.org. If you do not have EZ Net access, a user access Request form is required.
  The EZ Net user access request form is in the "FORMS" section of this manual and is also available in the ***Claims*** section at the CPMG web site www.CPMGSanDiego.com
- Call CPMG/RCHN Customer Service at 1-877-276- 4543.
- The EZ Net user access request form is in the "FORMS" section of this manual and is also available in the ***Claims*** section at the CPMG web site www.CPMGSanDiego.com.

PROVIDER DISPUTE RESOLUTION

Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care.

California regulations require that every provider dispute include the following information:

- Provider’s name
- Provider’s NPI number
- Provider’s tax identification number
- Provider’s contact information

A detailed description of the Provider Dispute Resolution (PDR) process is available on the CPMG web site at www.CPMGSanDiego.com. The PDR form is located in the “FORMS” section of this manual and also is available on the CPMG web site.

INFORMATIONAL RESOURCES

- CPMG Customer Service Department is available Monday through Friday from 8-5 to assist with questions on member authorizations, claim inquiries, and appeals and any additional questions you may have at 1-877-276-4543.

- CPMG Provider Relations Department is also available to help with Contractual, reimbursement or operational questions at 858-634-4951 or 858-634-4954.

- CPMG web site, www.CPMGSanDiego.com has many resources for providers. User name and password follows, please remember that both user name and password are case sensitive.

  - User Name: cpmgdocs
  - Password: Cpmgdocs2010
  - Additional resources available on the website include:
    - Clinical Guidelines
    - CPMG Events
    - CPMG/RCHN Provider Rosters
    - Educational information
    - EZ Net Form
    - Quick Reference Guide (QRG)
    - Urgent Care Roster

CLINICAL GUIDELINES
UM/QI POLICY AND PROCEDURES

- All clinical guidelines are reviewed by the appropriate department and providers annually. They are approved by the Quality of Care Committee on an annual basis.

- The CPMG/RCHN Clinical Guidelines that are available on the web site www.CPMGSanDiego.com are:
    - Asthma
    - Blood Pressure Assessment
    - Dermatology
    - Gastroenterology
    - Headache
    - Otitis Media
    - Overweight/Obesity
    - Plagiocephaly/Brachycephaly
    - Pneumonia
    - Rheumatology
    - Urology
    - Vision

- CPMG/RCHN updates our Policies and Procedures throughout the year to be compliant with all requirements by the National Committee for Quality Assurance, contracted health plans and the Industry Collaboration Effort.

Quality Program

What is Align, Measure, Perform (AMP)?

- The California AMP program is the largest nongovernmental physician incentive program in the United States.
- Founded in 2001, it is managed by the Integrated Healthcare Association (IHA) on behalf of eight health plans representing 10 million insured persons.
- IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in over 200 physician groups.

There are currently 4 different domains to the IHA P4P program:

1. **Clinical Domain**
    - ❖ Appropriate Testing for Children with Pharyngitis
    - ❖ Asthma Medication Ratio
    - ❖ Childhood Immunization Status
    - ❖ Chlamydia Screening in Women
    - ❖ Immunizations for Adolescents – Combo 1
    - ❖ Immunizations for Adolescents – Combo 2
2. **Advancing Care Information (formerly Meaningful Use of Health IT) Domain**
3. **Patient Experience Domain**
4. **Appropriate Resource Use Domain**

What is Healthcare Effectiveness Data & Information Set (HEDIS)?

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. HEDIS measures address a broad range of important health issues.

To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by National Committee of Quality Assurance (NCQA).

HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans.

See more at: http://www.ncqa.org/hedis-quality-measurement

*The AMP and HEDIS measures are updated annually. Please see our yearly Quality Program documents for more details.

**CHILDREN'S PHYSICIANS MEDICAL GROUP/
RADY CHILDREN'S HEALTH NETWORK
CASE MANAGEMENT DEPARTMENT**

The CPMG/RCHN Case Management Department strives to help members and their families with care coordination. Our Registered Nurses have many years of experience in both clinical pediatric nursing and managed care. CPMG/RCHN has several methods to identify members who could benefit from case management: provider referrals, inpatient referrals, health plan referrals, direct requests from the member or family, and utilization review.

The Case Management Department can help with a many types of cases including: complex needs, traumatic or catastrophic injury, transition into adult medical groups, help with coordination of health plan benefits or high utilization cases (including ER/UC).

Parents of these members will be contacted by a CPMG/RCHN RN Case Manager and offered case management services. These services are free to the member and are voluntary.

If you have a member you would like to refer to Case Management please complete the attached form and fax it to (858) 309-7977, attn: CPMG/RCHN Case Management Department.

Rady Children's Health Network

Children's Physicians Medical Group Case Management Request Form

Children's Physicians Medical group strives to provide your patients with the best quality of care. The Case Managers at CPMG are highly qualified registered nurses who will help to ensure members receive appropriate health services. The case managers can help with education, coordination between providers and answer any questions the member or their family might have.

Member Name: ______ Member DOB: ______ Health Plan: ______

Member's Primary Diagnosis: ______

Provider Requesting Case Management: ______

Reason for Referral to Case Management:

- [ ] Chronic Illness
- [ ] High Utilization (In and Out of Network)
- [ ] Transplant
- [ ] Overwhelmed Family/Caregiver(s)
- [ ] Multiple Specialty/DME needs
- [ ] Frequent ER or UC Utilization
- [ ] Other ____________________________

Comments: ____

____

____

Please fax back to (858) 309-7977, Attn: CPMG Case Management

GRIEVANCES

CPMG/RCHN receives official grievances directly from our contracted health plans. We are required to research the grievance, obtain a written response from the physician and medical records directly related to the grievance, and return all the requested information to the health plan by a specific due date. When CPMG/RCHN receives a grievance, we forward the information to the physician or office manager. A fax cover sheet will state what items we need to receive back and the due date. Please always be sure to send the response directly back to CPMG/RCHN and not to the health plan. Please be sure to include all items requested on the fax cover sheet.

All grievances are taken to the CPMG/RCHN Quality of Care Committee (QOC) meetings. Grievances are reviewed and the committee decides on the acuity level. All grievances presented at QOC are “blinded” (they contain no physician or member name information). If the committee determines a grievance acuity level to be greater then “0”, you may be contacted by the CPMG/RCHN Medical Director. Please see the acuity levels below:

<u>Level 0</u>
No opportunity for improvement/No quality of care issue

<u>Level 1</u>
Opportunity for improvement in quality of care or quality of service with no or minimal adverse outcomes to the patient

- 1-A Physician Related
- 1-B Site/Division Related
- 1-C System-wide Related

<u>Level 2</u>
Opportunity for improvement in quality of care or quality of service with mild to moderate effect on the patient, or the potential for more serious adverse effects

- 2-A Physician Related
- 2-B Site/Division Related
- 2-C System –wide Related

<u>Level 3</u>
Error in quality of service or quality of care resulting in serious adverse effects on the patient

- 3-A Physician Related
- 3-B Site/Division Related
- 3-C System-wide Related

If you have any questions about the above process, please feel free to call the Director, UM Operations & Customer Service.

CULTURAL COMPETENCY

As a reminder, California law requires HMO health plans to provide language assistance services to their enrollees whose proficiency in English is limited. Language assistance services, which are available at no cost to patients and physicians, include oral interpreter services at each patient point of contact, such as at a doctor's office or when calling a customer service number.

Accessing an HMO Health Plan's Language Assistance Services

If an HMO patient contacts your office by phone or in person and is in need of an oral interpreter, please help facilitate the patient's access to language assistance services by contacting the patient's HMO health plan at the phone number listed below.

CPMG Contracted Health Plans	Phone Number for Oral Interpreter
Aetna	800-525-3148
Aetna Better Health (Medi-Cal)	855-772-9076
Anthem Blue Cross	888-254-2721
Blue Shield	866-346-7198
Blue Shield Promise (Medi-Cal)	855-699-5557
Cigna	800-806-2059
Health Net	800-522-0088
Health Net Medi-Cal	800-675-6110
United Healthcare	800-730-7270 (Spanish) 800-938-2300 (Chinese) 800-624-8822 (All Other Languages)
Scripps Health Plan	844-337-3700
Sharp Health Plan	800-359-2002

Documenting Patient Refusal of Language Assistance Services

Best Practice Tip: If a patient whose English proficiency is limited refuses to access the patient's HMO health plan's language assistance services, it is recommended that the physician office notate the patient's refusal of the language assistance services in the patient's medical record.

Use of Bilingual Staff as Interpreters

Best Practice Tip: To ensure access to trained healthcare interpreters, it is recommended that practices direct patients with limited English proficiency to the HMO health plan's free language assistance services, rather than rely on their own bilingual staff. The health plan's interpreters are trained in medical and insurance terminology in addition to being proficient in – and culturally sensitive to – diverse ethnic and linguistic nuances. However, the law does not require a limited English proficient patient to

access a health plan's interpretation services or prevent a patient from speaking with bilingual provider staff.

Use of Family Members for Interpretation

The law does not prohibit family members from serving as interpreters for patients, but patients need not feel dependent on using family members as interpreters. Patients can now access their HMO health plan's language assistance services at no cost and keep information about their healthcare private and confidential from their family or relatives.

Documenting Language Preference

Best Practice Tip: It is recommended that physicians document each patient's preferred language in the patient's medical record.

Additional Information

HMO health plans are required to notify their enrollees of their free language assistance services. CPMG/RCHN physicians may obtain additional information on language assistance, including tips on working with interpreters and patients, by visiting our website, www.CPMGSanDiego.com.

- To assist you with culturally diverse patients, the following Industry Collaboration Effort (ICE) documents have been included:
    - Tips for Documenting Refusal of Interpretive Service
    - Tips for Working with Interpreters
    - Tips for Working with Limited Proficient English Members

Tips for Documenting Interpretive Services
for Limited English Proficient (LEP) Patients:
Notating the Provision or the Refusal of Interpretive Services

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

- **Documenting refusal of interpretive services** in the medical record not only protects you and your practice, it also ensures consistency when your medical records are monitored through site reviews/audits by contracted health plans to ensure adequacy of the plan's Language Assistance Program.
  - It is preferable to use professionally trained interpreters and to document the use of the interpreter in the patient's medical record.
  - If the patient was offered an interpreter and refused the service, it is important to note that refusal in the medical record for that visit.
  - Although using a family member or friend to interpret should be discouraged, if the patient insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.
    - Smart Practice Tip: Consider offering a telephonic interpreter *in addition* to the family member/friend to ensure accuracy of interpretation.
  - For all LEP patients, it is a best practice to document the patient's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.*
    - For a paper record, one way to do this is to post color stickers on patient's chart to flag when an interpreter is needed. (For example: Orange = Spanish, Yellow = Vietnamese, Green = Russian)*
    - For EMRs, contact your IT department to determine the best method of advising all health care team members of a preferred spoken language.

**Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers;* www.iceforhealth.org

***The universal symbol for interpretive services at the top left of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:* http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

ICE Approval: 6/20/08

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

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

- When the interpreter comes onto the line let the interpreter know the following: **
  - Who you are
  - Who else is in the room
  - What sort of office practice this is
  - What sort of appointment this is

  For example, "Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **
- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it. **

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

Footnotes:

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

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

Tips for Working with Limited English Proficient (LEP) Members

- **California law** requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

- **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 limited English proficient (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**
  1) Member speaks no English and you are unable to discern the language
  ➔ Connect with contracted telephonic interpretation vendor to identify language needed.

  2) 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 Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at: http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

Better Communication, Better Care:

Provider Tools to Care for Diverse Populations

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable 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. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

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

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

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

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

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

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

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

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

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

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

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

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

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

2. Make sure patients know what you do.

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

3. Keep patients' expectations realistic.

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

4. Work to build patients' trust in you.

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

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

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

6. Give patients the information they need.

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

7. Make sure patients know what to do.

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

NON- VERBAL COMMUNICATION AND PATIENT CARE

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

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

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

Eye Contact

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

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

Touch and Use of Space

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

Talk the patient through each exam so that the need for the physical contact is

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1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

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

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

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

Body Posture and Presentation

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

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

Use of Voice

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

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

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

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

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

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *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.? What is the patient's age and sex?	
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 doctor?*	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**- *asks 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-** *identifies 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 FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as *"the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing."*

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

Possible Signs of Low Health Literacy

Your patients may frequently say:
- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

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

Barriers to Health Literacy

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

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

- ✓ 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 load.
- ✓ Speak slowly (don't shout).
- ✓ Use body language to support what you are saying.
- ✓ Draw pictures, use posters, models or physical demonstrations.
- ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

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

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

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

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

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

American Medical Association (AMA)

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

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[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

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.

INTERVIEW QUESTIONS

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

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

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

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

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

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

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

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

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, please visit: www.ada.gov/effective-comm.htm.

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

EFFECTIVE COMMUNICATION

Overview

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

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This 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 (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

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

Some easy solutions work in relatively simple and straightforward situations. 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, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	These are some options we can provide for you…..
Am blind or have vision impairments that keep me 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 - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

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

Resources

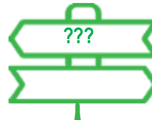
- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-_People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:

The KEY to Patient Engagement

Where do I start?

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



Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

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

Where do I start?

Get Ready:

- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

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

What language service needs should I begin to identify?

Keep it simple and write down:

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

Where can I find resources?

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

Get Ready, Get Set, Go!

Get ready!

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

Get set!

- Review resources and identify those most useful for your office

Go!

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

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

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

211

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

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

711

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

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

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

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

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

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. This leads to poor health outcomes and longer hospital stays.

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

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

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

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

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 limited English proficient (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 Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; 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 Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

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

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

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

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

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

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

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

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

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 (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

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

For example:

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

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

Identify services available do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

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.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool 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 have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry
Collaboration
Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic □□l
J l..a>l p.·,·+.w LoS ...s J□ - p. □•• J l..a:i□l p.,•+•.w '3 .&sJ ..) l _J--U'j
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Portuguese Portugues
Indique o seu idioma. Um interprete sera chamado. A interpretaQao e fornecida sem qualquer custo para vocEi.

Punjabi □
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□ □it□re3"i:f')f m3'□□l

Russian PyccK111111
YKatKl-'ITe J13blK, Ha KOTOpOM Bbl rosop1-1Te. BaM Bbl30Byr nepeBOA41-1Ka. Ycnyrn nepeBOA41-1Ka npeAOCTaBnHioTrn 6ecnnarno.

Samoan Fa'asamoa
Fa'asino lau gagana. Ole a vala'au se fa'amatala'upu. Ua saunia se fa'amatala'upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada... Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Espanol
Senale su idioma y llamaremos a un interprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai "Vl J
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□11J"l:i.iG1uJLjaA1t'lf□1a

Tongan Tongan Lea Faka-Tonga
Tuhu'I mai ho'o lea fakafonua. 'E ui ha fakatonulea. 'Oki ta'etotongi kia ·a e fakatonulea.

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-15' c:L>L.s ,,j E.P"□ ..) '+.S4yy f f Ua.i:;l LS

Vietnamese Ti□ng Vi$t
Hay chi vao ng6n ngu cua quy vi. Mot thong djch vien se dlJ'Q'C goi den, quy v[se kh6ng phai tra tien cho thong d[ch vien.

Provided courtesy of Industry Collaboration Effort and Languageline Solutions.

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COMMON SIGNS IN MULTIPLE LANGUAGES

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

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

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

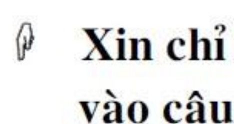
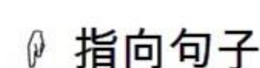
English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieät	*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 English Proficient (LEP) patients. Point to the sentences you wish to communicate and your LEP patient may read in his/her language of preference. The patient can then point to the next message.

English	Spanish / Español	Vietnamese / Tiếng Việt	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。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**p 指向句子**

Courtesy statements	*Frases de cortesía*	*Từ ngữ lịch sự*	*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**	**p 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 doctor, because…	Vine a ver al doctor 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

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vào câu	p 指向句子
Patient may say…	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	***病人可能會說...***
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？
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 giúp 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?	Quí vị thích dùng ngôn ngữ nào?	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.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	Señale una frase	Xin chỉ vào câu	p 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。。。***
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*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

This tool is designed for office staff to assist in basic entry-level communication with Limited English Proficient (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 th 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.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kreyòl
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.
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 ent̀pr̀t
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin ẁ dokt̀ a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri f̀ vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twal̀t 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?	ˋske mwen ka gen yon ent̀pr̀t?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

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 f̀ 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 eǹtp̀rt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon eǹtp̀rt 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?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

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 write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **pou pasyan an**:
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
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 enfimasyon yo mande nan papye sa yo.*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation vs. Translation	
	Interpretation: Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

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

Employee's Name: ______________________________ **Department/Job Title:** ____________________ __________________________

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

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

Language	Dialect, region, or country	Fluency: see attached key (Circle)			I would like to use my language skills to speak with patients (Circle)	I would like to use my reading language skills to communicate with patients (Circle)	I would like to use my language skills to write patient communications (Circle)
		Speaking	Reading	Writing			
1.		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: _______________

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on 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 following tools 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. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?
Health Equity is attainment of the highest level of health for all people.

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

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

What are health disparities and why do they matter to all of us?
A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

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

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

Source: http://minorityhealth.hhs.gov/npa

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

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

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

The Difference between Health Equality and Health Equity

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

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

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

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

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

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

For more background and information on CLAS, visit 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, offers the latest resources and tools to promote cultural and linguistic competency in health care.

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

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

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

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

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

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

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

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

LET'S TALK ABOUT SEX

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

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• 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 t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
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 or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] 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[2], LGBT health disparities include:

Psychosocial Considerations

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

Clinical Considerations

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

Visit glma.org for more information about:

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

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

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.
[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

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

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

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

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

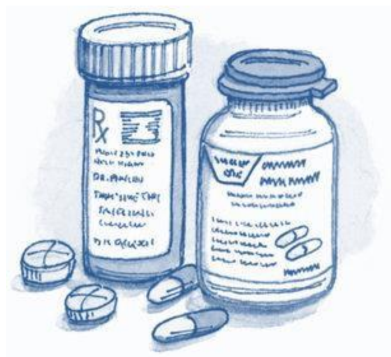
- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.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

Infant Health

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

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient 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 doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.
- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.
- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.
- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

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

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I 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 hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I 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. (See Kleinman's Questions)
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.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

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

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

Areas of Cultural Variation	Points to Consider	Suggestions
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. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
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, IV, or IM.	• 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.
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	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

Areas of Cultural Variation	Points to Consider	Suggestions
	medications and doses have changed.	• Assure your patient you are watching their 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 their pain. • Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• 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 they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

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

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

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

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

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

This section includes:

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

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

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

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

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

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

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

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

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

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

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

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

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

Principal Standard:

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

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

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

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

Section 1. Goals.

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

Sec. 2. Federally Conducted Programs and Activities.

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

Sec. 3. Federally Assisted Programs and Activities.

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

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

Sec. 4. Consultations.

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

Sec. 5. Judicial Review.

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

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

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

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

Office of Management and Budget (OMB) Ethnicity Categories:

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

Office of Management and Budget (OMB) Race Categories:

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

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity

  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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www.whitehouse.gov/omb/fedreg_race-ethnicity

www.who.int.healthsystems/topics/equity

CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid
: services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid
: services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)
: a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier
: an obstacle, impediment, obstruction, boundary, or separation.

Braille
: a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language
: the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication
: the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal
: the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal
: in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence
: sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

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

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

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

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

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

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

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

Interpretation
In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
one who translates orally for parties conversing in different languages.

Language
the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
Anything intended to aid memory.

Race
the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
an asset valuable commodity or service.

Service
help or assistance.

Speech
the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials: email Diana M. Carr, ICE Co-Chair at Diana.M.Carr@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

MEMBER RIGHTS AND RESPONSIBILITIES

We believe all families and/or those individuals legally responsible for family members of CPMG/RCHN have the right to:

- Courteous, considerate, respectful care at all times
- Access preventative health care services, including all childhood immunizations
- No-cost language translation assistance when necessary
- Privacy and confidentiality of all communications pertaining to your child's care
- Information about benefits, our organization, and where and how to seek care
- Timely responses to requests for services, inquiries and complaints
- Actively participate in all decision making for your child's care
- Request a second opinion regarding treatment options
- Discuss the cost of your child's care, examine your child's medical bills and receive an explanation of charges and payments
- Information regarding the medical group or health plan process for expressing concerns or grievances

Each parent, legal guardian and child has the responsibility to:

- Provide accurate and complete information about the child's health.
- Participate actively in decisions about care.
- Know the child's health care requirements following a visit to the pediatrician.
- Be considerate of other patients, families and staff.
- Voice questions or concerns about care or service by communicating with the appropriate staff.
- Provide accurate and complete information about the family's health insurance.
- Accept the financial responsibility (i.e., co-payments, coinsurance and deductibles) associated with services received while under the care of a physician or while a patient at a facility.
- Review information regarding covered services, policies and procedures given to you by your health plan.

WHO SHOULD SUBMIT AN AUTHORIZATION REQUEST?

- Authorization requests should primarily be submitted by the member's Primary Care Physician's (PCP's) office.
- Requests can also be submitted by specialists and ancillary providers contracted with CPMG/RCHN.
- Requests from out of network providers are not accepted without consensus from the PCP regarding the requested services.

WHAT SERVICES REQUIRE PRIOR AUTHORIZATION?

- Review the Quick Reference Guide (QRG) found in the "Forms" section of this manual, or on our website, www.cpmgsandiego.com.
- Utilize CPMG/RCHN rosters to determine in network providers
- Direct access to specialists within RCSSD, no notification to CPMG/RCHN is required
- **All** services with out of network providers require prior authorization.
- If the required services are not available in-network with a contracted provider, the PCP or specialist can submit an out of network (OON) authorization request for consideration. Information included in the request should explain the reason for requesting an OON provider.
- *Member requested* second opinions with an in-network physician should be processed using normal CPMG/RCHN authorization guidelines.
- *Member requested* second opinions with out of network physicians should be processed by the member's health plan directly.
- *Physician requested* (out-of-network) second opinions should be submitted to CPMG/RCHN for authorization review.

AUTHORIZATION SUBMISSION REQUIREMENTS

- Authorization requests should include all relevant clinical notes from the specialist or primary care physician who is requesting authorization.

- Signed prescriptions are required for some authorizations; these include speech therapy, physical therapy, occupational therapy, durable medical equipment, formula, orthotics, and prosthetics.

- Certain services may require an additional CPMG authorization form, as well as additional clinical information (i.e. labs). The services requiring additional forms are listed below. The forms can be found in the "Forms" section of this manual, or on our website, www.cpmgsandiego.com, after Physician Login > Authorizations > Forms.
  - Endocrinology Consultation related to a diagnosis of Short Stature
  - Gastroenterology Consultation related to a diagnosis of chronic abdominal pain, constipation, and reflux.
  - Growth Hormone Therapy – New and continuing
  - Injectable Medication Authorization-RX Solutions
  - MRI or CT related to a diagnosis of Headache
  - Nutrition Counseling related to a diagnosis of Obesity
  - Synagis
  - Urology or General Surgery Consultation related to circumcision

HOW TO SUBMIT AN AUTHORIZATION REQUEST

- All authorization requests are submitted to CPMG/RCHN via our Provider Portal EZ Net, www.eznet.rchsd.org.

- Requests can be submitted as:

  - Urgent - Requests should only be marked "Urgent" if the treatment is required to prevent serious deterioration in the member's health.

  - Routine – Requests for authorization of services not yet performed that are not urgent in nature will be processed using routine turnaround time guidelines.

  - Retroactive – Requests for authorization of services that have already been provided should be marked "Retro" and will be processed using retroactive turnaround time guidelines.

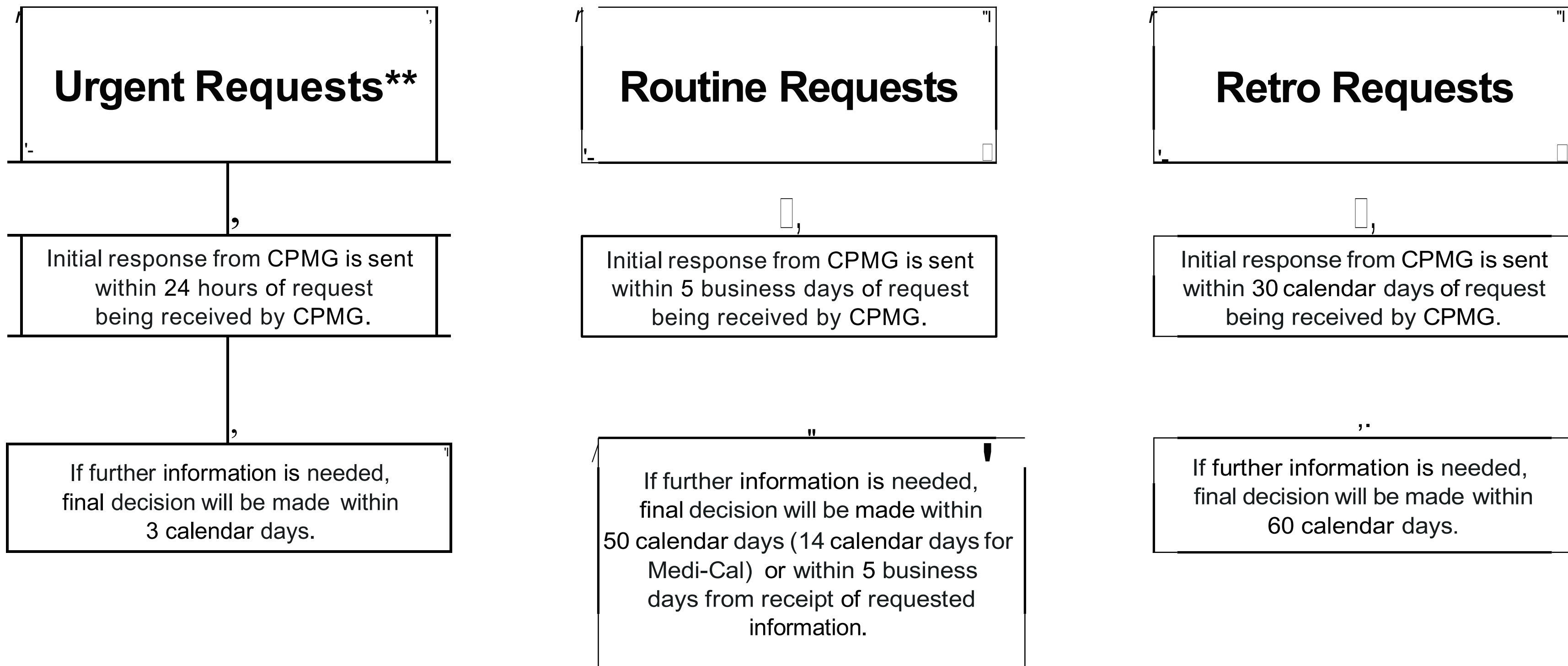
- For expected turnaround time of authorization request processing, please refer to the grid on the next page.

- Incomplete authorization forms, missing clinical information (such as progress notes, growth charts or lab results), or missing prescription may delay processing depending upon the type of authorization requested. In these situations, requests will be placed into a "pended" status, which will lengthen turnaround time guidelines.

- Requests can be submitted via fax if the Provider Portal is unavailable. The forms can be found in the “Forms” section of this manual, or on our website, www.cpmgsandiego.com.
  - CPMG Fax Number: 858-309-7977
- Provider Portal, www.eznet.rchsd.org

PEER & UM APPEAL PROCESS

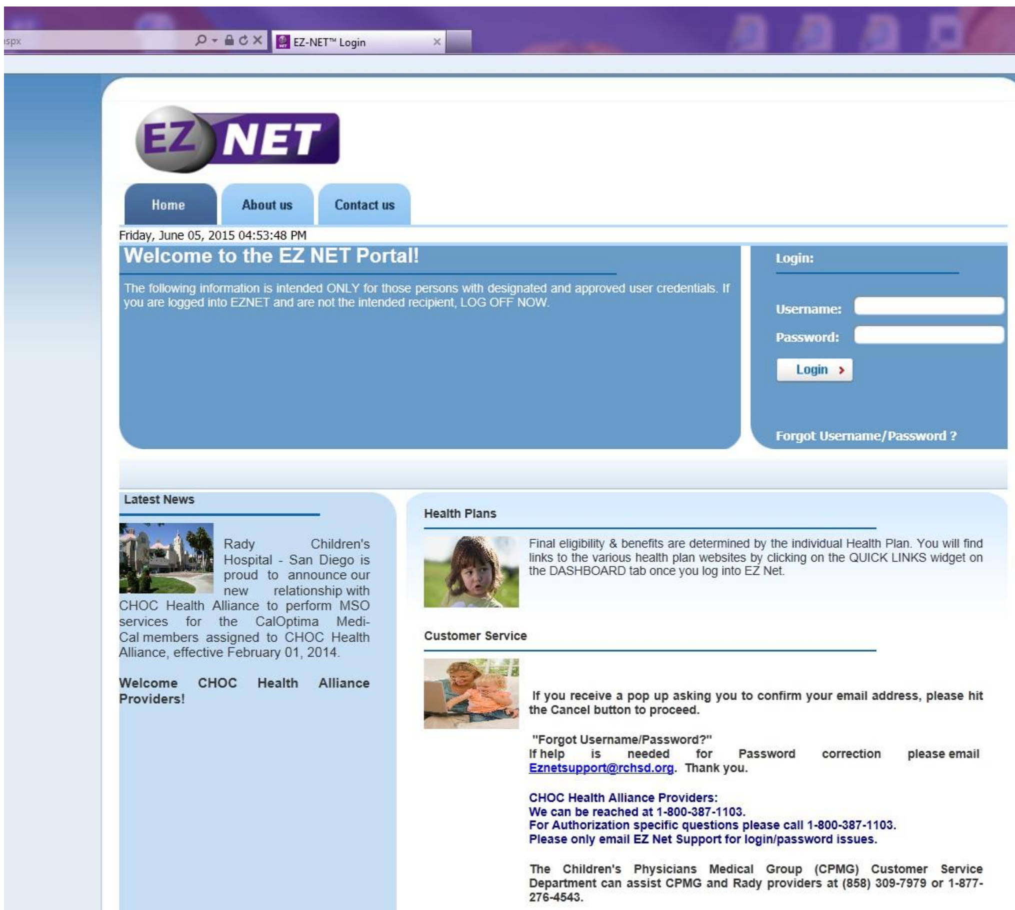
- Providers may request a peer to peer conversation with the Medical Director to discuss the denial of a request for authorization by phoning our Customer Service department. Copies of the policies and clinical criteria used to make the decision are available to providers upon request.
- Providers can appeal a UM denial decision by faxing the request to our UM department. The request must include the reason for appeal, new or additional information that was not previously reviewed, and/or justification for potential reversal of decision.
- The medical director will review all information and make a determination to either uphold or overturn the denial. Providers will be notified by phone of the appeal decision.



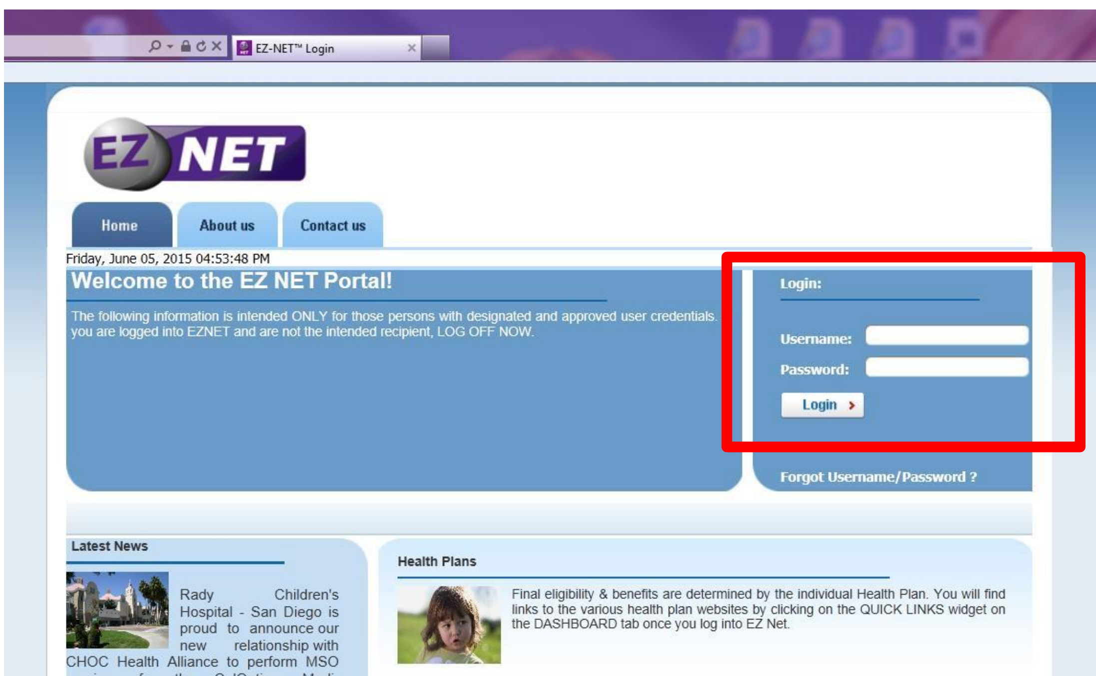
<u>DO NOT SUBMIT AS URGENT UNLESS</u>** the treatment is required to prevent serious deterioration in the member's health. Requests not meeting this definition will be handled as non-urgent.

EZ-Net Authorization Submission

1. Go to www.eznet.rchsd.org You will see a login screen that should look similar to this:



2. Go to the Login area and type in the Username and Password you were provided with. You may be prompted to change your password the first time you login. Please remember that passwords are case sensitive.

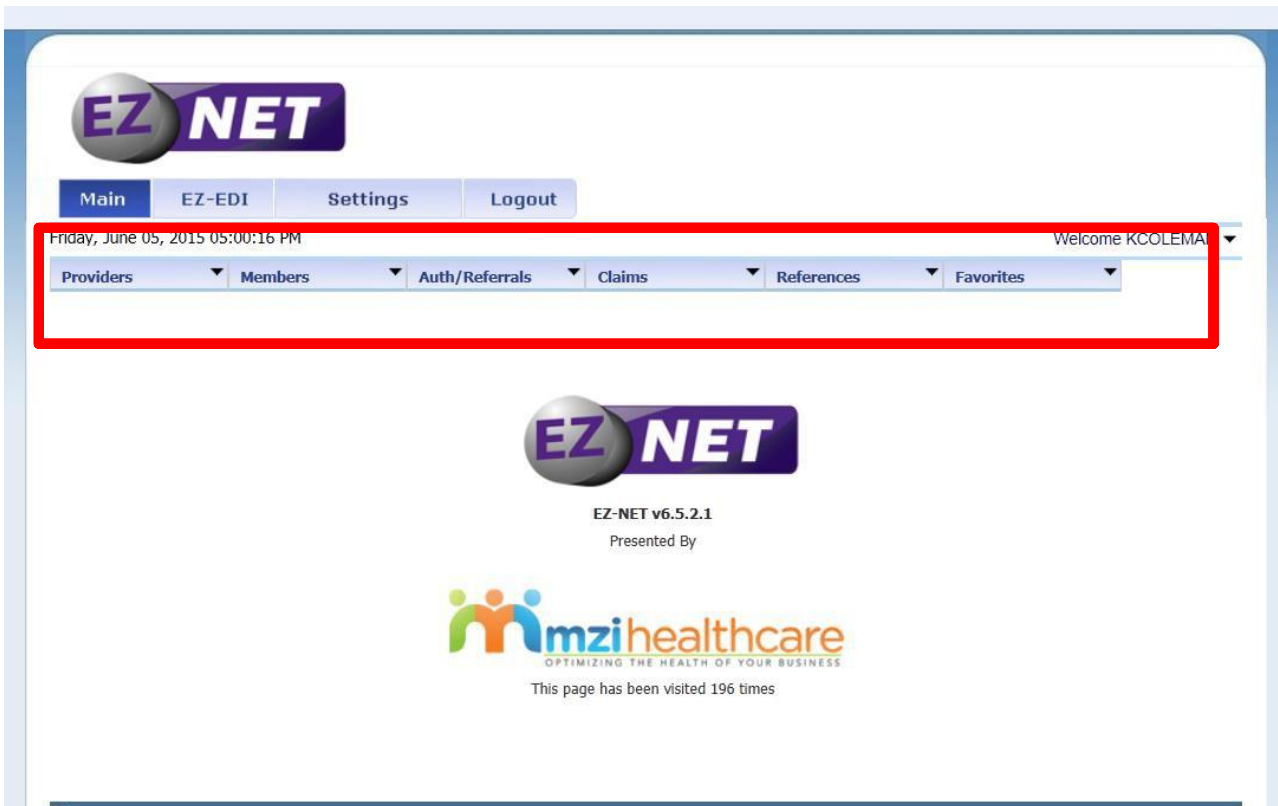


3. If you have trouble logging in, please go to the FAQ page at the end of this document.
4. Click Login after typing your Username and Password in the boxes provided. You may receive a pop-up like the one below, click Cancel to move past the pop-up.

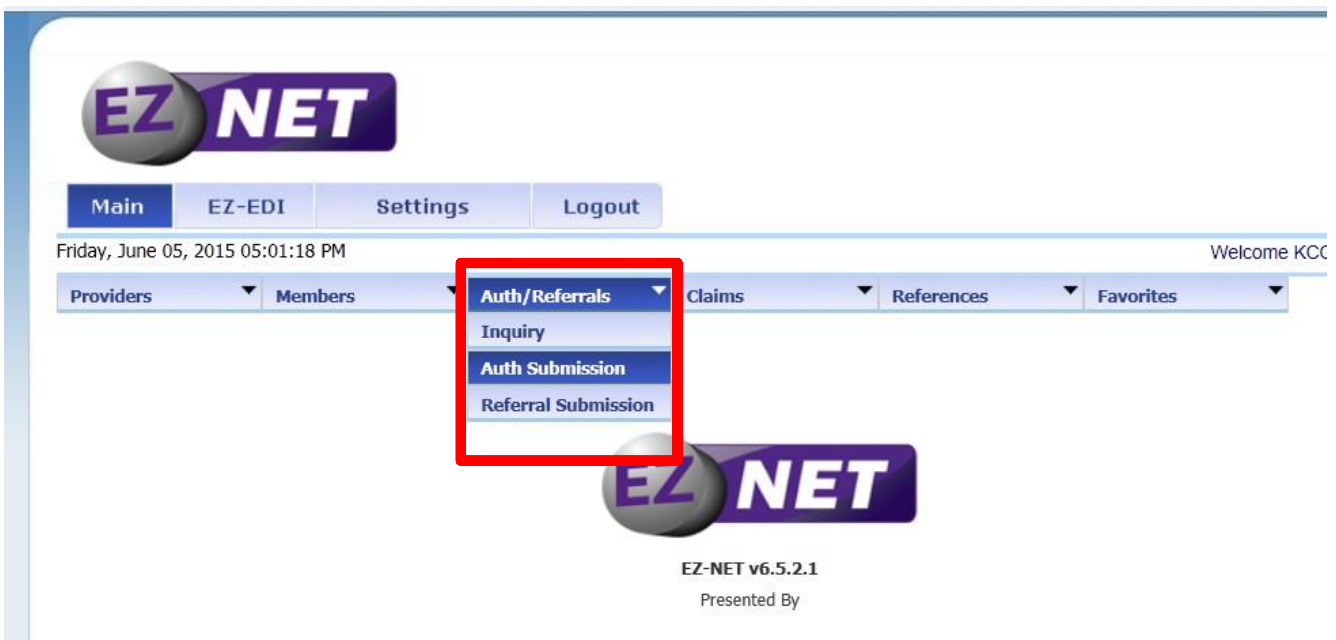
5. This will take you to a main screen that should be similar to this one:

6. Click on the Main tab to see options for authorizations, claims, and eligibility.

7. The Main tab is where you will find all of your search and submission options available through EZ-Net.



8. Place your mouse over the Auth/Referrals tab to see the list of options:



9. Click Auth Submission to submit an authorization request for consideration.

10. This will take you to the authorization entry page of EZ-Net:

EZ NET

Main | EZ-EDI | Settings | Logout

Friday, June 05, 2015 05:09:28 PM

Welcome KCOLEMAN

Providers | Members | Auth/Referrals | Claims | References | Favorites

Home >> Main Menu >> Auth/Referrals >> Auth Submission

Authorization Submission Entry

Company ID: RCHN - RADY CHILDRENS HEALTH NE

Master Record

Requested Date: 6/5/2015 Time: 17:09:13

Priority Status:

LOS: 0

Member ID:

Name:

Authorizing Provider ID:

Requested Provider ID:

Facility ID:

Place Of Service: SELECT A VALUE From Favorites

Auth Action: 6/5/2015

Auth Expiration: 9/3/2015

Authorized Units: 0

Healthplan Name:

Gender: **DOB:**

Requested Units: 0

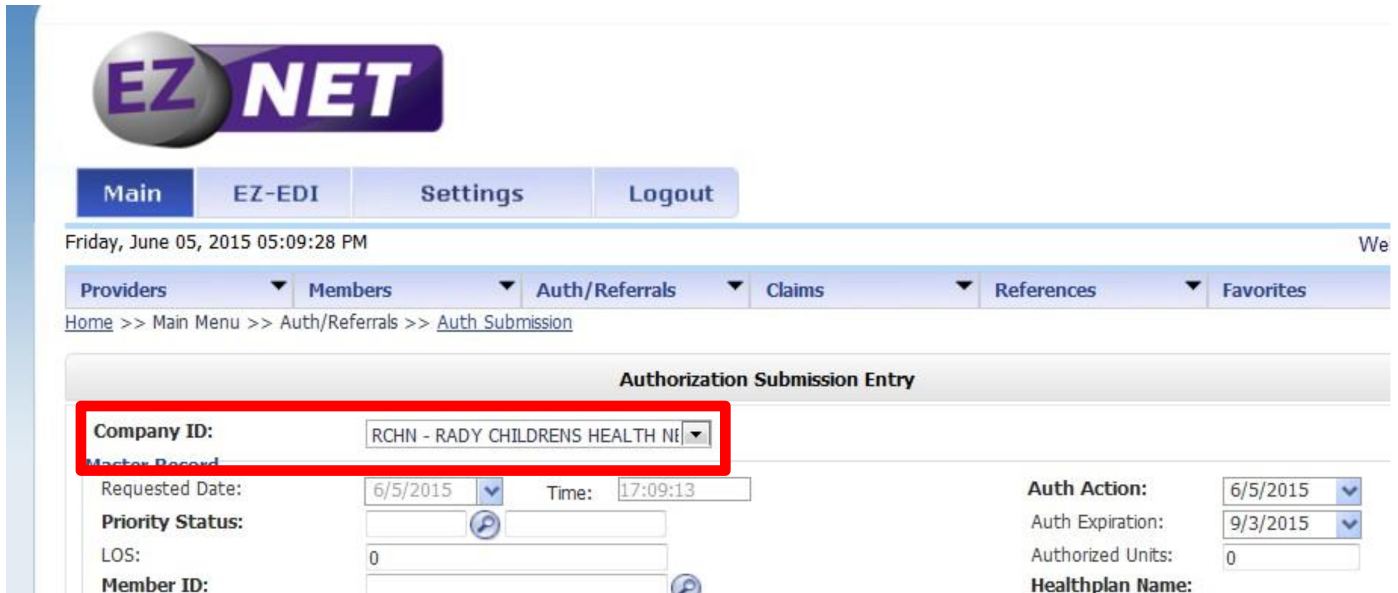
Additional Information

RETRO DOS::

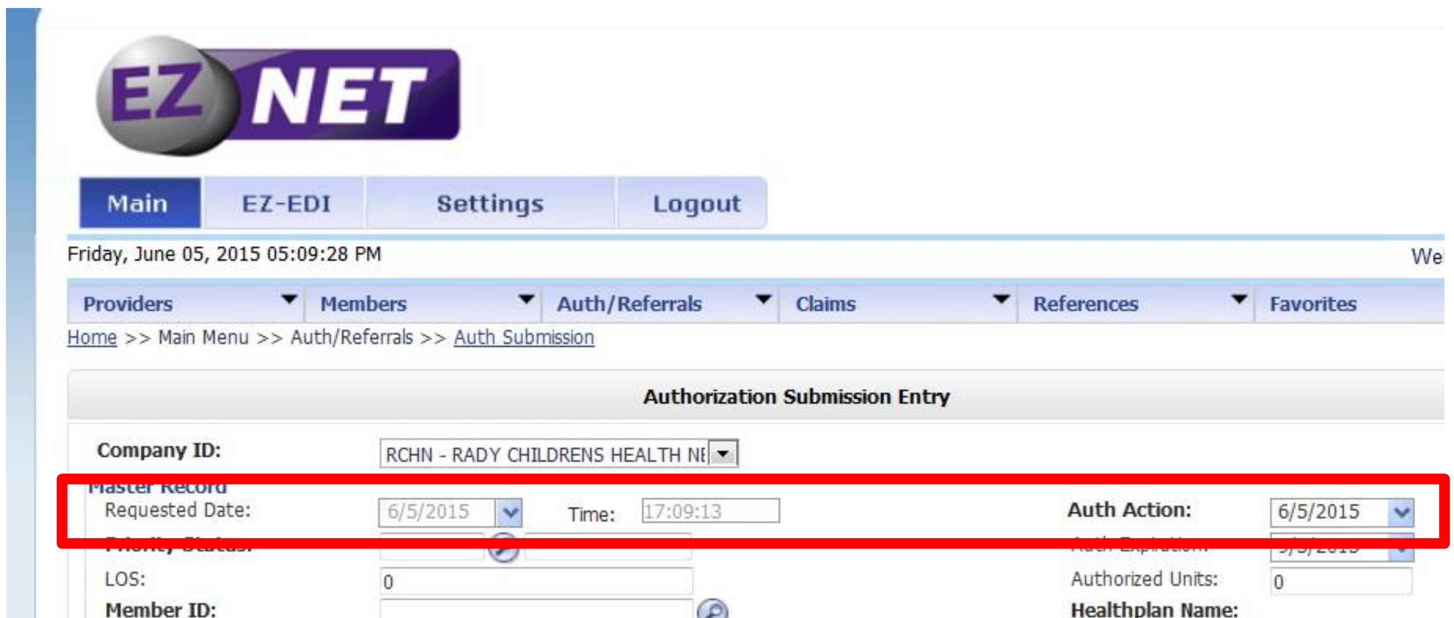
Diagnosis

Diagnosis Code: Add Diag *(Only 12 diagnosis codes allowed)*

11. Select the Company that you are submitting a request for using the drop down menu available under Company ID. Depending on your access level, you may only see one option.



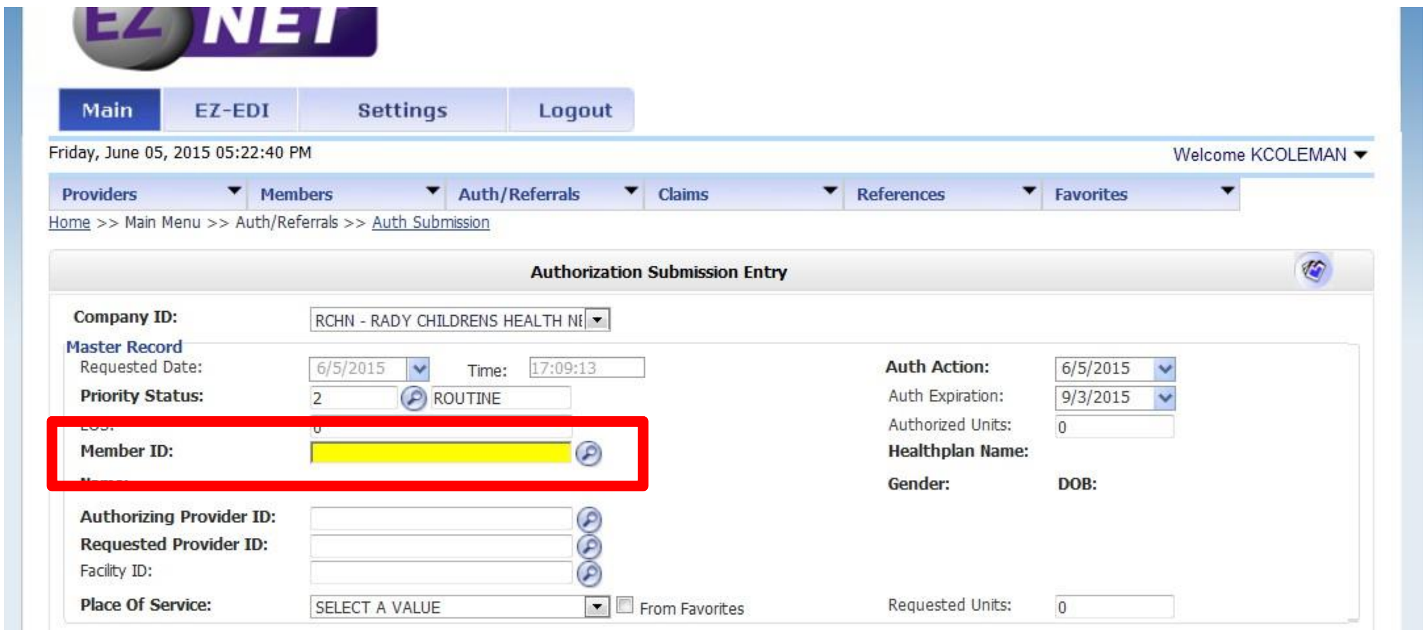
12. **Do not** change the dates listed under Requested Date or Auth Action Date. These dates will default to the date you are submitting your request, if your request is for a retro date of service you will be able to enter that information later in the authorization submission process.



13. Next, select the Priority Status of the authorization you are submitting. For definitions of Urgent, Routine, and Retro, please see the FAQ page at the end of this document.

14. Next, adjust the expiration date if needed. The expiration date defaults to 3 months from the Action Date. If the requested service will be provided at a later date, or is being provided over multiple months, adjust the expiration date to cover the dates requested.

15. Next, go to the Member ID field to select the appropriate member that you are submitting an authorization request regarding. Click the magnifying glass option to access search options that are available.



16. Type in either member name or ID number and then click Search.

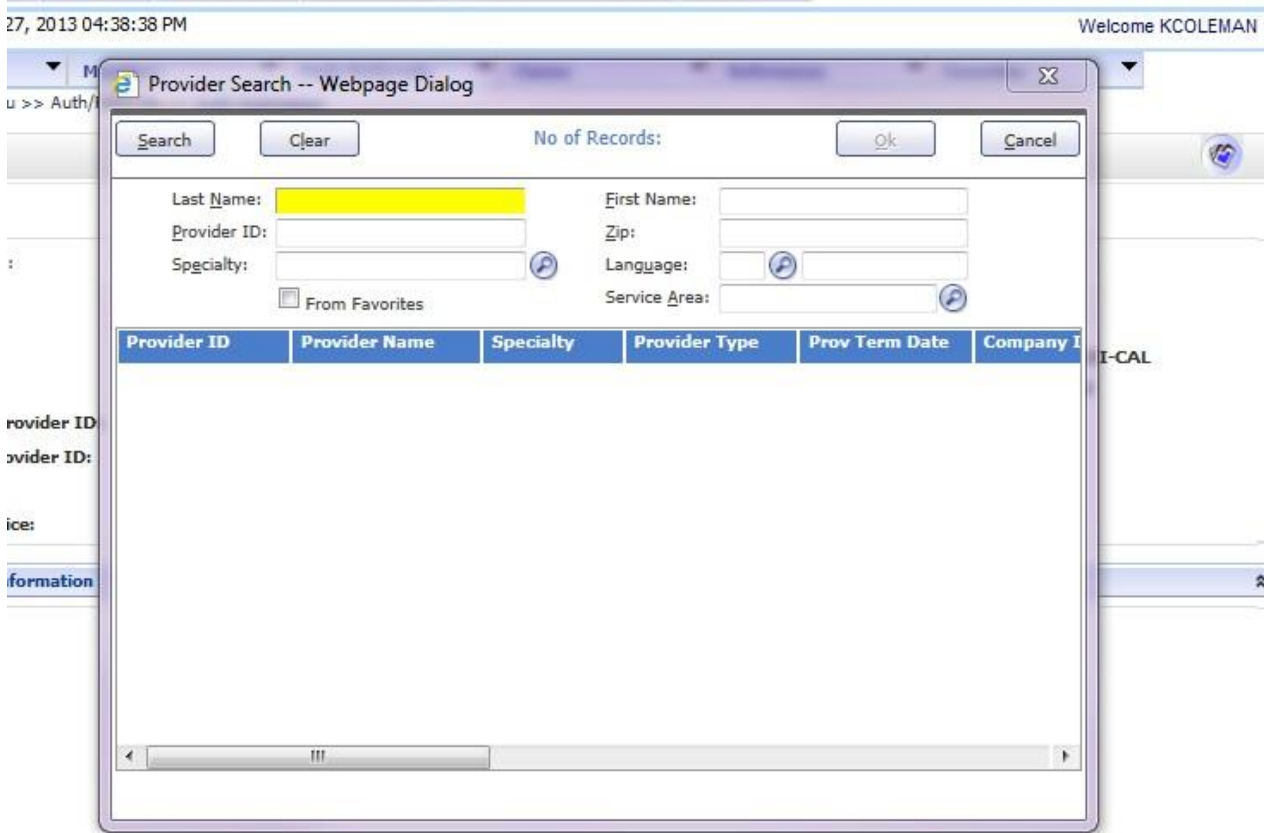
17. See the FAQ page at the end of this document for tips on searching. Select the correct member from the list displayed by either double clicking or clicking the correct member and then clicking OK.

18. This will automatically populate the Member ID, Name, Gender, Health Plan, and DOB.

19. Next, move to the Authorizing Provider ID field and click the magnifying glass icon to search and select the appropriate authorizing provider. (Search process is similar to the one just described for the member search)

20. Next, enter the Requested Provider – this is the provider, hospital, or vendor that will be providing the requested services to the member. Click the magnifying glass to view search options.

21. Available search options include last name, first name, provider ID, Provider Specialty, or Zip Code.



22. Next, select the appropriate Place of Service for the requested services from the list provided:

Priority Status: 2 ROUTINE
Auth Expiration: 9/3
LOS: 0
Authorized Units: 0
Member ID: 12345678
Healthplan Name: ANT
Name: COLEMAN, KATIE
Gender: F
DOB
Authorizing Provider ID: 951691313FFS
RADY CHILDREN'S HOSP & HEALTH CTR
Requested Provider ID: 951691313FFS
Facility ID:
Place Of Service: SELECT A VALUE
From Favorites
Requested Units: 0
Additional Information
RETRO DOS::

SELECT A VALUE
01 - PHARMACY
11 - OFFICE
12 - HOME
13 - ASSISTED LIVING FACILITY
14 - GROUP HOME
15 - MOBILE UNIT
16 - TEMPORARY LODGING
17 - WALK-IN RETAIL HEALTH CLINIC
18 - PLACE OF EMPLOYMENT-WORKSITE
20 - URGENT CARE FACILITY
21 - INPATIENT HOSPITAL
22 - OUTPATIENT HOSPITAL
23 - EMERG ROOM HOSPITAL
24 - AMBULATORY SURG CENTER
25 - BIRTHING CENTER
26 - MILITARY TREATMENT FACILITY
31 - SKILLED NURSING FACILITY
32 - NURSING FACILITY
33 - CUSTODIAL CARE FACILITY
34 - HOSPICE
41 - AMBULANCE - LAND
42 - AMBULANCE - AIR/WATER
49 - INDEPENDENT CLINIC
50 - FED QUALIFIED HEALTH CNTR
51 - INPATIENT PSYCH FACILITY
52 - PSYCH FACILITY PARTIAL HOSP.
53 - COMMUNITY MENTAL HLTH CENTER
54 - INTERMED CARE - MENTAL RETARD.
55 - RESIDENTIAL SUBST. ABUSE TRMT

22 - OUTPATIENT HOSPITAL

Diagnosis
Diagnosis Code:
Add Diag
(Only 12 diagnosis coc
Number
Code

23. Next, enter the Requested Units for the authorization. For example: if the request was for authorization of physical therapy treatment 2 times per week for 6 weeks, you would enter the number 12 in the Requested Units field. If the request was for an Office Consultation, the Requested Units would be 1.

Friday, December 27, 2013 04:45:01 PM
Welcome KCOLEMAN

Providers | Members | Auth/Referrals | Claims | References | Favorites

Home >> Main Menu >> Auth/Referrals >> Auth Submission

Authorization Submission Entry

Company ID: CPMG - CHILDRENS PHYSICIANS M

Master Record

Requested Date:	12/27/2013 Time: 16:33:51	Auth Action:	12/27/2013
Priority Status:		Auth Expiration:	3/27/2014
LOS:	0	Authorized Units:	0
Member ID:	123456789	Healthplan Name:	HEALTH NET MEDI-CAL
Name:	COLEMAN TEST, KATIE	Gender: F	DOB: 1/1/2010
Authorizing Provider ID:	G39469	SNYDER MD JOEL	
Requested Provider ID:	951691313TH	RADY CHILDREN'S HOSP & HEALTH CTR THERAP	
Facility ID:			
Place Of Service:	62 - COMPREHENSIVE OUTPAT REH	From Favorites	Requested Units: 12

Additional Information

RETRO DOS::

24. Next, if the request is for a Retroactive Date of Service, enter the date that services were rendered in the box labeled RETRO DOS:. If the services being requested have not already been rendered, skip to the next step in the process and leave this box blank.

vorites Tools Help

Friday, December 27, 2013 04:46:54 PM
Welcome KCOLEMAN

Providers | Members | Auth/Referrals | Claims | References | Favorites

Home >> Main Menu >> Auth/Referrals >> Auth Submission

Authorization Submission Entry

Company ID: CPMG - CHILDRENS PHYSICIANS M

Master Record

Requested Date:	12/27/2013 Time: 16:33:51	Auth Action:	12/27/2013
Priority Status:		Auth Expiration:	3/27/2014
LOS:	0	Authorized Units:	0
Member ID:	123456789	Healthplan Name:	HEALTH NET MEDI-CAL
Name:	COLEMAN TEST, KATIE	Gender: F	DOB: 1/1/2010
Authorizing Provider ID:	G39469	SNYDER MD JOEL	
Requested Provider ID:	951691313TH	RADY CHILDREN'S HOSP & HEALTH CTR THERAP	
Facility ID:			
Place Of Service:	62 - COMPREHENSIVE OUTPAT REH	From Favorites	Requested Units: 12

Additional Information

RETRO DOS::

25. Next, enter all diagnosis codes associated with the requested service. Click the magnifying glass icon to search for codes if you are not sure what the ICD-9 code is. You can search by partial ICD-9 code, or by description.

Diagnosis
Diagnosis Code:
Add Diag *(Only 12 diagnosis codes allowed)*

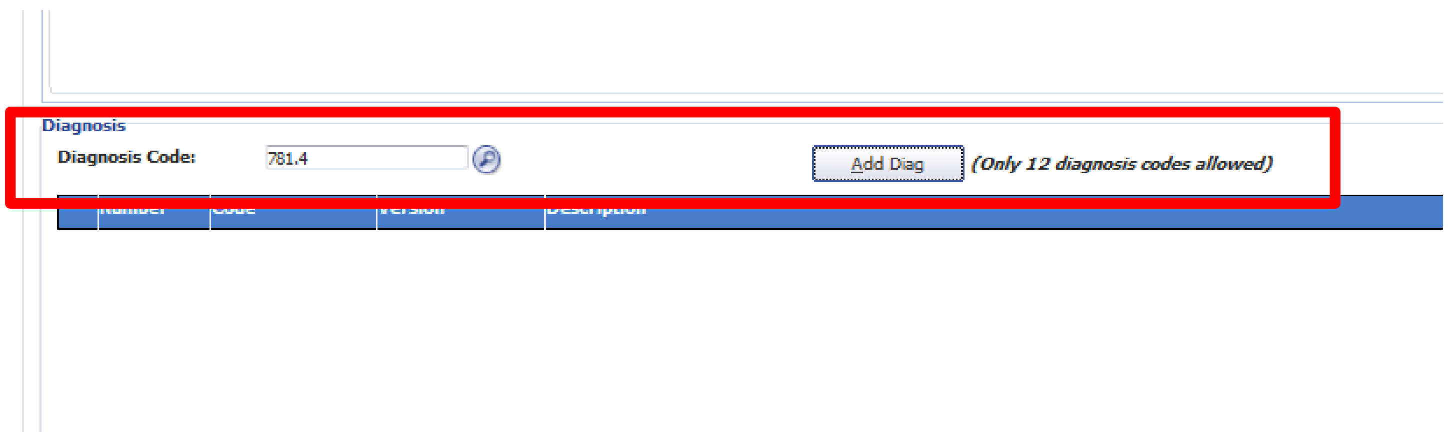
Diagnosis Code Search -- Webpage Dialog
Search Clear No of Records: Ok Cancel
Diagnosis Code: Description:
Version: SELECT

		Code	Description	From Date	To Date	C/H	Version

Service Requested
Auth Action:
Procedure Code
Auth Procedure
Modifier 1:
Modifier 2:
Modifier 3:
Modifier 4:
Admit Date:
Number of Days:
Admit Source:
Add Proc

Auth Action	Auth Expiration	Auth Proc Grp	Service	Type	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type

26. Once you have either typed in, or searched for and selected, the appropriate ICD-9 Code, click the Add Diag button.



27. The diagnosis code with description will then move to the box underneath the Add Diag button. See example below:

Diagnosis
Diagnosis Code: Add Diag (Only 12 diagnosis codes allowed)

	Number	Code	Version	Description
	1	781.4		[TRANSIENT LIMB PARALYSIS]

28. Next, add the CPT/HCPCS codes for the services being requested. Please only request one type of service on each authorization (example: a member in need of an occupational therapy evaluation and a physical therapy evaluation should have 2 separate authorization requests submitted), however if that service requires multiple CPT/HCPCS codes, you can enter more than one code using the steps below.
29. To enter the code, go to the Procedure Code box and either type in the code or click the magnifying glass for search options.

Service Requested
Auth Action: Auth Expiration:
Procedure Code: 97001 Service Type: PROF
Auth Procedure Group:
Modifier 1: SELECT A VALUE From Favorites Auth Qty: 1.0 Diag Ref: 1
Modifier 2: SELECT A VALUE
Modifier 3: SELECT A VALUE
Modifier 4: SELECT A VALUE
Admit Date: Discharge Date:
Number of Days: 0 Admit Type:
Admit Source: Requested Qty: 1.0
Add Proc

Auth Action	Auth Expiration	Auth Proc Grp	Service Type	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type

30. Enter the number of visits requested under the Requested Qty field.

Procedure Code: 97001 Service Type: PROF
Auth Procedure Group:
Modifier 1: SELECT A VALUE From Favorites Auth Qty: 1.0 Diag Ref: 1
Modifier 2: SELECT A VALUE
Modifier 3: SELECT A VALUE
Modifier 4: SELECT A VALUE
Admit Date: Discharge Date:
Number of Days: 0 Admit Type:
Admit Source: Requested Qty: 1.0
Add Proc

Auth Action	Auth	Auth Service Type	Description	Mod1	Mod2	Mod3	Mod4	Auth	Diag Ref	Admit Date	Discharge	Admit

31. Click the Add Proc button to add the code to the authorization request.

Auth Action:
Procedure Code: 97001
Auth Procedure Group:
Modifier 1: SELECT A VALUE
From Favorites
Modifier 2: SELECT A VALUE
Modifier 3: SELECT A VALUE
Modifier 4: SELECT A VALUE
Admit Date:
Number of Days: 0
Admit Source:
Service Type: PROF
Auth Qty: 1.0
Diag Ref: 1
Discharge Date:
Admit Type:
Requested Qty: 1.0

Add Proc

Auth Action	Auth Expiration	Auth Proc Grp	Service Type	Description				Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type

32. The code and description will then move to the box below the Add Proc button.

Auth Action:
Procedure Code:
Auth Procedure Group:
Modifier 1: SELECT A VALUE
From Favorites
Modifier 2: SELECT A VALUE
Modifier 3: SELECT A VALUE
Modifier 4: SELECT A VALUE
Admit Date:
Number of Days: 0
Admit Source:
Auth Expiration:
Service Type: PROF
Auth Qty: 1.0
Diag Ref: 1
Discharge Date:
Admit Type:
Requested Qty: 1.0

Add Proc

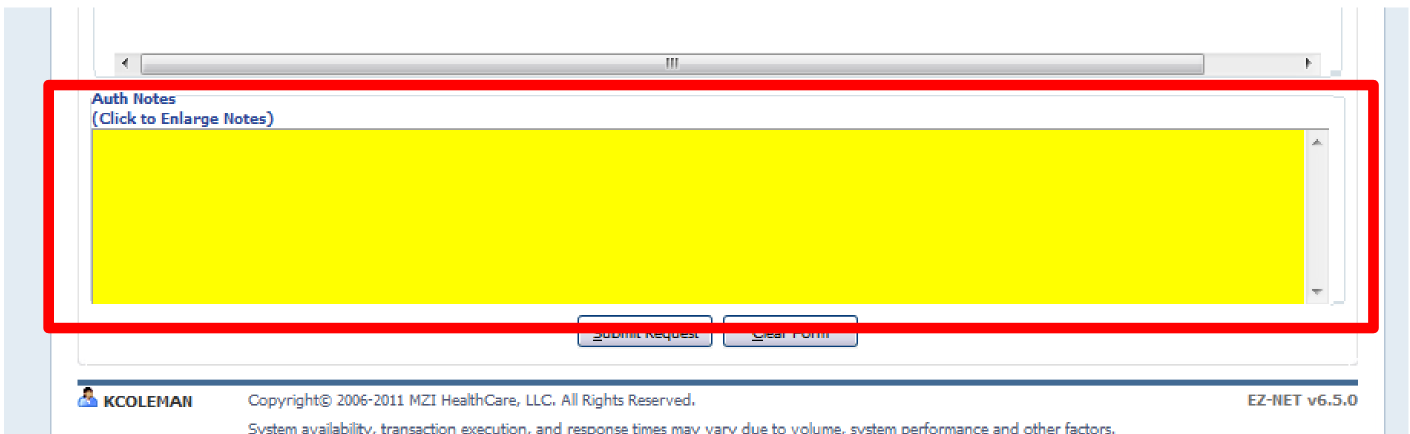
	Auth Action	Auth Expiration	Auth Proc Grp	Service	Type	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type	Ad Sou
				97001	P	PT EVALUATION					1.0	1				

33. If you accidentally add the wrong CPT/HCPCS code to an authorization request, you can click the red "X" located on the left side of the line to remove the incorrect code.

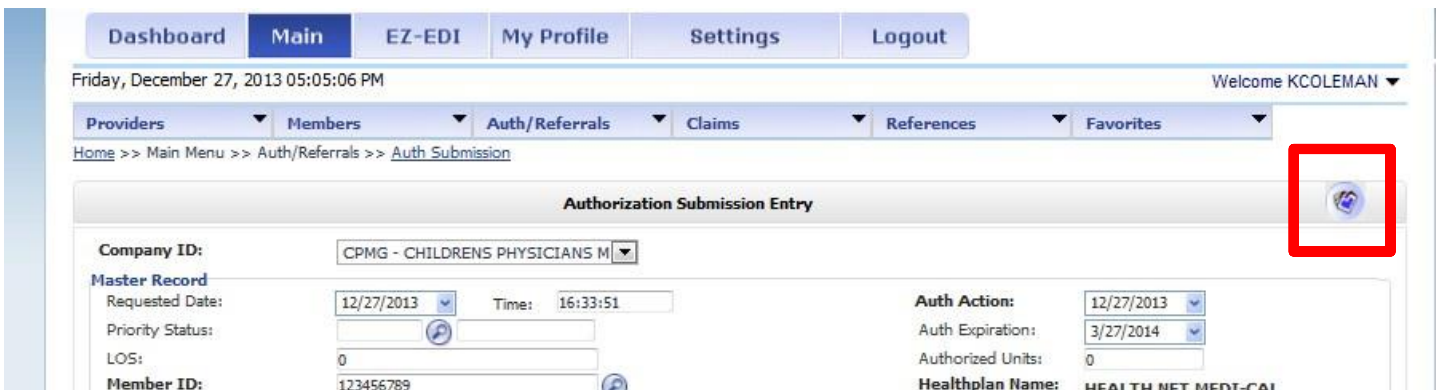
Add Proc

	Auth Action	Auth Expiration	Auth Proc Grp	Service	Type	Description	Mod1	Mod2	Mod3	Mod4	Auth Qty	Diag Ref	Admit Date	Discharge Date	Admit Type	Ad Sou
				97001	P	PT EVALUATION					1.0	1				

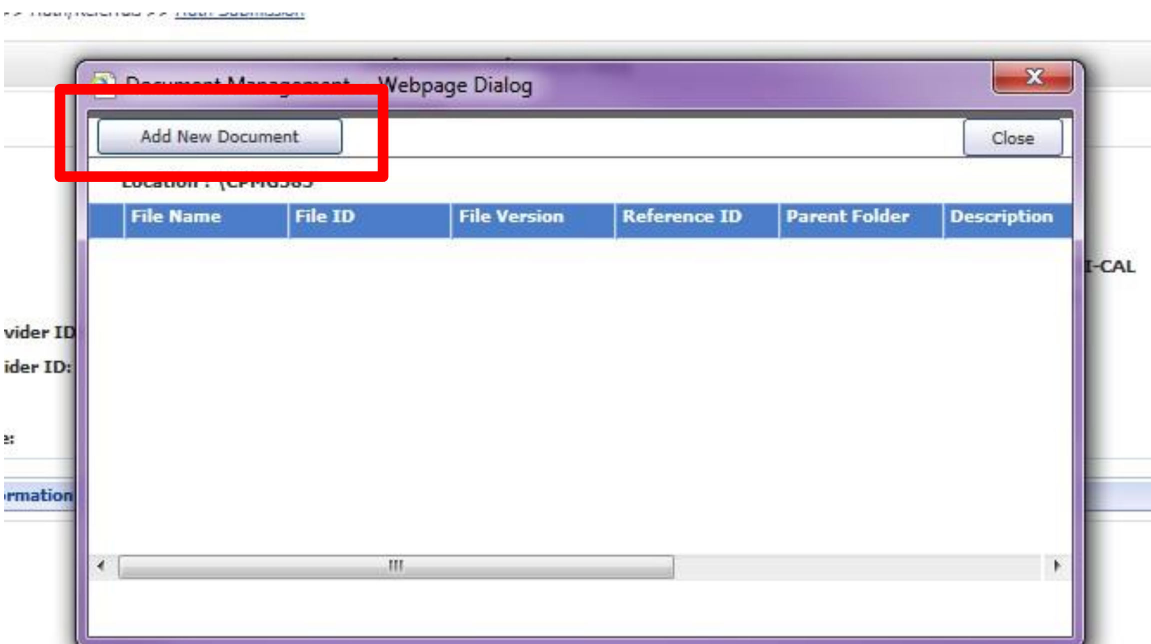
34. At the bottom of the authorization entry screen, there is an Auth Notes section. If you would like to make sure that we are aware of anything specific, please place the information in this section. Please do not copy clinical notes into this section – clinical notes should be uploaded using the steps below.



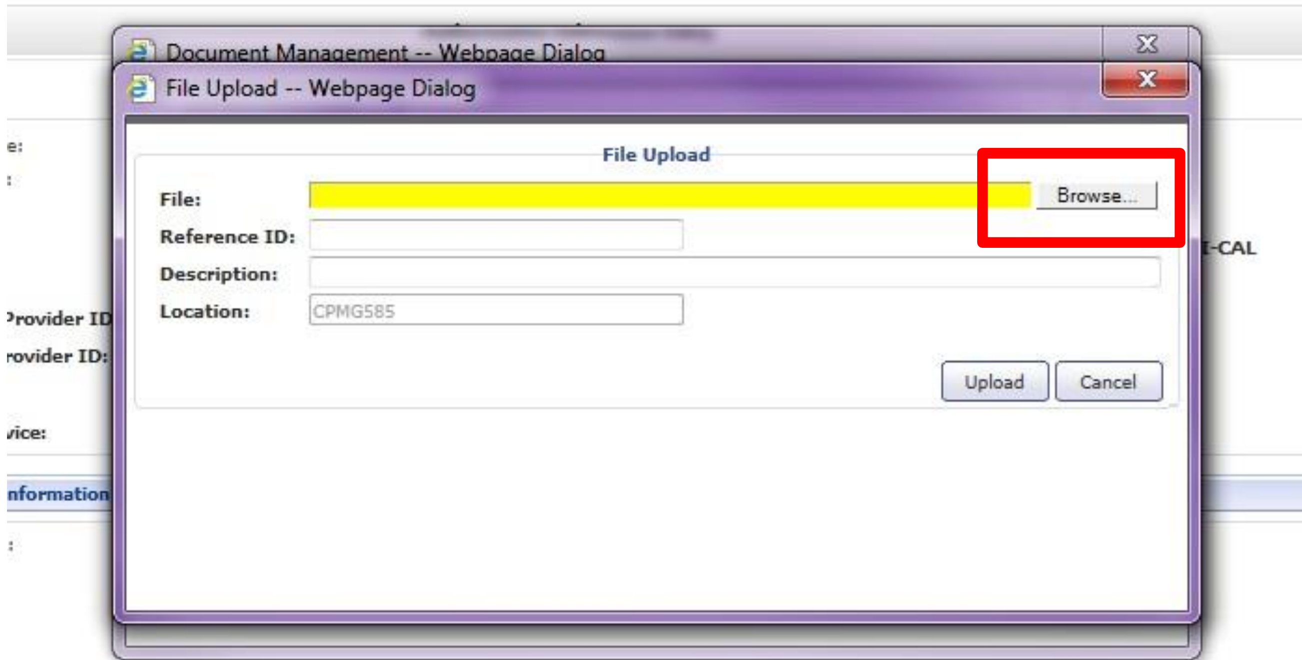
35. To attach documentation to an authorization request, click the icon located in the upper right corner of the authorization entry screen.



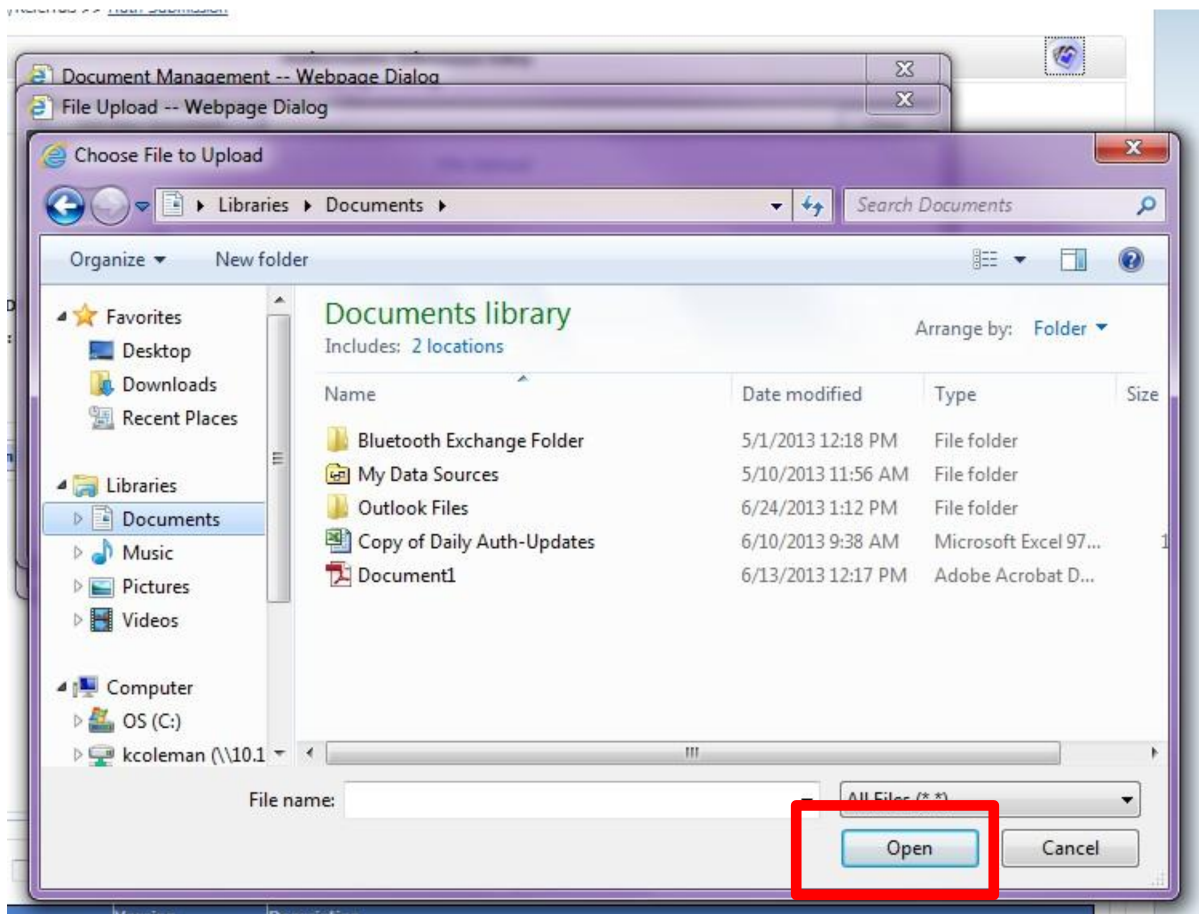
36. Then click the Add New Document button:



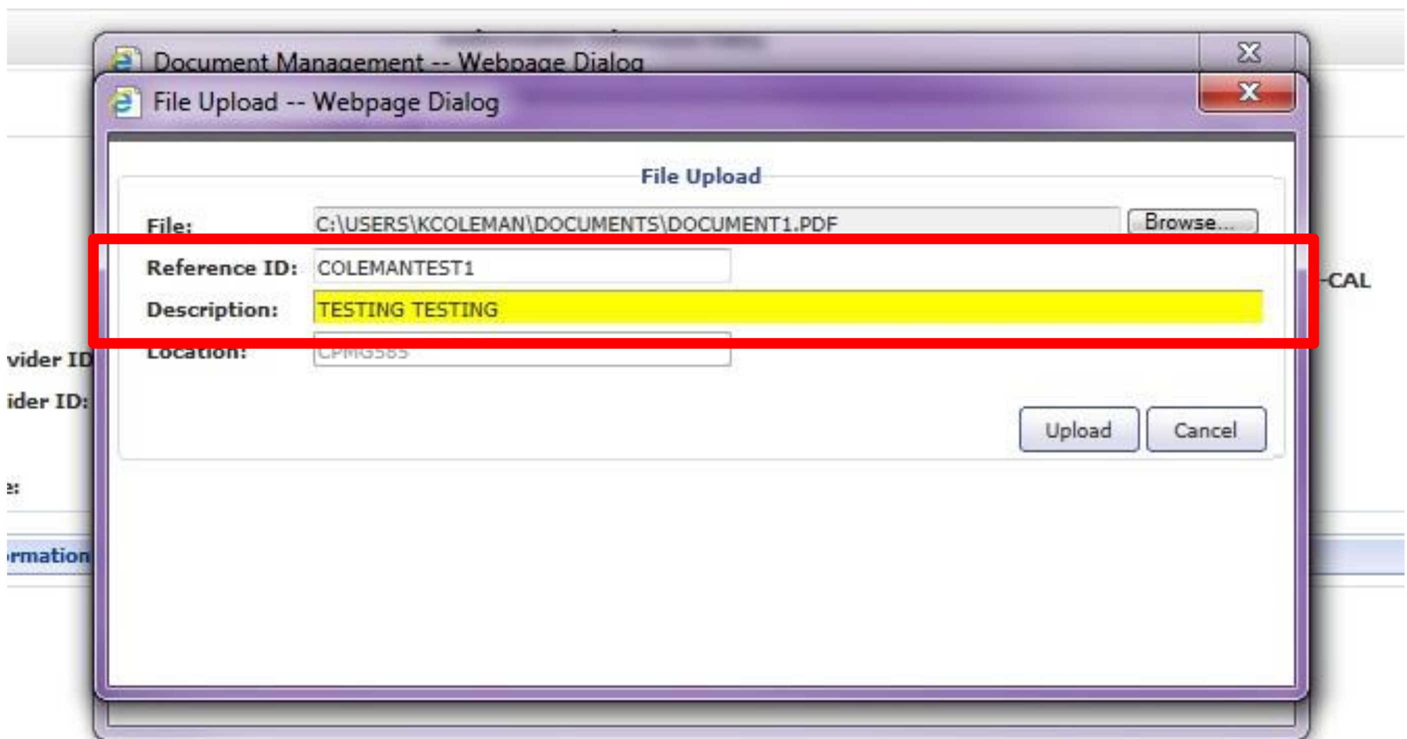
37. Then click the Browse button to select the document that you would like to attach.



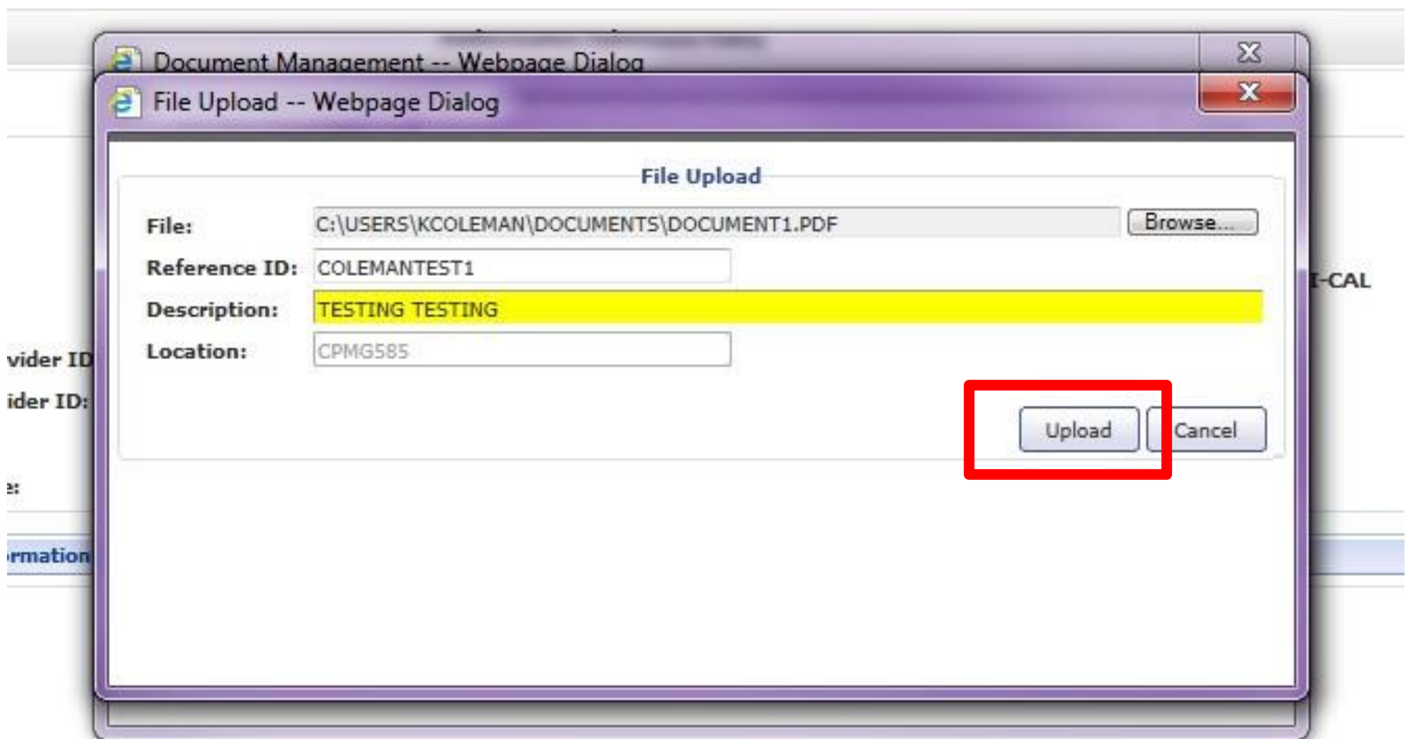
38. Select the document from your computer that you would like to upload by clicking the file name and then clicking Open.



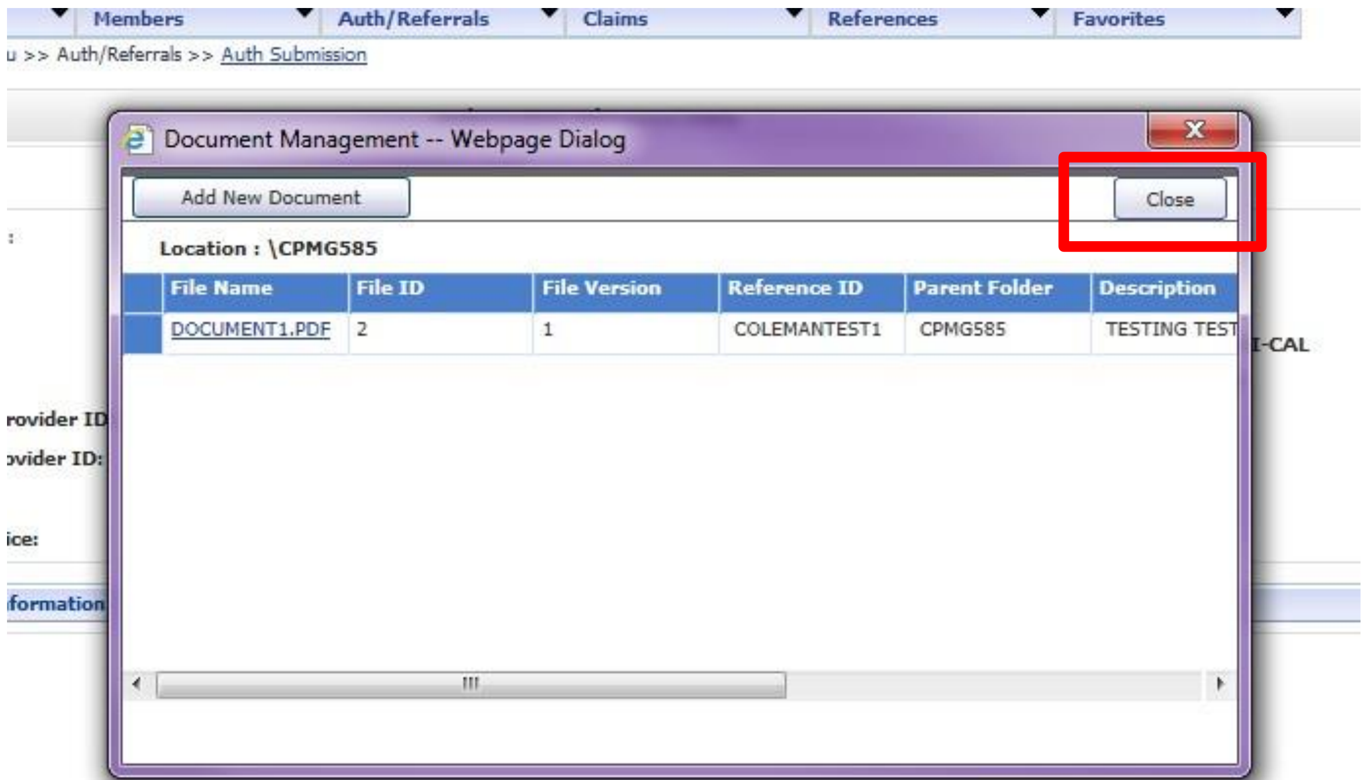
39. Enter a Reference ID (such as patient name, service, etc.) and a Description of the document (such as PCP notes, x-ray results, etc.)



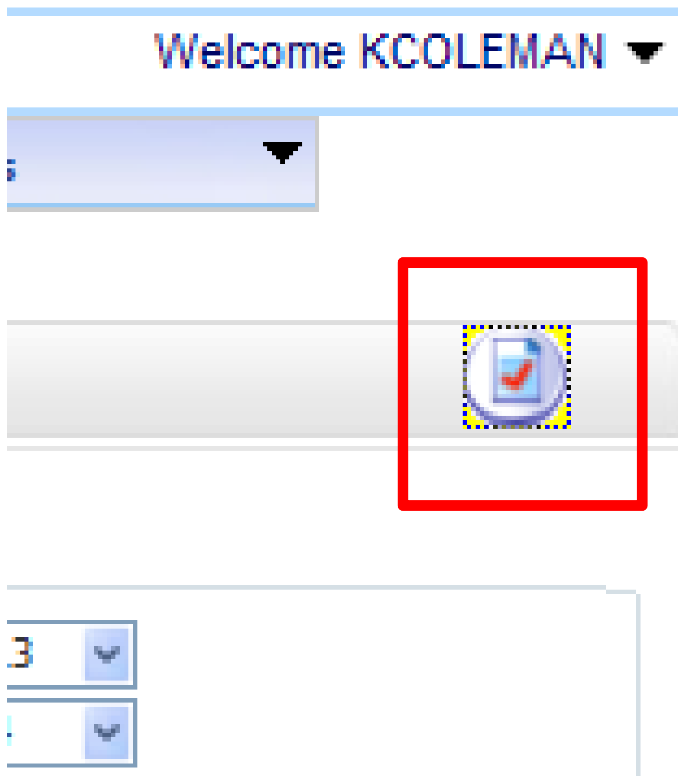
40. Click Upload.



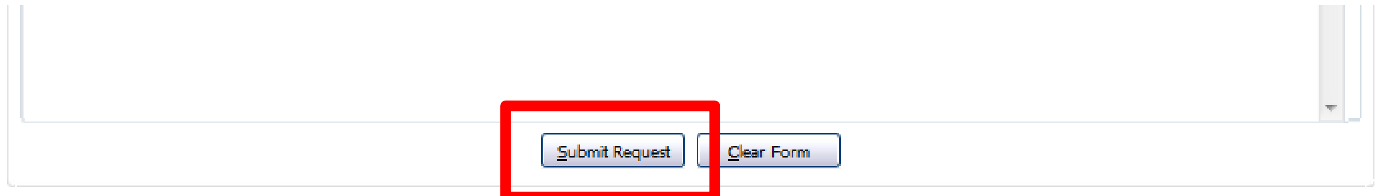
41. The document should now be listed in the Document Management window, click Close.



42. The icon for Document attachment should now be a red check mark:



43. Scroll to the bottom of the authorization entry page and click the Submit Request button to finalize your authorization submission.



44. The system will then give you a message advising that the authorization has successfully been entered into EZ-Cap with a tracking number provided.

Dashboard | Main | EZ-EDI | My Profile | Settings | Logout

Friday, December 27, 2013 05:18:07 PM

Welcome KCOLEMAN

Providers | Members | Auth/Referrals | Claims | References | Favorites

Home >> Main Menu >> Auth/Referrals >> Auth Submission

Summary of Auth Submission

Request succeeded! there are some warning/pend conditions:

The Authorization was successfully entered into EZ-CAP

Your Tracking number is: 20131227710058500001

Performing Physician Information

Name: RADY CHILDREN'S HOSP & HEALTH CTR THERAP

Address: 3020 CHILDREN'S WAY

SAN DIEGO, CA -

Phone:

Fax: (858)966-4051

Master information warning/pend conditions:

1. Warning - Member status = 2 PROVISIONAL.

Submit Another Auth

KCOLEMAN

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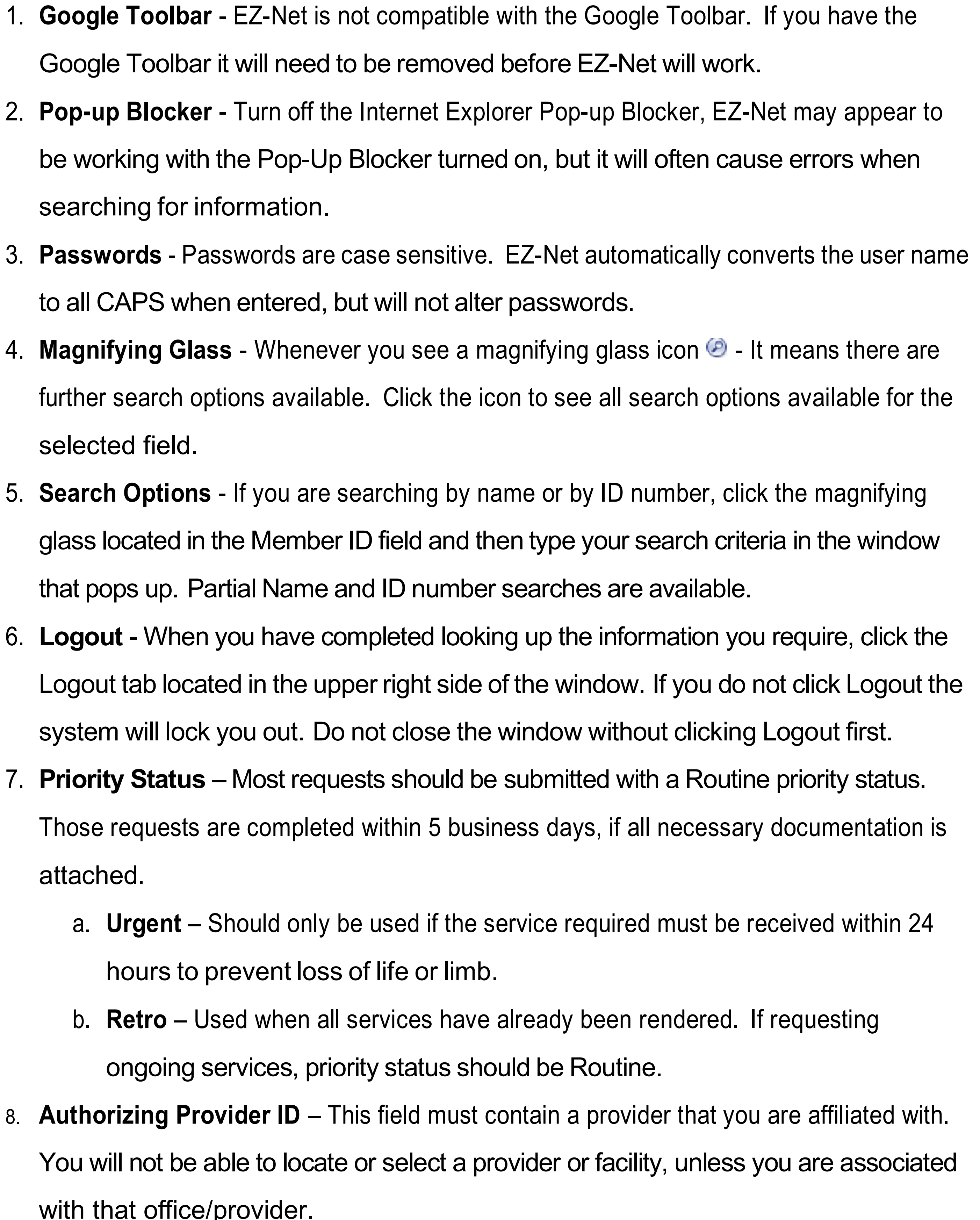
EZ-NET v6.5.0

System availability, transaction execution, and response times may vary due to volume, system performance and other factors.

Technology provided by MZI HealthCare.

45. For information on checking the status of any submitted authorization, please view the EZ-Net Training Guide.

<u>EZ-Net FAQ's</u>



1. **Google Toolbar** - EZ-Net is not compatible with the Google Toolbar. If you have the Google Toolbar it will need to be removed before EZ-Net will work.
2. **Pop-up Blocker** - Turn off the Internet Explorer Pop-up Blocker, EZ-Net may appear to be working with the Pop-Up Blocker turned on, but it will often cause errors when searching for information.
3. **Passwords** - Passwords are case sensitive. EZ-Net automatically converts the user name to all CAPS when entered, but will not alter passwords.
4. **Magnifying Glass** - Whenever you see a magnifying glass icon - It means there are further search options available. Click the icon to see all search options available for the selected field.
5. **Search Options** - If you are searching by name or by ID number, click the magnifying glass located in the Member ID field and then type your search criteria in the window that pops up. Partial Name and ID number searches are available.
6. **Logout** - When you have completed looking up the information you require, click the Logout tab located in the upper right side of the window. If you do not click Logout the system will lock you out. Do not close the window without clicking Logout first.
7. **Priority Status** – Most requests should be submitted with a Routine priority status. Those requests are completed within 5 business days, if all necessary documentation is attached.
    a. **Urgent** – Should only be used if the service required must be received within 24 hours to prevent loss of life or limb.
    b. **Retro** – Used when all services have already been rendered. If requesting ongoing services, priority status should be Routine.
8. **Authorizing Provider ID** – This field must contain a provider that you are affiliated with. You will not be able to locate or select a provider or facility, unless you are associated with that office/provider.

Notifications

- **Automatic Fax Notification**:
  - A faxed notification is automatically sent at the end of each business day to the Primary Care Physician, the requesting provider, and the requested provider. This notification includes important information on the status of the submitted request.
  - This notification is faxed beginning the day the submitted authorization request is entered in to the system and will be re-faxed each time changes or decisions are made to the authorization request.
  - This type of notification is sent whether the authorization is currently deferred, approved, cancelled, or denied so it is very important to note the **status** field when interpreting these notifications.
  - Please see the image below as an example of this type of notification and note the line indicated by the arrow which includes Status, Authorization Number, Member Name, Member ID, and Member DOB as well as effective dates for the authorization:

Confidential Transmission - Pediatric Referral/Authorization Listing

Children's Physicians Medical Grou
3860 Calle Fortunada, # 21
San Diego, CA 9212
Phone: (877) 276-454
Fax: (858) 309-7977

To: Healthcare Provider

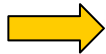
From: Children's Physicians Medical Group

This daily report is an update of all referral records created, changed and/or updated by Children's Physicians Medical Group. Please confirm your fax number. If it is incorrect, please contact Children's Physicians Medical Group at (877) 276-4543. We welcome your suggestions and/or comments. The information contained in this facsimile transmission is intended ONLY for the designated recipients named below. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this transmission is strictly prohibited. If you have received this communication in error, please notify us IMMEDIATELY by telephone so that we may arrange to retrieve this transmission at no cost to you. UM Staff and a physician reviewer who made the decision are available at (877) 276-4543 for any questions.

This Referral/Authorization verifies medical necessity only. Payment for services is dependent upon the patient's eligibility/benefits at the time services are rendered.

Referral requests identified as "Deferred" were received with incomplete information. Please submit information as requested asap. Upon receipt of the information reasonably necessary and requested, a decision will be rendered to approve, modify or deny the referral request. If no additional information or incomplete information is received, a deferred letter specifically identifying missing information will be mailed to PCP, requesting provider, requested provider and member family.

PCP/REQUESTING PROVIDER: **DATE ADD/CHANGE:** 8/4/09 5:55 pm



STATUS	AUTH NUMBER	MEMBER	MEMBER ID	BIRTH DATE	AUTH DATE	EXP DATE	PROVIDER	PLAN
APPROVED	200908045850				8/4/09	11/2/09		CC

PLACE OF SERVICE: OUTPATIENT HOSPITAL

PROCEDURE	QTY	DIAGNOSIS	
99244 - OFFICE CONSULTATION	1	789.0	ABDOMINAL PAIN*
PRIRTN - PRIOR AUTH ROUTINE REF S	1	789.0	ABDOMINAL PAIN*
APRAUTOAPR - APPROVED PER AUTO-APPRVL	1	789.0	ABDOMINAL PAIN*

- **Mailed Notifications**:
  - **Approval Letters** – Letters indicating approval of an authorization are mailed directly to the parent/guardian of the member each business day. These letters include information on the type of service, the approved provider, and a customer service phone number for questions regarding the authorization.

- **Deferral Letters** – Letters requesting further clinical information, expert review of the request, or other information are mailed to the requesting provider, requested provider, and the member's parent/guardian once the request has reached the Turn Around Time guidelines. (Please reference the flowchart located in section E-2b for detailed information on turn around time guidelines.) An example of a deferral letter is located below, the arrow indicates the section of the letter which will provide details on what information is required to complete authorization processing: **Please ensure letters and information requested is provided.**

COMMERCIAL
Extension Needed Non-Urgent due to:
Additional Information Needed

[Date of Mailing]

To the Parents/Guardians of:
[Member Name]
[Member Address Line 1]
[Member Address Line 2]

Member Name: [Member Name]
DOB: [Member Date of Birth]
Member ID: [Member ID Number]
Health Plan Name: [Health Plan]
Requested Provider: [Requested Provider]
Requesting Provider/Physician: [Requesting Provider]
Requested Service: 1. Code: [CPT Code & Description]

Dear Parents/Guardians of [Member Name]:

This correspondence is in response to your request or your physician's request on [Received Date] for the above referenced service. In some instances Children's Physicians Medical Group needs additional time in order to obtain all the necessary information to render a determination.

Information has been requested but has not been received or the information received to date is insufficient to render a determination.

In the case of your request, the following extension is required:

We are requesting additional information be submitted within *45 calendar days*. A decision will be made within 5 business days of receipt of the requested information. The physician reviewer is unable to make a determination on the service request based on available information. If we do not obtain additional information by this deadline, we may have to issue a denial. Your physician can re-submit the request for authorization at a later date.

Specifically, [Deferral Language – includes what information is needed to complete processing]

During this extension, please note that there is no action required by you the member at this time. We are requesting the additional information from your provider in order to process this request.

Thank you for your patience during this process. Please direct any further questions or information to Children's Physicians Medical Group at (877) 276-4543 or Fax (858) 309-7977.

Sincerely,
Utilization Management Department
Children's Physicians Medical Group

Commercial Delay Extension Rev. 3/01/08

- **Redirect Letters** – There are certain services that are not reviewed by CPMG/RCHN due to contract guidelines. When CPMG/RCHN receives an authorization request for one of these “carved out” services, the authorization request is processed and a Redirect Letter is mailed to the requesting provider and the parent/guardian of the member. An example of that letter is below:

[Health Plan]
COMMERCIAL
Information Letter to Member and/or Provider/Physician

[Day of the Week], [Month Day, Year]

To the parents/guardians of:
[Member Name]
[Address Line 1]
[Address Line 2]

Member Name:	**[Member Name]**
Member ID#:	[Member ID Number]
DOB:	[Member Date of Birth]
Health Plan Name:	**[Health Plan]**
Requested Provider:	[Requested Provider]
Requesting Provider/Physician:	[Requesting Provider]
Requested Service:	
Dear [Member Name] :	

This notice is to inform you that Children's Physicians Medical Group, under contract with [Health Plan], is not responsible for authorizing the above requested service(s). This is not a denial of service.

Please contact [Health Plan] Member Services at [Health Plan Phone Number] for further assistance regarding the requested service(s).

Sincerely,

Children's Physicians Medical Group

cc: Member File
Requesting Physician : [Requesting Physician]
PCP : [PRIMARY CARE PHYSICIAN]
Health Plan : [Health Plan]

- **Denial or Modification Letters** – Letters indicating that an authorization request has been denied or modified are mailed to the requesting provider and to the parent/guardian of the member. The letter will provide a detailed explanation of the denial or modification reason and will also provide information to the member on how to file an appeal of the denial directly with their health plan. An example of a denial letter is included below with the arrow indicating where the denial details will be located:

[Health Plan]
COMMERCIAL
DENIAL NOTICE

[Day of the week, Month, Day, Year]

To the parents/guardians of:
[Member Name]
[Member Address Line 1]
[Member Address Line 2]

Member Name:	[Member Name]
DOB:	[Date of Birth]
Member ID#:	[Health Plan ID Number]
Health Plan Name:	[Health Plan]
Requested Provider:	[Requested Provider]
Requested Service:	[Requested Service]
Requesting Provider/Physician:	[Requesting Provider]
Authorization Request Reference#:	[Authorization Number]

Dear [Member Name]:

The requesting provider/physician has asked for the above referenced service. The service requested is being denied by Children's Physicians Medical Group because there is lack of medical necessity. This decision was based on your medical information.

[Denial Language]

You may obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, by calling Children's Physicians Medical Group at 1(877)276-4543.

The requesting provider/physician has been advised of this denial and given the opportunity to discuss this determination with Children's Physicians Medical Group's physician reviewer.

<u>How to Dispute This Determination*</u>

If you disagree with this decision, you have the right to appeal by filing a grievance with your health plan. Your health plan requests that you submit your grievance within 180 days from the postmark date of this notice. You or someone you designate (your authorized representative) may submit your grievance verbally or in writing. You may call your health plan to learn how to name your authorized representative.

APPEALS AND GRIEVANCES

- Member appeals/ grievances:
  - Members can appeal the denial or modification of an authorization request by contacting their health plan directly.
    - The health plan will then submit a notification of appeal to CPMG/RCHN requesting all information used to make the denial decision.
    - The Health Plan will forward any information the member has submitted in their appeal to CPMG/RCHN, for review and consideration during the appeal process.
    - CPMG/RCHN will review the submitted information for possible reconsideration of denial/ modification decision. All information is forwarded to the health plan for their review and decision.
  - Members can appeal the denial of a claim by contacting their health plan directly.
  - Further appeal rights, such as Independent Medical Review (IMR) will be offered to the member by the health plan.
  - Members can file a grievance against a physician, provider, provider office or CPM/RCHN, by contacting their health plan directly.
- Provider Appeals:
  - Providers can appeal denial claims directly through CPMG/RCHN by submitting one of the items below:
    - New Clinical Information
    - A letter of Explanation/Medical Necessity
  - Provider appeals are reviewed by the UM Committee for a possible reconsideration of decision.

Rady Children's Health Network

Rady Children's Health

EZ-NET USER REQUEST FORM

eznet.rchsd.org

DATE: ____________ ☐ NEW USER ☐ EDIT USER ☐ DELETE USER

NAME: LAST ____________ FIRST: ____________

TITLE: ____________ E-MAIL: ____________

TELEPHONE: ____________ FAX: ____________

OFFICE/DEPARTMENT NAME: ____________

OFFICE ADDRESS: ____________

CITY: ____________ STATE: ______ ZIP: ____________

OFFICE TYPE: ____________ FAX NO: ____________
(PCP; SPECIALIST; ANCILLARY; ADMIN; ETC.)

PROVIDER TAX ID #: ____________ SUPERVISOR NAME____________

Confidentiality Statement
Through the EzNet system, the User will have access to confidential patient and financial data. User agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. User agrees to maintain the confidentiality of all information received via the EzNet system in accordance with all applicable state and federal laws and regulations.

____
User Signature

Provider Warranty and Approval
Provider agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. Provider warrants the User understands and agrees to maintain the confidentiality of all information received via EzNet system in accordance with all applicable state and federal laws and regulations.

Provider confirms/approves access for the above User.

____
Provider or Supervisor Signature

PLEASE FAX COMPLETED FORM TO EZ-NET SUPPORT (858) 309-6279

**********************************ADMIN USE ONLY*************************************

COMPANY	ACCESS LEVEL			
	CLAIMS	ELIGIBILITY	AUTHORIZATIONS	
			VIEW	REQUEST
RCPS				
CHG				
MOLINA				
SRSMG				
RCHN				
SHPIND				

CPMG/RCHN Approval ____________ Date____________

RCSSD MF Approval____________ Date____________

******************To be completed by EZ-Net Support**

User Login: ____________ Password: ____________
Note: Password must be changed the first time user logs into EzNet

Completed by: ____________*Date Created:* ____________

Please note: Access levels will be determined based on position/title and business need. User ID and password will be sent via email to the email address listed above. Please allow 7-10 business days for processing. Thank you.

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: CPMG Provider Disputes
  5855 Copley Drive, Suite 100
  San Diego, CA 92111

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other ____________________________
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:_____

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) **Title** **Phone Number**
( )

Signature **Date** **Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only
TRACKING NUMBER ________________________ PROV ID# ___________
CONTRACTED ______ NON-CONTRACTED ______

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page ______of ______

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

ICE Approved 10/5/07, effective 1/1/08

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	**PROVIDER ID or NPI#:**
a. PROVIDER NAME:	**b. CONTRACTED PROVIDER: _____YES _____NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF INITIAL PAYMENT OR ACTION:**

e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____NO (If NO, should be returned to provider without action)

f.1. DISPUTE TYPE: ☐ CLAIM ☐ APPEAL OF MEDICAL NECESSITY/UM DECISION ☐ BILLING DETERMINATION

☐ OVERPAYMENT DISPUTE ☐ CONTRACT DISPUTE ☐ OTHER ______________________________
(Please specify type of "other")

f.2. PROVIDER TYPE: ☐ PROFESSIONAL ☐ INSTITUTIONAL ☐ OTHER

g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

<u>TYPE OF LETTER SENT:</u> **(List the various ICE letters as applicable)**

<u>IF NO ADDITIONAL INFORMATION REQUESTED:</u>

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION** ☐ UPHELD ☐ OVERTURNED ☐ OTHER

<u>IF ADDITIONAL INFORMATION REQUESTED:</u>

m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**

q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION** ☐ UPHELD ☐ OVERTURNED ☐ OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

Children's Physicians Medical Group Case Management Request Form

Children's Physicians Medical group strives to provide your patients with the best quality of care. The Case Managers at CPMG are highly qualified registered nurses who will help to ensure members receive appropriate health services. The case managers can help with education, coordination between providers and answer any questions the member or their family might have.

Member Name: Member DOB: Health Plan:

Member's Primary Diagnosis:

Provider Requesting Case Management:

Reason for Referral to Case Management:

- ☐ Chronic Illness
- ☐ High Utilization (In and Out of Network)
- ☐ Transplant
- ☐ Overwhelmed Family/Caregiver(s)
- ☐ Multiple Specialty/DME needs
- ☐ Frequent ER or UC Utilization
- ☐ Other ___________________________

Comments: ____

____

____

Please fax back to (858) 309-7977, Attn: CPMG Case Management

AUTHORIZATION FORMS INDEX**

- CPMG/RCHN Quick Reference Guide (F.6.a)
- CHG Quick Reference Guide (F.6.b)
- Molina Quick Reference Guide (F.6.c)
- Pediatric Referral & Authorization Form (F.6.d)
- Request for Authorization of Referral to Endocrinology for Short Stature (F.6.e)
- Request for Authorization of Referral to GI for Chronic Abdominal Pain (F.6.f)
- Request for Authorization of Referral to GI for Constipation or Reflux (F .6.g)
- Request for Authorization of Referral to Nutrition/Dietary for Obesity/Overweight (F.6.h)
- Request for Authorization of Referral to Urology or General Surgery for Circumcision (F.6.i)
- Request for Growth Hormone – Initial (F.6.j)
- Request for Growth Hormone – Reauthorization (F.6.k)
- Request for MRI or CT for the Evaluation of Headache (F.6.l)
- Request for Synagis Authorization (F.6.m)

**These forms are also available on the CPMG website