Cultural Competency & Disability Training

Toolkit to Serve Diverse Populations

Santa Clara Family Health Plan
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1-800-260-2055
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www.scfhp.com
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## RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

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About this Toolkit

Cultural and linguistic competencies are widely recognized as fundamental aspects of quality in health care to diverse population. Due to rapid changes in demographics in California and new requirements, health care providers are constantly presented with new challenges in delivering quality health care to their patients.

Santa Clara Family Health Plan (SCFHP) is committed to providing culturally and linguistically appropriate care to all members. This toolkit was developed to assist health care providers and staff in providing high quality, effective and compassionate care to patients and meeting the challenging service requirements mandated by State and Federal regulatory agencies. Health care providers include but are not limited to medical, behavioral health, long term support services, and pharmacy network providers. Staff includes but is not limited to SCFHP staff and provider offices’ staff.

The toolkit is organized into four sections which contain helpful information and tools that can be reproduced and used as needed. Below you will find a list of section topics and overviews of their contents.

**Section 1: Resources to Communicate Across Language Barriers**
Provides tips on working with interpreters, communicating with multi-ethnic groups, and documenting language assistance services.

**Section 2: Resources to Communicate with Seniors and People with Disabilities**
Focuses on how to provide culturally sensitive services to seniors and people with disabilities.

**Section 3: Resources to Increase Awareness of Cultural Diversity**
Provides tips for providers and their clinical staff regarding patient interviews, literacy problems, and hiring clinical staff with an awareness of diversity issues.

**Section 4: Additional Cultural Competence Web Resources**
Lists additional resources for cultural competence training and implementation, including on-line trainings, manuals, and tools for educational purposes. Inclusion in this list does not imply endorsement by SCFHP of the source organization. Additionally, these resources should not be interpreted as medical advice.

We consider this toolkit a work in progress. We encourage you to use what is helpful, disregard what is not, provide us with any feedback you might have. We hope that you will use the toolkit as a reference guide in communicating with our diverse members.
Section 1

Resources to Communicate Across Language Barriers

Research indicates that non-English speaking, Limited English Proficient (LEP) and deaf patients face linguistic barriers when accessing health care services. These barriers have a negative impact 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 reduce linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

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

The following materials are available in this section:

**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.

**Guides to Using Interpreting Services**
Instructions on how to access SCFHP’s interpreting services.

**Tips on Using California Relay Services**
Suggestions to maximize the effectiveness of an operator.

**Tips for Documenting Interpretation Services**
Suggestions to document interpreting services in the patient’s medical records.

**Bilingual Language Proficiency Self-Assessment**
Instructions to self-assess bilingual language capability.
**Tips for Communicating Across Language Barriers**

Non-English speaking, Limited English Proficient (LEP) and deaf patients are faced with language barriers that undermine their ability to understand information given by healthcare providers. This includes understanding 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.

**A. Tips on Identifying 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 about the availability of interpreter services.
- Make available and encourage patients to carry “I speak…” or “Language ID” cards.

**B. Tips on Assessing which Type of Interpreter to Use**
- Telephone interpreter services are easily accessed and are available for short conversations.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provide consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members as interpreters.

**C. Tips on Overcoming Language Barriers**
- Use simple words.
- Limit/avoid technical language.
- Speak slowly; don’t shout.
- Articulate words completely.
- Repeat important information.
- Provide educational material in the languages your patients read.
- Use pictures, demonstrations, video or audiotapes to increase understanding.
- Give *information* in small chunks and verify comprehension before going on.
- Always confirm the patient’s understanding of the information.
Tips for Working with Interpreters

A. Telephonic Interpreter

1. Tell the interpreter the purpose of your call.
2. Give the interpreter the opportunity to introduce himself or herself quickly to the patient.
4. Express one idea at a time.
5. Avoid the use of double negative, 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.”
6. Speak in the first person. Avoid the “he said/she said.”
7. Use simple words.
8. Pause occasionally to ask the interpreter if he or she understands the information that you are providing.
9. BE PATIENT with the interpreter, the client and yourself!
10. Thank the interpreter for performing a difficult and valuable service.

B. On-site Interpreter

1. Greet the patient first, not the interpreter.
2. 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.
3. For American Sign Language (ASL) interpreting, it is best to position the interpreter beside the patient so the patient can capture the hand signals easily.
4. 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.
5. Be attentive to cultural biases in the form of preferences. 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 simply a polite way of declining to give a definite answer at that juncture.
6. Pause often to allow the interpreter to interpret.
7. Don’t say anything that you don’t want interpreted. It is the interpreter’s job to interpret everything.
8. 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.
9. Acknowledge the interpreter as a professional in communication.
10. Respect the interpreter’s role.
Guides to Using Interpreting Services

SCFHP provides foreign language and American Sign Language interpreters to members for any covered service—at no cost to members or providers.

A. Telephonic Language Interpreters

Interpreting services are available for more than 170 languages, and are available 24 hours a day, 7 days a week. To access interpreting services:

1. Call Language Line Interpreter Services directly at 1-888-898-1364
2. Press 1 for Spanish, Press 2 for other languages and speak the name of the language.
3. An agent will come on the line. Provide the agent with:
   a. Access code: network providers use operator Access Code 8033
   b. Your first name
   c. Your department and/or the office’s name
   d. Member’s ID

NOTE: California Relay Service is available in English and Spanish
1. TTY:
   a. English: 1-800-735-2929, or dial 711
   b. Spanish: 1-800-855-3000
2. Voice:
   a. English: 1-800-735-2922
   b. Spanish: 1-800-855-3000

B. In-Person Language Interpreters

In-person interpreter services are available for more than 100 languages. If possible, please schedule an in-person interpreter at least 72 hours in advance. You need the following information when scheduling in-person interpreter services:

1. Information needed when scheduling in-person interpreter services:
   - Member’s name and date of birth
   - Provider’s name and address
   - Language needed (if unknown, show member the “Language Identification Card” available from SCFHP)
   - Appointment date, time, and location
   - Type of assignment (doctor’s check-up, surgery, consultation, etc.)
   - Onsite contact (representative’s name, department, phone number, etc.)
   - Preference, if any, for male or female interpreter
2. Call SCFHP Member Services at **1-800-260-2055**, Monday – Friday, 8:30 a.m. – 5:00 p.m. Interpreters can be scheduled for any day/any time, but all in-person appointments, including in-person American Sign Language (ASL), must be set up during regular Member Services business hours.
**Tips on Using California Relay Services**

CA Relay Services is a telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled. Specially trained Communication Assistants (CAs) complete all calls and stay on-line to relay messages electronically over a text telephone (TT), called TTY for “teletype,” or to relay messages verbally to hearing parties.

A. **How to make a traditional VOICE relay call using Standard Telephone:**

1. Call CA Relay Services directly at **1-800-735-2922** (English) or **1-800-855-3000** (Spanish)
2. Give the CA the area code and telephone number you wish to call and any further instructions.
3. Talk to the CA as though you are speaking directly to the person you called. (Avoid saying “tell him” or “tell her”).
4. Say “go ahead” each time you have finished speaking.
5. Continue steps # 3 and # 4 throughout your call.
6. When you are done, says “GA to SK” (go ahead to stop keying), then hang up.

B. **How to receive a traditional relay call:**

1. Your phone rings and you answer it. A CA says, “Hello, this is CA Relay Services, Communication Assistant # XXX with a relay call for this number.”
2. You (or the staff member who answered the call) say “go ahead.”
3. The CA types your message to the TTY user and reads the reply to you.
4. Say “go ahead” each time you have finished speaking.
5. Continue steps # 3 and # 4 throughout your call. When you are done, says “GA to SK” (go ahead to stop keying), then hang up.

C. **How to make a traditional relay call using the TTY:**

1. Dial CA Relay Services directly at **1-800-735-2929** (English) or **1-800-855-3000** (Spanish)
2. Type the area code and telephone number you are calling.
3. The CA places your call and informs you of the call status: “ringing” or “busy.”
4. If the phone is answered, the CA relays the greeting s/he hears and then types “GA” for you to “Go ahead”.
5. The CA speaks what you have typed to the person you have called.
6. Continue with this process through the call. When you are ready to end your call, type “SK” for “stop keying” then hang up.
**Tips for Documenting Interpretation Services**

Documenting refusal of interpreting services in the patient’s medical record protects you and your practice. It also ensures consistency when your medical records are monitored through site reviews/audits by contracted health plans.

SCFHP asks providers to assist us in ensuring adequacy standards of the plan’s Language Assistance Program to all members by doing the following:

- 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, minor, or friend to interpret should be discouraged, if the patient insists on using a family member, minor, 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 qualified telephonic interpreter *in addition* to the family member/friend to ensure accuracy of interpretation.

- For all non-English speaking, LEP, and deaf 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 the 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.
Bilingual Language Proficiency Self-Assessment

Santa Clara Family Health (SCFHP) Plan must comply with State and Federal requirements by ensuring that all monolingual, non-English-speaking, or Limited English Proficient (LEP) members have 24-hours a day oral interpretation services available to them at all key points of contact, either through interpreters, telephone language services, or via any electronic options health plans choose to utilize.

Providers and office staff can use the “Self-Assessment Language Capabilities” tool to assess their bilingual language proficiencies. Providers and office staff who rate themselves on speaking, reading, or writing capabilities below level 3, as defined on the “Self-Assessment Language Capabilities” tool, should not serve as interpreters and/or translators.

Qualified interpreting services are available through SCFHP. This includes telephonic and face-to-face interpreting services, including American Sign Language. Please refer to Guides to Using Interpreting Services, beginning on page 8.
Providers and Staff Self-Assessment of Language Capabilities
Evaluation Guidelines

Use these guidelines when rating your own language capabilities.

1. Poor
   - Minimum courtesy requirements.
   - Unable to understand or communicate most healthcare concepts.
   - Able to understand and respond to 2-3 word entry-level questions.
   - May require slow speech and repetition.

2. Fair
   - Meet basic conversational needs.
   - Has great difficulty with many healthcare concepts.
   - Able to understand and respond to simple questions.
   - Can handle casual conversation about work, school, and family.
   - Has difficulty with vocabulary and grammar.

3. Good
   - Able to converse on most familiar topics.
   - Usually has some difficulty communicating necessary health concepts.
   - Able to speak with accuracy.

4. Very Good
   - Able to use language fluently and accurately on most topics.
   - May have occasional difficulty with healthcare concepts.
   - Can understand and participate in any conversation with a high degree of fluency and precision of vocabulary.
   - Unaffected by rate of speech.

5. Excellent
   - Speaks fluently. Often has received extensive formal education and living experience in that language.
   - Has no difficulty with healthcare concepts.
   - 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.
# Self-Assessment of Language Capabilities for Providers

Please complete one form per office for all Providers  
Make copies if additional lines are needed  
Fax completed form to SCFHP at 408-874-1949

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**Scale: 1 Poor – 5 Excellent**

1. Please indicate which language(s) you speak, read and write, and your level of fluency for each language. Please refer to the Providers and Staff Self-Assessment of Language Capabilities Evaluation Guidelines to determine your level of fluency.

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<tr>
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<th>Write (1-5)</th>
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* For each language where you responded level 4 or 5 for fluency in either speaking, reading OR writing, please complete questions 2 & 3.

2. What language(s) did you grow up speaking at home?

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<th>Language</th>
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3. Have you ever attended school taught in a language other than English?

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<th>Language</th>
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Self-Assessment of Language Capabilities for Staff

Please complete one form per office for all Staff members
Make copies if additional lines are needed
Fax completed form to SCFHP at 408-874-1949

Provider/Practice Name: ______________________ Phone Number: ______________________

Contact Name ______________________ Fax Number: ______________________

Scale: 1 Poor – 5 Excellent

1. Please indicate which language(s) you speak, read and write, and your level of fluency for each language. Please refer to the Providers and Staff Self-Assessment of Language Capabilities Evaluation Guidelines to determine your level of fluency.

<table>
<thead>
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<th>Staff Person Name</th>
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<th>Write (1-5)</th>
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* For each language where you responded level 4 or 5 for fluency in either speaking, reading or writing, please complete questions 2 & 3.

2. What language(s) did you grow up speaking at home?

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3. Have you ever attended school taught in a language other than English?

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Section 2
Resources to Communicate with Seniors and People with Disabilities

Research has shown that people with disabilities have less access to health care services and therefore experience unmet health care needs. This section offers resources to help health care providers (1) be more aware of limitations of seniors and people with disabilities; and (2) know how to communicate with seniors and people with disabilities. Materials are made available by the Harris Family Center for Disability and Health Policy at Western University of Health Sciences.

General Tips on Interacting with Seniors and People with Disabilities
Offer basic understanding of challenges and barriers for seniors and people with disabilities.

Etiquette Tips When Providing Services for Seniors and People with Disabilities
Suggestions to provide sensitive care to seniors and people with disabilities.

A. Interacting with People with Visual Disabilities
Effective methods to communicate with people who have visual disabilities.

B. Interacting with People with Cognitive, Intellectual or Psychiatric Disabilities
Understand how cognitive, intellectual or psychiatric disabilities can affect people’s behaviors when making health care decisions.

C. Interacting with People with Physical Disabilities
Tips to reduce barriers for people with physical disabilities.

D. Interacting with People with Hearing Disabilities
How to communicate with people with hearing disabilities.

E. Interacting with People with Speech Disabilities
Suggestions to communicate most effectively with people with speech disabilities.

Video Trainings for Directors and Managers in Medical, Customer Service, and Grievance and Appeals
Best practices in serving seniors and people with disabilities.

Language Tips and Preferred Terms
Best practices in communicating with seniors and people with disabilities.

Etiquette for Augmentative and Alternative Communication (AAC)
Tips and strategies for respectful and successful communication using an AAC system.
General Tips on Interacting with Seniors and People with Disabilities

A disability may be present from birth, or occur during a person's lifetime. A disability may be physical, cognitive, mental, sensory, emotional, developmental or some combination of these. Below are general tips to communicate with seniors and people with disabilities.

- Focus on the person, not on the disability.
- Offer people with a disability the same dignity, consideration, respect, and rights you expect for yourself.
- If you don't know what to do, allow the person to help put you at ease.
- Do not be afraid to make a mistake. Relax.
- Do not patronize people by patting them on the head or shoulder.
- Treat adults as adults. Address people with disabilities by their first names only when extending the same familiarity to all others present.
- Do not assume that a person with a disability needs assistance.
- Ask before acting. If you offer assistance, wait until the offer is accepted. Then wait for or ask for instructions.
- Respect the person's right to indicate the kind of help needed.
- Do not be offended if your help is not accepted. Many people do not need help.
- Insisting on helping a person is the same as taking control away from them.
- If the person with a disability is accompanied by a friend or family member, look at and speak directly to the person with the disability rather than to or through the other person.
- Do not assume that a person with a disability is more fragile than others. These feelings may make you reluctant to ask certain questions that should be asked.
- If service counters are too high for some users, such as people of short stature and people using wheelchairs, step around counters to provide service.
- Know the location of accessible routes including parking spaces, rest rooms, drinking fountains, dressing rooms, and telephones.
- Understanding disability access issues and responding accurately, quickly and respectfully to requests for information, directions or assistance conveys true welcome.
- Watch for and remove these common barriers:
  - Vehicles blocking ramps
  - Housekeeping and cleaning carts blocking hallways and restroom
  - Potted plants, benches, ashtrays, trash cans and other items blocking access to ramps, railings and elevator call buttons
  - Parking personnel using an accessible parking space as waiting areas
  - Snow and ice on walkways, ramps and parking areas
Etiquette Tips When Providing Services for Seniors and People with Disabilities

A. Interacting with People with Visual Disabilities

Having visual disabilities may mean a person has no vision or low vision, or requires large print.

- When offering help, identify yourself and gently touch the person’s arm.
- When serving as a guide, ask “Would you like to take my left (or right) arm?”
- Speak directly facing the person, and speak in a natural tone.
- Avoid pointing when giving directions. Be specific on directions such as “the restroom stall is about 7 steps in front of you.”
- When leading a person through a narrow space, put your arm that the person is holding onto behind your back as a signal for the person to walk directly behind you. Give verbal instructions as “We will be walking through a narrow row of chairs.”

B. Interacting with People with Cognitive, Intellectual or Psychiatric Disabilities

A cognitive, intellectual, or psychiatric disability can affect a person’s understanding, memory, language, judgment, learning and related information processing and communication functions.

- Offer information in a clear, concise, concrete, and simple manner.
- Use common words and short simple sentences. Try to limit sentences to one idea per sentence.
- A slow response or lack of response does not necessarily mean the person is not aware of you or what you said. Allow time for people to process your words, to respond slowly and to respond in their own way.
- When offering help, wait until your offer is accepted before doing anything.
- Don’t assume all people can read or read at all. Use simple pictures or drawings to show instructions.

C. Interacting with People with Physical Disabilities

Mobility and physical disabilities can be mild or can cause significant limitations. Physical disabilities can limit movement, strength, and endurance.

- Avoid leaning or holding onto the person’s wheelchair. Leaning onto a person’s wheelchair is similar to leaning onto a person.
- When pushing people using a wheelchair, let them know that you are ready to push. Avoid sudden turns or speed changes and carefully watch for changes in levels and pavement cracks.
- Ask for permission before moving someone’s cane, crutches, walker, or wheelchair.
- When giving directions, be specific about distance and barriers such as steps, stairs, ramp, and construction areas.
- People with limited hand use or who use prostheses can usually shake hands. If people have no arms, lightly touch their shoulder.

**D. Interacting with People with Hearing Disabilities**

Hearing loss falls along a continuum, from people who are totally deaf to many more who are hard of hearing and may or may not use a variety of sound amplification devices. Sometimes an individual’s ability to speak is also affected.

- Ask people how they prefer to communicate.
- To get the attention of a person, lightly touch the individual or wave your hand.
- Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. Not all people can lip-read. For those who do, be sensitive to their needs by positioning yourself facing them and the light source.
- Keep your hands and food away from your mouth when speaking.
- Avoid chewing gum and smoking while speaking.
- Use a normal tone of voice unless you are asked to raise your voice. Shouting or exaggerating your words will be of no help.
- Slow your speaking rate if you tend to be a rapid speaker.
- Make sure you have good light on your face.
- Do not run your words together.
- Avoid complex and long sentences.
- Pause between sentences to make sure you are understood.
- If you are giving specific information such as time, place, addresses, or phone numbers, it is good practice to have the information repeated back to you.
- If you cannot understand what is said, ask people to repeat it or write it down. Do not act as if you understand unless you do.

**E. Interacting with People with Speech Disabilities**

There are people whose speech is difficult to understand. There are also people who are unable to speak so others can understand them. People unable to communicate using natural speech may use a variety of methods that allow them to communicate. Some (not all) people with limited speech also have difficulty understanding what people say to them because of their disability, age, a hearing loss, cognitive difficulties and/or language differences.

- Do not raise your voice. People with speech disabilities can hear you.
- Give individuals your full attention and take time to listen carefully.
- Always repeat what the person tells you to confirm that you understood.
- Ask questions one at a time.
• Give individuals extra time to respond.
• Take time to understand the message when a person is using a communication device such as a letter, a word board or a device that produces speech.
• Pay attention to pointing, gestures, nods, sounds, eye gaze and eye blinks.
• Do not interrupt or finish individuals’ sentences. If you have trouble understanding a person's speech do not be afraid to ask them to repeat what they are saying, even three or four times. It is better for them to know that you do not understand than to make an error.
• If you still cannot communicate, try using paper and pen or ask them to spell the message. Do not guess.
• Teach and ask them the following commands
  ▪ “Show me how you say YES.” Yes = move your left hand.
  ▪ “Show me how you say NO.” No = move your right hand.
  ▪ “I don’t know.” = blink one time.
  ▪ “Please repeat.” = blink two times.
  ▪ “I don’t understand.” = blink three times.
Video Trainings for Directors and Managers in Medical, Customer Service, and Grievance and Appeals

Use this series of video trainings as a tool for staff training.

- Who are People with Disabilities & Activity Limitations  
  http://www.westernu.edu/bbstream/hfcdhpvideo.html?flv=BB_courses/CDHP/Part1video030409.flv

- Introduction to Hassle Factors  
  http://www.westernu.edu/bbstream/hfcdhpvideo.html?flv=BB_courses/CDHP/june1final.flv

- Hassle Factors: Communication Access  
  http://www.westernu.edu/bbstream/hfcdhpvideo.html?flv=BB_courses/CDHP/june3final.flv

- Hassle Factors: Physical Access  
  http://www.westernu.edu/bbstream/hfcdhpvideo.html?flv=BB_courses/CDHP/june2final.flv

- Hassle Factors: Medical Equipment  
  http://www.westernu.edu/bbstream/hfcdhpvideo.html?flv=BB_courses/CDHP/june4final.flv
Language Tips and Preferred Terms

A. Language Best Practices

- Choose disability terms that describe diversity in accurate and respectful ways.

- Disability-specific language should be precise, objective, and neutral in order to avoid reinforcing negative values, biases and stereotypes.

- Avoid referring to people by their disability i.e., "an epileptic." A person is not a condition. Rather, they are "people with epilepsy" or people with disabilities.

- People are not "bound" or "confined" to wheelchairs. Wheelchairs are used to increase mobility and enhance freedom. It is more accurate to say, "wheelchair user" or "person who uses a wheelchair."

- It is not necessary to avoid these expressions when around people who are blind:
  - “Did you see that game?”
  - “See you later.”

Or around people who are deaf:
  - “Did you hear about John?”

Or around people who use wheelchairs:
  - “Let’s walk to the store.”
  - “Run over to the dorm to pick it up.”
### B. Language Tips

#### Examples of Preferred Terms Regarding People with Disabilities

<table>
<thead>
<tr>
<th>Acceptable – Neutral*</th>
<th>Unacceptable – Offensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>He had polio</td>
<td>He was <em>afflicted</em> with, <em>stricken</em> with, <em>suffers from</em>, <em>victim</em> of polio, multiple sclerosis, etc.</td>
</tr>
<tr>
<td>She has multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>He has arthritis</td>
<td>He is <em>arthritic</em></td>
</tr>
<tr>
<td>She has cerebral palsy</td>
<td>She is <em>cerebral palseied, spastic</em></td>
</tr>
<tr>
<td>A person who has had a disability since birth</td>
<td><strong>Birth defect</strong></td>
</tr>
<tr>
<td>A person who has a congenital disability</td>
<td></td>
</tr>
<tr>
<td>A person who uses a wheelchair</td>
<td>Confined to a wheelchair/wheelchair bound</td>
</tr>
<tr>
<td>A wheelchair user</td>
<td></td>
</tr>
<tr>
<td>A person who has a speech disability</td>
<td>Dumb, deaf <em>mute</em>, <em>dummy</em> (implies an intellectual disability occurs with a hearing loss or a speech disability)</td>
</tr>
<tr>
<td>A person who is hard of hearing</td>
<td></td>
</tr>
<tr>
<td>A person who is deaf</td>
<td></td>
</tr>
<tr>
<td>A person who has a spinal curvature</td>
<td>A <em>hunchback</em> or a <em>humpback</em></td>
</tr>
<tr>
<td>He has an emotional disability</td>
<td></td>
</tr>
<tr>
<td>He has a psychiatric disability</td>
<td></td>
</tr>
<tr>
<td>People of short stature</td>
<td>Midgets, dwarfs</td>
</tr>
<tr>
<td>A person who has a speech disability</td>
<td>Mute</td>
</tr>
<tr>
<td>A person without a disability as compared to a person with a disability</td>
<td>Normal person, whole person, healthy person, <em>able-bodied person</em> as compared to a disabled person</td>
</tr>
<tr>
<td>She lives with a disability</td>
<td>Overcame her disability</td>
</tr>
<tr>
<td>A person who has a developmental disability or intellectual disability</td>
<td>Retard, retardate, mentally retarded, feebleminded, idiot</td>
</tr>
<tr>
<td>Use only when a person is actually ill</td>
<td>Sick</td>
</tr>
<tr>
<td>Use only when a person is actively being seen or treated by a health care provider</td>
<td>Stroke <em>patient</em>, multiple sclerosis <em>patient</em></td>
</tr>
<tr>
<td>Seizure</td>
<td>Fit</td>
</tr>
<tr>
<td>Older people with disabilities</td>
<td>Frail</td>
</tr>
</tbody>
</table>

* Always subject to change and continuing debate

#### Other words to avoid because they are negative, reinforce stereotypes and evoke pity include:

<table>
<thead>
<tr>
<th>Abnormal</th>
<th>Invalid</th>
<th>Misshapen</th>
<th>Burden</th>
<th>Lame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spaz</td>
<td>Disfigured</td>
<td>Maimed</td>
<td>Unfortunate</td>
<td></td>
</tr>
</tbody>
</table>

Etiquette for Augmentative and Alternative Communication (AAC)

Communicating using an augmentative and alternative communication (AAC) system is often significantly slower than communicating through natural speech. This significant difference in rate can alter the basic flow of conversations. The gaps of silence or pauses in the conversation that occur as the communicator who is using AAC composes their messages can feel very awkward and this provides more opportunity for others to be unintentionally impolite. It can therefore be helpful to keep a few tips in mind about how you can politely accommodate this difference in your interactions with people who use AAC. As you look at this list of conversational tips, you might realize that these tips relate to being polite when talking with anyone, but they are particularly helpful to keep in mind when talking with someone who communicates slowly using AAC.

- **Conversational Foul #1**
  Never talk about someone who is present during a conversation. Talk to them.

- **Conversational Foul #2**
  Don’t “hog” the conversation. Be sure to provide adequate time for others to respond, even if it means giving extra pauses and time for them to take their conversational turn.

- **Conversational Foul #3**
  Don’t fire quick questions at people during conversations and avoid presenting bunches of questions that can be answered just by “yes” or “no”. Give people time to answer your question and consider using open-ended questions.

- **Conversational Foul #4**
  Always check with people before you start finishing their sentences and guessing about what they are going to say. Though these strategies may be well intended, some people just don’t like it and it can get the conversation off track if you guess wrong.

- **Conversational Foul #5**
  Be honest. Let people know when you don’t understand what they were trying to communicate. You might think you are being nice by just nodding your head politely, but it is really disrespectful. It suggests that what the person is communicating is not important and it also does not lead to finding out what they were really trying to say.

- **Conversational Foul #6**
  Don’t make assumptions and judgments about others based on appearances. Avoid talking “down” to others or talking unnecessarily loudly. Not everyone who has a speech impairment or who is in a wheelchair has problems hearing or understanding what you are saying.

- **Conversational Foul #7**
  Always respect the personal space of others. Keep in mind that items such as wheelchairs and trays, AAC devices, and other adaptations are part of the personal space of people who use them. It is always polite to check in with people prior to touching or even assisting with their wheelchairs, AAC devices, etc.

- **Conversational Foul #8**
  People who use AAC often must plan ahead for situations where there is a lot to
communicate in a short time frame, such as giving a presentation during a staff meeting. Fortunately, today’s AAC devices offer the option of preparing messages needed in advance of situations. With that in mind, it is extremely helpful for people who use AAC devices to know as far in advance as possible what topics, questions, or other communication expectations are coming up, allowing them to be as prepared as possible for these situations.

Any time you are a good listener in a conversation, you are demonstrating respect and confirming that what others are communicating is important to you. Patient, respectful listening is never more important than when you are talking with someone who uses an AAC system. Hopefully these tips and strategies will help you avoid being a conversational klutz!
Section 3

Resources to Increase Awareness of Cultural Diversity

We recognize that every patient encounter is unique. Every patient is different in age, sex, ethnicity, religion or sexual preference and will bring to the medical encounter their unique perspectives and experiences. This factor will always impact communication, compliance and health care outcomes.

The suggestions presented here are intended to help build sensitivity to differences and styles, minimize patient-provider and patient-office staff miscommunication, and foster an environment that is non-threatening and comfortable to the patient.

The following materials are available in this section:

**Tips for Successful Encounters with Diverse Patients**
A one page tip sheet designed to help providers enhance their patient communication skills.

**Tips for Identifying and Addressing Health Literacy Issues**
A handout elaborating on the signs of low health literacy and how to address them.

**Gender Roles in Health Care**
Basic information on gender roles in different cultures.

**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.

**Cultural Background: Information on Special Topics**
Points of reference to become familiar with diverse cultural backgrounds.
**Tips for Successful Encounters with Diverse Patients**

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.

**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. Some patients can tell you more about their health through story telling than by answering direct questions.
**Tips for Identifying and Addressing Health Literacy Issues**

Health literacy is the ability of a person to obtain, interpret, and understand basic health information and services. 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 years of education. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment. Low health literacy can prevent people from understanding basic health care services. This section provides tips to 1) identify barriers to health literacy; and 2) address low health literacy issues.

**A. 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.
  
  Example: All seniors may not have had the same educational opportunities afforded to them.

- A patient’s culture and life experience may have an effect on their health literacy.
  
  Example: A patient’s background culture may stress oral, not written, communication styles.

- An accent, or a lack of an accent, can be misread as an indicator of a person’s ability to read English.
  
  Example: A patient who has learned to speak English with very little accent may not be able to read instructions on a prescription bottle.

- 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.

**B. Possible Signs of Low Health Literacy**

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

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

### C. Tips for Dealing with Low Health Literacy

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

- Gender roles vary and change as a person ages (e.g. 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.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness

The following sets of questions are 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 who 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, 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 interviewee’s 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.
Cultural Background: Information on Special Topics

The following section provides information on how to become familiar with diverse cultural backgrounds. Information include basic understanding of (1) the use of alternative or herbal medications, (2) weight perception, (3) infant health traditions, (4) substance abuse, (5) physical abuse, (5) communication tips to the Elderly.

A. Use of Alternative or Herbal Medications

- People who have lived in poverty, or who 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, non-judgmental 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.

B. 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.

C. Weight

- In many poor countries, and among people who come from these countries, “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.

D. 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 good care of him.”

- 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.

E. 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.

F. 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.

• Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

G. 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.
Section 4

Additional Cultural Competence Web Resources

The following on-line trainings and resources are provided for educational purposes, and are not intended as a particular endorsement of any organization. Additionally, these resources should not be interpreted as medical advice.

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

**Americans with Disabilities Act (ADA) and Disability Awareness**

The following resources include information on: 1) ADA requirements; 2) working with people with disabilities; 3) providing reasonable accommodations; 4) communicating effectively; 5) best practices; 6) awareness and competency training; and 7) regulatory guidelines.

- Center for Persons with Disabilities [http://www.cpdusu.org/about/committee/awareness](http://www.cpdusu.org/about/committee/awareness)
- Council for Disability Awareness [http://www.disabilitycanhappen.org/resources](http://www.disabilitycanhappen.org/resources)
- North Carolina State University Online Americans with Disabilities Act (ADA) Training [http://www.ncsu.edu/project/oeo-training/ada/completing.htm](http://www.ncsu.edu/project/oeo-training/ada/completing.htm)
- U. S. Department of Justice [http://www.ada.gov/cguide.htm](http://www.ada.gov/cguide.htm)
- Harris Family Center for Disability and Health Policy [http://hfcdhp.org/training/](http://hfcdhp.org/training/)

**Aging**

These resources include information on: 1) challenges of aging; 2) understanding barriers; 3) methods to achieve cultural competence in target populations; and 4) resources to serve the target populations.

- Center on an Aging Society [http://ihcrp.georgetown.edu/agingsoociety](http://ihcrp.georgetown.edu/agingsoociety)
- Sourcewise (Formerly Council on Aging) [http://www.mysourcewise.com](http://www.mysourcewise.com)
**African American**
This section includes information on effective models to serve African Americans.


**Asian American/Pacific Islander**
This section includes information on how to: 1) increase awareness about concepts and preferences; 2) understand cultural differences; and 3) effectively communicate with Asian patients.

- University of Washington Medical Center [http://depts.washington.edu/pfes/CultureClues.htm](http://depts.washington.edu/pfes/CultureClues.htm)
- Vietnamese Reach for Health Coalition [http://viethealthcoalition.org/index.html](http://viethealthcoalition.org/index.html)

**Children & Youth with Special Health Care Needs**

- National Center for Cultural Competence [http://gucchdgeorgetown.net/NCCC/journey/](http://gucchdgeorgetown.net/NCCC/journey/)

**Free Patient Health Education Materials – Low Literacy and Other Languages**
This section includes basic information on low literacy and how it affects people in making health care decisions.


**General Cultural Competence**

- Resources for Cross-Cultural Health Care [http://www.diversityrx.org](http://www.diversityrx.org)
- Health Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community [http://kaiserf.am/OjfwFX](http://kaiserf.am/OjfwFX)
• Definitions of Cultural Competence  
  http://www.nccccurricula.info/culturalcompetence.html

• National Council on Interpreting in Health Care  http://www.ncihc.org


• The Cross Cultural Health Care Program  http://www.xculture.org/

**Hispanic/Latino American**

These resources provide overviews of Hispanic culture including 1) basic understanding about the culture; 2) how to outreach to Hispanic population; 3) how to provide competent care services.

• National Alliance for Hispanic Health  http://hispanichealth.org

• National Council of La Raza  http://www.nclr.org

• National Hispanic Council on Aging  http://www.nhcoa.org


**Mental Health/Substance Abuse**

This section focuses on: 1) understanding of mental health stigma; 2) skills to develop cultural competency; 3) how to communicate; 4) how to conduct cultural sensitivity assessment; 5) how to building bridges with families; and 6) effective outreach methods.

• NKI Center of Excellence in Culturally Competent Mental Health  

• Hogg Foundation for Mental Health  

• Temple University Collaborative: Cultural Competence in Mental Health  
References

- Center on an Aging Society, http://ihcrp.georgetown.edu/agingsoociety/
- Sourcewise (Formerly Council on Aging) http://www.mysourcewise.com
- Definitions of Cultural Competence http://www.nccccurricula.info/culturalcompetence.html
- Department of Health Care Services: Medi-Cal Managed Care Division, http://www.dhcs.ca.gov/individuals/Pages/PersonswithDisability.aspx
- North Carolina State University Online Americans with Disabilities Act (ADA) Training, http://www.ncsu.edu/project/oeo-training/ada/completing.htm
• On Lok Lifeways [http://www.onlok.org/]
• Resources for Cross-Cultural Health Care, [http://www.diversityrx.org]
• The Harris Family Center for Disability and Health Policy Western University of Health Sciences, [http://www.hfcdhp.org/links.html]
• University of Washington Medical Center, [http://depts.washington.edu/pfes/CultureClues.htm]
• Vietnamese Reach for Health Coalition [http://viethealthcoalition.org/index.html]