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# Cultural Competency and Health-Care Literacy Training

# Agenda

- Health Communication
- Health Literacy
- Auxiliary Aids and Interpreter Services
- Cultural Competency
- Disability Sensitivity
- Changing Attitudes
- Ensuring Compliance

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# Health Communication

# Health Communication

- Providers must be conscious of member's:
  - Level of health literacy.
  - Culture.
  - Language.
- Effective health communication contributes to:
  - Increased member use of preventive health services.
  - Positive health outcomes.
  - Members following provider instructions.
  - Decreased anxiety, pain and psychological adversity in members.
  - Increased trust between members and providers (emotional safety).
- Ineffective health communication contributes to:
  - Malpractice lawsuits.
  - Limited member participation in clinical research.
  - Member difficulty following instruction.
  - Increased visits to the emergency room.

# Health Communication

- Member-Centered
  - Treat each member as a unique individual.
  - Considered the characteristic of each member such as:
    - Age.
    - Cultural Beliefs.
    - Education.
    - Gender.
    - Income Level.
    - Primary Language.
    - Sexual Orientation.
    - Values.
  - Consider member's past experiences with the health-care system, and how they have shaped their attitude towards health-care issues.
- A Shared Responsibility
  - **Member's responsibility:** Ask questions and provide full and honest answers.
  - **Provider's responsibility:** Provide a welcoming environment to ensure that members feel comfortable enough to share information.

# Health Communication

- Communicate clearly with members.
  - Using clear oral communication strategies can help members feel more involved and better understand health information to increase their likelihood of closing care gaps and improve health outcomes.
- Keep it simple.
  - Use plain, non-medical language and avoid technical terms, jargon and acronyms.
  - Slow down, speak clearly, at a moderate pace and normal volume.
  - Be specific and concrete; don’t use vague subjective terms that can be interpreted in different ways.

# Health Communication

- Reinforce.
  - Limit and repeat content.
  - Use body language to support what you are saying.
  - Draw pictures, use posters/models or demonstrate how it’s done.
  - When using written materials, circle or highlight key information and read written instructions aloud.
- Get help.
  - Invite member participation and encourage members to ask questions and be involved.
  - Use video and audio media as an alternative to written information.
  - Use medically trained interpreters.
  - Utilize written translation services.

# Health Communication

- Apply teach-back.
  - Teach-back is a research-based health literacy intervention that promotes adherence to medications, any type of doctors order or recommendations, quality of care and member safety.
  - Tips for using teach-back:
    - **Ask** open-ended questions. Avoid questions that can be answered with a simple yes or no.
    - **Clarify** and check again; don't wait until the end of the interaction to initiate teach-back.
    - **Use** reader-friendly print/materials and point out important information. Have members write it down while you explain.
    - **Plan** your approach and think about how you will ask your members to teach back the information.
  - Sample teach-back questions:
    - *"Can you please describe the 3 things you agreed to do to help you control your blood pressure?"*
    - *"Can you show me how you will check your blood sugar levels?"*

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# Health Literacy

# Health Literacy

- Health literacy is the capacity to obtain, process and understand basic health information and services needed to make appropriate decisions.

- Only 12% of adults in the United States have proficient health literacy skills, and 1 in 3 U.S. adults have basic or below basic health literacy skills.[1]

- To successfully manage their health, people must be able "to obtain, process and understand basic health information and services needed to make appropriate health decisions."[2]

# Health Literacy

- Know the members you serve.
  - Up to 80% of members forget what their doctor tells them as soon as they leave the doctor's office, and nearly 50% of what members do remember is recalled incorrectly.[3]
  - Members may not ask questions because they are ashamed to admit they don't understand. Individuals with limited health literacy experience negative outcomes.
  - Health literacy encompasses a range of abilities such as:
    - Analyzing information.
    - Comprehension.
    - Decoding instructions, symbols, charts and diagrams.
    - Making decisions and taking action.
    - Reading.
    - Weighing benefits vs. risks.

# Health Literacy

- Low health literacy is more prevalent among:
  - Older adults.
  - Racial and ethnic minorities.
  - Non-native English speakers.
  - Individuals with a low socioeconomic status.
  - Medically underserved populations.
- Members with low health literacy may have difficulty:
  - Locating providers and services.
  - Filling out complex health forms.
  - Sharing their medical history with providers.
  - Knowing the connection between risky behaviors and health.
  - Managing chronic health conditions.

# Health Literacy

- Signs the member may have limited health literacy:
  - Not getting their prescriptions filled or not taking medications as prescribed.
  - Consistently arriving late to appointments.
  - Returning forms without completing them.
  - Requiring several calls between appointments.
- Members with limited health literacy may make statements like:
  - *“I’ll take this home for my family to read.”*
  - *“What does this say? I don’t understand this.”*

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# Auxiliary Aids and Interpreter Services

# Limited English Proficiency (LEP)

- Language barriers are experienced by members who have LEP (limited ability to read, write, speak or understand English), and members who use non-verbal forms of communication, such as sign language.
- Language barriers may cause inaccurate or incomplete communication or understanding of information communicated by providers, leading to poor health outcomes such as:
  - Reduced access to primary health care.
  - Decreased understanding of their diagnoses, medications and follow-up instructions.
  - Dissatisfaction with care received.
  - Reduced likelihood of receiving equivalent levels of preventive care.

# Interpreters/Translators

- Assess language preferences and language assistance needs.
  - Ask members what language they prefer to speak and read, and if they would like an interpreter.
  - Document the member's preferred spoken and written languages in their record.
- Superior has resources and processes for supporting members with language services. Superior language services include:
  - Telephone interpreters.
  - In-person interpreters.
  - Written translations.

# Auxiliary Aids and Written Translations

- Use auxiliary aids and services such as:
  - Assistive listening devices.
  - Audio recordings
  - Braille.
  - Captioning.
  - Graphic materials.
  - Large print.
  - Qualified readers and/or interpreters.
  - Relay service.
  - Translated written materials.
- Provide written materials in members' preferred languages and formats.
- Do not assume that non-English speakers, including speakers of American Sign Language, will understand notes or other materials written in English.
- Ensure that members are receiving materials in their preferred alternate format.
- For translated materials, replace text written in one language (source language) into an equivalent text written in another language (target language of member).
- Translated materials should not substitute oral communication.

# Working with Interpreters/Translators

- Use acceptable language assistance services, such as:
  - Certified bilingual clinicians or staff members whose proficiency has been confirmed; can communicate directly with members in their preferred language.
  - On-site trained medical interpreters.
  - Telephone or video medical interpreter services.
- Unacceptable language assistance services include:
  - Clinicians or staff who are not certified as bilingual certified staff.
  - Minor children.
  - Member’s family or friends.

# Working with Interpreters

- Tips for working with interpreters:
  - Keep your sentences short, pausing to allow for interpretation. Stop in natural places to allow the interpreter to pass along your message.
  - Speak directly to the member and not to the interpreter.
  - Ask only one question at a time.
  - Be prepared to repeat yourself using different words if your message is not understood.
  - Check to make sure that your message is understood.

- Complimentary Interpretation Services
  - Superior offers interpretation services to providers at no cost.
  - To access telephonic interpreters for your members or to schedule an in-person interpreter, please contact Superior's Member Services department.
    - Contact information can be found at www.SuperiorHealthPlan.com/contact-us/phone-directory.html.

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# Cultural Competency

# Cultural Competency

- **Cultural competence** is having interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups, and the sensitivity to know how these differences influence relations with members.

# Cultural Competency

- Religion, culture, beliefs and ethnic customs can influence how members understand health concepts, how they take care of their health and how they make decisions related to their health, such as:
  - **Talking with their providers.** Each culture has its own way of expressing health-related information For example, depression may be expressed as lethargy, or pain may be expressed as a burning sensation.
  - **Involving their families.** The family plays an important role in many cultures. Involve the family in the member's health care if it is important to them.
  - **Making food choices.** Foods that are commonly eaten by certain cultures may need to be restricted because of members' conditions. Explain to members how they can modify their intake of these foods.
  - **Advocating for their health.** Some cultures feel that speaking up is challenging the doctor and that it is disrespectful. Let members know you would like them to speak up and ask questions.

# Become Culturally Competent, Aware and Sensitive

- Cultural competence emphasizes the idea of effectively operating in different cultural contexts, and altering practices to reach different cultural groups. Cultural knowledge, sensitivity and awareness do not include this concept. Although they imply an understanding of cultural similarities and differences, they do not include action or structural change.[4]
- Gain knowledge of a member's culture.
  - Become familiar with aspects of cultures.
  - Understand the linguistic, economic and social barriers that members from different cultures face, which may prevent access to health care and social services.
  - Make reasonable attempts to collect race and language specific member information.

# Become Culturally Competent, Aware and Sensitive

- Value diversity and accept differences.
  - Ask members how they define health and family, about their beliefs and way of life, to ensure you understand how their values may impact their care.
  - Avoid stereotyping.
  - Understand that each person is an individual and may or may not adhere to certain cultural beliefs or practices common in their culture.
- Practice self-awareness and consciousness of the impact of culture when we interact.
  - Be aware of how our own culture influences the ways we act and think.
  - Do not place everyone within a particular ethnic group in the same category.
  - Respect cultural differences regarding physical distance and contact, eye contact and rate and volume of voice.
  - Misinterpretations or misjudgments may occur.

# Become Culturally Competent, Aware and Sensitive

- Demonstrate adaptation of skills.
  - Provide services that reflect an understanding of diversity between and within cultures.
  - Understand that some cultures have a range of healing practices and treatments.
  - Develop treatment plans with consideration of the member's race, country or origin, native language, social class, religion, mental or physical abilities, age, gender and/or sexual orientation.
- Raise awareness about cultural competence awareness among your staff.
  - Hire staff that reflect the demographics of your member population; they can help contribute to a comfortable environment for members and can share insights with other staff regarding the customs of their religious or ethnic groups.
  - Require staff to complete cultural competence trainings and share what they learned with each other during staff meetings.

# Cross-Cultural Communication

- Let the person see your lips as you speak, if possible.
- Be careful with your pronunciation.
- Project a friendly demeanor/attitude.
- Stick to the main point.
- Be aware of your assumptions.
- Emphasize or repeat key words.
- Don’t rush the person.
- Control your vocabulary. Avoid jargon, slang and difficult words.
- Listen carefully.
- Make your statement in a variety of ways to increase the chance of getting the thought across.
- Speak clearly but not more loudly.
- Write down key information for them to refer to later.

# Learn from Other Sources: Websites

- **Culture Clues** are one-page tip sheets that offer insight into the health-care preferences and perceptions on members from 10 different cultures and special needs groups, including people who are Deaf/hard of hearing.
  - https://depts.washington.edu/pfes/CultureClues.htm
- The **Culture, Language and Health Literacy website** provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions and special populations.
  - https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy
- **EthnoMed** is a website containing information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
  - https://ethnomed.org/
- **Superior's Quality Improvement (QI) webpage** offers information about cultural and linguistic competency, and available interpreter and translation services.
  - www.SuperiorHealthPlan.com/providers/resources/quality-improvement.html

# Learn from Other Sources: Community Organizations

- Invite a member of a relevant cultural group to attend a staff meeting and share observations about how cultural beliefs may impact health care.
- Invite an expert to conduct an in-service training to educate staff about cultural competence.

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# Disability Sensitivity

# Disability Sensitivity

- The American with Disabilities Act (ADA) defines a person with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities."
  - This includes people who have a record of a disability, even if they do not currently have a disability.
  - It also includes individuals who do not have a disability, but are regarded as having a disability.

# Disability Sensitivity

- Providers have a legal obligation to conform to ADA requirements as noted in their contract with Superior, and to maintain reasonable accommodations for members with disabilities, including seniors and persons with disabilities.
- Reasonable accommodations ensure that:
  - Services are provided in the most integrated setting appropriate for a person's needs.
  - Members have full and equal access to health-care services and facilities.
  - Reasonable modifications to policies, practices and procedures are made when necessary, to ensure health-care services are fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of services (i.e. alter the essential nature of services).

# Disability Sensitivity

- Examples of reasonable accommodations can include, but are not limited to:
  - Improving the physical environment throughout an office or facility by using universal symbols and signage.
  - Creating adequate space within waiting rooms and exam rooms to comfortably accommodate individuals with physical disabilities (e.g. individuals who use wheelchairs) and non-physical disabilities.
  - Having medical equipment that accommodates individuals with disabilities (e.g. height adjustable exam tables, Hoyer type lifts, wheelchair accessible weight scales, moveable exam chairs).
  - Ensuring the office is accessible with ramps, and adequate parking with proper signage.
  - Providing exam room and waiting room furniture that can accommodate individuals with physical and non-physical disabilities.

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# Changing Attitudes

# Changing Attitudes

- Hypertension and diabetes are the most prevalent chronic conditions that affect Superior members.
- Some members may face mental health issues that require crisis prevention and treatment.
- Superior is committed to:
  - Care coordination to support member's medical and behavioral health needs.
  - Promoting independence in the community.
  - Changing attitudes.
  - Promoting cultural competency and disability sensitivity through evidence-based practices that ensure each member's progress is measured by improvements in specific levels of quality-based outcomes.
- Providers are reminded that there are successful models that work to improve the quality and outcomes for members and promote independence within the community.

# Changing Attitudes: Recovery Model

- William Anthony, Director of the Boston Center for Psychiatric Rehabilitation defines recovery as follows:
  - "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."
- Recovery is a unique experience for each individual with intellectual or developmental disabilities. There are certain concepts and factors common to recovery:
  - Education/knowledge.
  - Employment/meaningful activity.
  - Empowerment.
  - Hope.
  - Medication/treatment.
  - Self-help.
  - Spirituality
  - Support.

# Changing Attitudes: Medical vs. Independent Living Model

| Medical Model | Independent Living Model |
| --- | --- |
| Decisions made by rehabilitation professional. | Decisions made by the individual. |
| Focus is on problems or deficiencies/disability. | Focus is on social and attitudinal barriers. |
| Having a disability is perceived as being unnatural and a tragedy. | Having a disability is a natural, common experience in life. |

# Changing Attitudes: Medical vs. Social Model of Disability

- An **impairment** is defined as long-term limitation of a person's physical, mental or sensory function.
- **Barriers are not always physical**. Prejudice and stereotypes often shape attitudes that prevent individuals from having equal opportunity in society.

| Medical Model of Disability | Social Model of Disability |
|---|---|
| States: People are disabled by their impairments or differences. | States: Disability is caused by the way society is organized. |
| Focus is on fixing or changing impairments or differences with medical or other treatments – even when there is no pain or illness associated with them. | Focus is on removing/reducing barriers that restrict life choices (e.g. ramps for access, supported employment and employment assistance, audio books). |
| Focus is on what is "wrong" with the person. | Focus is on what the individual "needs." |
| Outcome: Individuals with disabilities are given low expectations and loss of independence, choice and control over their new life. | Outcome: Individuals with disabilities are independent and equal in society, with increased choice and control over their lives. |

# Changing Attitudes: Person First Language

- A person is not defined by their disability. Be conscious of how you address or refer to members under your care.

| Avoid | Use |
|---|---|
| Handicap/handicapped | Accessible parking/accessible seating |
| Handicapped parking/seating | Accessible parking/accessible seating |
| Stricken/victim/suffering from | Had or has a disability |
| Retard/mongoloid | Cognitive or intellectual impairment |
| Wheelchair bound/confined | Uses a wheelchair |
| Dumb/deaf/mute | Person with a communication disorder |
| The deaf | A person who is deaf |
| The blind | A person who is blind |

# Disability Etiquette

| Type of Disability | Tips |
|---|---|
| **Speech Disorders** | • Do not finish the member's sentences.<br>• Ask them to repeat, or you can repeat to make sure you understand. |
| **Seizure Disorders** | • Do not interfere with the seizure, but protect their head during the event.<br>• Do not assume they need you to call 911. |
| **Multiple Chemical Sensitivity (MCS) Respiratory Disorders** | • Do not wear perfumes, or use sprays or chemicals.<br>• Maintain good ventilation. |
| **Developmental Disabilities** | • Speak clearly, using simple words.<br>• Do not use baby talk or talk down to the person.<br>• Do not assume they cannot make their own decisions, unless you have been told otherwise. |

# Disability Etiquette

| Type of Disability | Tips |
|---|---|
| **Mobility Impairments** | • Do not push or touch someone's wheelchair.<br>• Do not lean on the chair.<br>• When possible, bring yourself down to their level to speak to them. |
| **Visually Impaired** | • Identify yourself.<br>• Do not speak to or touch a guide dog who is working. |
| **Deaf or Hard of Hearing** | • Speak directly to that person and not to the interpreter.<br>• Do not assume that they can read your lips.<br>• Do not chew gum, wear sunglasses or otherwise obscure your face. |

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# Ensuring Compliance

# Ensuring Compliance

- Title VI of the Civil Rights Act of 1964
  - Take reasonable steps to provide meaningful access for LEP members.
- Title II of the ADA
  - Prohibits excluding or denying benefits based on an individual's disability (the definition of disability is broad and includes HIV status).
- The Age Discrimination Act of 1975
  - Prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance.
- Title IX of the Education Amendments of 1972
  - Prohibits discrimination on the basis of sex in education programs and activities.

# Ensuring Compliance

- Federal Health Care Provider Conscience Protection Statuses
  - Prohibits discrimination on the basis of religious or moral objections.
- Section 1553 of the Affordable Care Act (ACA)
  - Prohibits discrimination against individuals or institutional health-care entities that do not provide assisted suicides services.
- Section 1557 of the ACA
  - Prohibits discrimination in federally assisted and some federally conducted health programs and activities, and programs and activities administered by entities created under Title I of the ACA.

# Contact Information

| For help coordinating care for members with disabilities, or securing an interpreter for members, please contact Superior's Member Services: |
|---|
| STAR and CHIP: 1-800-783-5386 |
| STAR+PLUS: 1-877-277-9772 |
| STAR+PLUS Medicare-Medicaid Plan (MMP): 1-866-896-1844 |
| STAR Kids: 1-844-590-4883 |
| STAR Health: 1-866-912-6283 |
| Allwell from Superior HealthPlan (HMO): 1-844-796-6811 |
| Allwell from Superior HealthPlan (HMO SNP): 1-877-935-8023 |
| Ambetter from Superior HealthPlan: 1-877-687-1196 |

# Contact Information

| For questions or additional provider information, please contact Superior's Provider Services: |
|---|
| CHIP, STAR, STAR Kids, STAR Health, STAR+PLUS and STAR+PLUS MMP: 1-877-391-5921 |
| Allwell from Superior HealthPlan: 1-877-391-5921 |
| Ambetter from Superior HealthPlan: 1-877-687-1196 |

# Resources

1. *https://www.cdc.gov/healthliteracy/learn/UnderstandingLiteracy.html*
2. *Ratzan SC, Parker RM, Selden CR, Zorn M, Ratzan SC, Parker RM . National library of medicine current bibliographies in medicine: Health literacy. 2000.*
3. *Roy P C Kessels. Journal of the Royal Society of Medicine: Patients' Memory For Medical Information. 2003*
4. *Centers for Disease Control and Prevention: Nation Prevention Information Network, Cultural Competence in Health and Human Services, https://npin.cdc.gov/pages/cultural-competence*
5. *Health Resources and Services Administration (HRSA):* https://www.hrsa.gov/cultural-competence/index.html
6. *Health Literacy Universal Precautions Toolkit:* http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf

# Resources

7. *Health Literacy Universal Precautions Toolkit, 2nd Edition:* https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html
8. HRSA- About Health Literacy: http://www.hrsa.gov/about/organization/bureaus/ohe/healthliteracy/
9. *U.S. Department of Health and Human Services- HRSA: Addressing Health Disparities Through Civil Rights Enforcements:* http://services.choruscall.com/links/hrsa120919.html
10. "*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*," the Institute of Medicine, 2002": https://www.ncbi.nlm.nih.gov/pubmed/25032386
11. National Center for Cultural competence, Georgetown University: http://nccc.georgetown.edu/
12. Cultural Competence Health Practitioner Assessment (CCHPA): http://nccc.georgetown.edu/assessments


*Note: For additional information and resources regarding health-care communication, health literacy, cultural competency, etc., please visit the Health Resources and Services Administration (HRSA) at https://www.hrsa.gov/cultural-competence/index.html.*