

SECTION III: Provider Roles and Responsibilities

PCP GATEKEEPER ROLE

The Primary Care Physician (PCP) serves as the gatekeeper for the health care services of his/her assigned members. Care1st contracts with PCPs for the specialties of Internal Medicine, Family Practice, General Practice, Pediatrics and sometimes OB/GYNs. The PCP is responsible for coordinating, supervising, and delivering care rendered to assigned members. PCPs are responsible for providing AHCCCS covered services that are included in their contracts and are within the scope of the physician's practice. If a referral to a specialist or ancillary medical service is necessary, the PCP is to follow the established process for obtaining such services (described in Section IX). Only contracted providers should be used for referrals, except in extenuating circumstances, given prior approval by Care1st.

Additional responsibilities include:

- Coordinating care except for children's dental services when provided without a PCP referral.
- Ensuring behavioral health information is included in the member's medical record.
- Utilizing the AHCCCS approved EPSDT tracking forms or approved electronic versions.
- Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.
- Enrolling as a Vaccines for Children (VFC) provider if serving children.

In addition to the items noted above, we ask that PCPs for our DDD members also:

- Participate in the Individual Support Plan (ISP) process when the PCP's expertise is required to ensure the most appropriate placement and plan of care.
- Review the ISP submitted by the DES/DDD Support Coordinator to become familiar with the member's needs and requirements.

Care1st has no policies which prevent the PCP from advocating on behalf of the member.

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PCP ASSIGNMENT AND PANEL RESTRICTIONS

All members are provided with the opportunity to choose their PCP. If the member does not select a PCP, they are assigned to a provider based on geographic location, provider availability, the member's age, and any special medical needs of the member.

A PCP may limit the size of their panel by making a request to voluntarily close their panel. When a provider closes his/her panel, the provider is no longer open for the auto-assignment default process or member choice selection. Exceptions may be made for immediate family of members already on the PCP's panel or other reasons requested by the PCP. PCPs may also request a maximum number of members to be assigned at the time of contracting.

Conversely, Care1st may elect to close or limit a provider's panel if the provider has difficulty meeting appointment or wait time standards, or if there are concerns regarding quality, utilization, or related issues. The provider's panel may be re-opened upon Care1st's approval of a corrective action plan.

SPECIALIST RESPONSIBILITY

Specialists are qualified and licensed to provide AHCCCS covered services within the scope of their specialty. Contracted Specialists will accept referrals from PCPs and provide medically necessary services covered by AHCCCS and Care1st within the scope of their specialty. For members requiring additional specialty services, refer to the procedure outlined in Section IX. Specialists are expected to provide appropriate visit documentation to the PCP.

Care1st has no policies which prevent providers from advocating on behalf of the member.

SERVICE DELIVERY RESPONSIBILITIES

Providers are responsible for member coverage 24 hours a day, 7 days a week. This may be accomplished through an answering service that contacts the physician or on-call physician. The provider may also use an answering machine that directs the patient to the on-call physician. An answering machine on which the member is expected to leave a message is not acceptable. It is unacceptable to use a hospital emergency department as a means of providing 24 hour coverage.

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EXCLUDED PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS

Important reminder, as a registered provider with the AHCCCS Administration you are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>

CARE COORDINATION

PCPs are responsible for coordinating medical care for members who may be receiving services from other state and community agencies which may include:

- Arizona Long Term Care System (ALTCS)
- Children’s Rehabilitative Services (CRS)
- Regional Behavioral Health Authority (RBHA)

APPOINTMENT AND WAIT TIME STANDARDS

AHCCCS has established appointment availability and office wait time standards to which the provider is expected to adhere. These standards are monitored on an ongoing basis to ensure compliance. Appointment availability standards are measured for both “Established” and “New” patients for Primary Care, Specialist and Dental providers.

An “Established” Patient is defined as a member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

A “New” Patient is defined as a member that has not received any professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

APPOINTMENT AVAILABILITY STANDARDS

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| PCP | SPECIALTY / DENTAL | MATERNITY |
|--|--|--|
| <p>Emergency Same day of request or within 24 hours of request</p> <p>*Urgent Within 2 days of request</p> <p>Routine Within 21 days of request</p> | <p>Emergency Within 24 hours of referral</p> <p>*Urgent Within 3 days of referral</p> <p>Routine Within 45 days of referral</p> | <p>First Trimester Within 14 days of request</p> <p>Second Trimester Within 7 days of request</p> <p>Third Trimester Within 3 days of request</p> <p>High Risk Pregnancies Within 3 days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists</p> |
| <p><small>*Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.</small></p> | | |

WAIT TIME STANDARDS

A member should wait no more than 45 minutes for a scheduled appointment with a PCP or specialist, except when the provider is unavailable due to an emergency.

NON-EMERGENCY TRANSPORTATION STANDARDS

Transportation providers must schedule the transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; does not have to wait more than one hour after calling for transportation after the conclusion of the appointment to be picked up; nor have to wait for more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of the treatment.

PROVIDER NETWORK CHANGES

All provider changes must be submitted in writing to your Care1st Provider Network Representative in advance. The provider changes affected by this policy include terminations, office relocations, leaves of absence, or extended vacation.

PCP TERMINATIONS/MEMBER REASSIGNMENT

a. If the terminating PCP practices under a group vendor contract, the members may remain with the group if Care1st determines that to be the appropriate course of action.

b. If the terminating PCP practices under a solo vendor contract, the members will be reassigned to another contracted PCP.

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PROVIDER LEAVE OF ABSENCE OR VACATION

PCPs must provide adequate coverage when on leave of absence or on vacation. PCPs must submit a coverage plan to their Care1st Provider Network Representative for any absences longer than four (4) weeks. Absences over ninety (90) days may require transfer of members to another PCP.

REMOVAL OF MEMBER FROM PANEL

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Member Services Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. To request a member be removed from a panel, follow the procedure outlined in Section V, Eligibility and Enrollment.

PROVIDER INQUIRIES, COMPLAINTS, REQUESTS FOR INFORMATION AND GENERAL GRIEVANCES/DISPUTES

Providers are instructed to contact Provider Network Operations regarding an inquiry, complaint, requests for information and general grievances/disputes.

The Provider Network Representative (PNR) works with internal departments, the provider and other applicable parties to facilitate the resolution of inquiries, complaints, requests for information and grievance/disputes. Every effort is made to resolve the provider's concern within five working days. Resolution and communication of resolution does not exceed 30 days unless a different time frame is agreed upon by the PNR and the provider.

PROVIDER DIRECTORY

The Care1st Provider Directory is updated on a regular basis. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their assigned PNR. The Provider Directory is available on our website - www.care1st.com/az, or you may contact Provider Network Operations for a printed version.

ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to rendering medical services. To verify eligibility providers can use the Interactive Voice Response system, visit our website www.care1st.com/az or contact Member Services.

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Specialists should always verify member eligibility on the day of the appointment. PCPs must verify both eligibility and member assignment on the date of service. Care1st will not reimburse providers for services rendered to members who are not eligible on the date of service. Providers should not rely solely on member identification cards to verify eligibility.

CANCELLED AND MISSED APPOINTMENTS

Providers are expected to develop a system for documenting and following up on cancelled or missed appointments. This is especially critical for children receiving EPSDT services and pregnant members. Please use our *No Show Appointment Log* to notify our EPSDT Team when a Care1st member “no shows” to a scheduled visit. Member outreach and education will occur immediately. The *No Show Appointment Log* is available on our website on the Forms section of our Provider drop down menu. You may also contact Provider Network Operations and a copy can be faxed/mailed to your office.

AHCCCS COST SHARING & COPAYMENTS

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS expanded member copayment requirements effective *October 1, 2010*. The expanded copayment requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copayments for certain populations, higher optional (nominal) copayment amounts for certain populations, and clarification of the services and populations which are exempt from both mandatory and optional copayments.

MANDATORY COPAYMENTS

AHCCCS members who have mandatory copayments for certain services effective *October 1, 2010* are:

- ▲ Transitional Medical Assistance (TMA) members (Copay Level 50)

AHCCCS members who have mandatory copayments for certain services effective *November 1, 2010* are:

- ▲ "Childless Adults" and MED members (also referred to collectively as the “AHCCCS Expansion Population” or the “TWG (Title XIX Waiver Group) Population.”) (Copay Level 40).

TMA Copays

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| | |
|--|--------|
| Pharmacy | \$2.30 |
| Office Visits | \$4.00 |
| Outpatient Professional Therapies | \$3.00 |
| Surgeries (In Office; Outpatient non-emergent; ASCs) | \$3.00 |

TWG (Childless Adults and MED Members) Copay

| | |
|---|---------|
| Generic Prescriptions and Brand Name Prescriptions when there is no generic | \$4.00 |
| Brand Name Prescriptions when there is a generic that can be used | \$10.00 |
| Non-emergency use of an emergency room | \$30.00 |
| Office Visits | \$5.00 |

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments. Please be aware that payments to providers are reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment.*

These copayments do not apply to:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Children eligible to receive services from the Children's Rehabilitative Services program
- People who are in nursing homes, residential facilities such as an Assisted Living Home or who receive Home and Community Based Services such as attendant care or a visiting nurse.
- People who receive hospice care

Services that do not require a co-pay include:

- Hospitalizations and services received while in a hospital
- Emergent use of an emergency room
- Family Planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women

OPTIONAL (NOMINAL) COPAYMENTS

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Optional (also known as nominal) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment. The optional copayment amounts have been updated to reflect slightly higher amounts beginning October 1, 2010. Members who are subject to the nominal copayments are not responsible for making additional copayments in a quarter when the total aggregate amount of copayments that have been made exceeds 5% of the family's income.

HOW TO DETERMINE IF A MEMBER HAS A MANDATORY COPAYMENT

Providers can identify whether a member has a mandatory copayment by using a member's specific copay level available through various AHCCCS eligibility verification systems ***other than IVR***. EVS, the web, and HIPAA transactions 270 and 271 will identify a member's copay level, but IVR will not. A member's copay level in the AHCCCS verification system corresponds to specific copayment amounts for specific services.

AHCCCS Online, <https://azweb.statemedicaid.us/Home.asp>, has the most current eligibility and copayment information for all AHCCCS members. If you are not registered to use this system, register by choosing the "Click Here" link under "New Account". The Co-Payment section at the bottom of the first page of the member's eligibility screen indicates the member copay level and provides a link to the AHCCCS Copay Grid, which provides you the detail on the mandatory copay levels and applicable services.

COPAYMENT TRACKING

AHCCCS Administration tracks each member's specific copayment levels by service type, and this information will also identify those members who have reached the 5% copayment limit. AHCCCS further identifies whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments.

Ongoing updates from AHCCCS regarding copayment requirements can be found at: <http://www.azahcccs.gov/commercial/ProviderBilling/copayments.aspx>

Please refer to Section V, Eligibility and Enrollment and Section XI, Billing, Claims and Encounters of this Provider Manual for additional information.

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Physicians are responsible for providing all covered services described in Section VI as medically necessary and appropriate. PCPs are responsible for ensuring that their members receive EPSDT services and immunizations according to the periodicity schedule with which they have been provided.

ASIIS

The State of Arizona (ARS 36-135 and AAC R9-6-706 and R9-6-707) requires that immunizations administered to children covered by AHCCCS be reported to the Arizona State Health Department ASIIS system. ASIIS - which stands for the Arizona State Immunization Information System - requires that all immunizations are reported at least monthly, and it is recommended that high volume immunization providers report more frequently. Your office can report to ASIIS electronically or by paper, and ASIIS can also accept data exports from a patient management/billing system. Training by ADHS is provided free of charge.

Contact Information: ASIIS website www.azdhs.gov/phs/asiis • For Technical Support call 602.364.3899 or 1.877.491.5741 • For free ASIIS web-based application call 602.364.3899 or 1.877.491.5741 • For paper forms call 602.364.3899 or 1.877.491.5741 • For assistance with other methods of electronic data transfer call 602.364.3619.

REFERRALS AND PRIOR AUTHORIZATION

PCPs are responsible for initiating and coordinating referrals for their assigned members when medically appropriate. Providers are responsible for receiving prior authorization, as required. Refer to the Prior Authorization Guidelines available on our website and the Prior Authorization process outlined in Section IX, Medical Operations.

SUBMITTING CLAIMS AND ENCOUNTERS

All services, including capitated services, provided to Care1st members must be documented and submitted to the health plan on the appropriate claim form. AHCCCS conducts routine data validation studies to ensure that providers are submitting accurate information. Providers must adhere to claim submission and encounter reporting requirements pursuant to their contracts. Refer to Section XI, Billing, Claims and Encounters for additional information.

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INAPPROPRIATE USE OF THE EMERGENCY ROOM

PCPs are expected to discourage the inappropriate use of the emergency room by members. Members should be instructed to call 911 any time they believe they have a life-threatening emergency. In non-emergent situations, PCPs should not refer members to the Emergency Department as a means of resolving appointment availability issues.

A more detailed description of covered emergency services is found in Section VI, Covered Services.

DOCUMENTATION

Please refer to Section X for Medical Record requirements. Providers are required to keep a medical record on each patient that is consistent with accepted medical standards. Records should include the patient's advance directives and notations of any recommendations or discussions regarding patient education, family planning, or preventive services. Providers are required to establish a medical record for each assigned child under age 21 for the purpose of documenting EPSDT services, regardless of whether the child has been seen by the provider.

The PCP must also establish a medical record for those members for whom behavioral health information is received by the Regional Behavioral Health Authority (RBHA) even if the PCP has not yet seen the assigned member. In lieu of an actual medical record, the information may be kept in an appropriately labeled file until the member's medical record is established.

DATA VALIDATION

Each year as part of a federal requirement, AHCCCS requests medical records from providers and hospitals for services provided to AHCCCS members during a previous AHCCCS contract year (October 1st through September 30th). This process is referred to as Data Validation. The study audits the integrity of claims submitted to AHCCCS health plans and ultimately to AHCCCS Administration. Care1st quality indicators are affected by the accuracy of the claims submitted and reimbursement to your practice can be negatively impacted by inaccurate claims submission.

Omission and correctness errors are two examples of common data validation errors.

- An omission error is defined as an encounter for a medical record entry of a service that a plan paid a provider for but did not submit claim data to AHCCCS (or provider did not bill the service to the plan). Also, if a claim is inappropriately deleted from AHCCCS historical files, or voided and not resubmitted it is an omission.

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- A correctness error is defined as an inconsistency between the medical record documentation and the claim submitted in respect to procedure, diagnosis, and/or date of service.

Following the tips below will reduce the errors defined above and will help to ensure each Data Validation study is successful:

1. Medical record copies must be legible. Please check the ink in your printers or review the quality of the photocopies before records are packaged and mailed.
2. Physician signatures must be legible on all documentation per Medicare requirements. If the signature is not legible, the printed name should be included under the signature and must be legible.
3. All medical record documentation must have the date of services and the patient's name on every page.
4. Documentation for office visits/consults must support the level of service being billed.
5. Documentation must support the number of units billed.
6. Documentation for time based services (i.e. anesthesia) must include the time element.
7. Diagnoses must be reported to the highest level of specificity.
8. Ambulance mileage must be documented on the medical record.

Care1st appreciates and values your assistance and partnership during the annual data validation study.

ADVANCE DIRECTIVES

PCPs are required to notify their adult members about advance directives and to document such discussion and member preferences in the medical record. Advance directives include living wills and health care/medical powers of attorney. A living will clarifies what life-saving or life-sustaining measures an individual chooses in the event that they become critically ill. A health care or medical power of attorney names a responsible party to make decisions in the event that the patient/member becomes unable to make decisions him/her self. For more information on health care directives refer to Section IV, Member Rights and Responsibilities.

NON-DISCRIMINATION POLICY

Care1st members have the right to receive courteous, considerate care regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, or source of payment. Providers must be compliant with the

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Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability.

CULTURALLY COMPETENT CARE

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds. Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location. Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction.

LANGUAGE SERVICES

Care1st is dedicated to working with its contracted providers to effectively deliver quality health care services to its culturally and linguistically diverse membership. Moreover, Care1st members have a right to interpretation services. To assist in meeting this challenge, Care1st offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All Care1st contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to Care1st so that you can focus on ensuring effective communication with your Care1st non-English speaking patients. Please call 1.800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 1.800.481.3289.

American Sign Interpretation and telephone services provided via Arizona Relay Service are available for the hearing impaired.

CULTURAL, LINGUISTIC AND APPROPRIATE SERVICES (CLAS) COMMITTEE

In addition to offering the CyraCom interpretation/translation services, Care1st has a CLAS committee. This is a committee comprised of health plan staff, providers, representatives from community-based organizations and Care1st members. The Committee discusses ways that Care1st can continue to provide culturally competent care

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and help to reduce health care disparities that may exist because of cultural issues. The US Dept of Health and Human Services' Office for Minority Health (OMH) issued the National CLAS Standards in December 2000 to ensure that all people entering the health system receive equitable, effective treatment in a culturally and linguistically appropriate manner. Below are the 14 CLAS Standards for your reference.

CLAS Standards

- 1 Health Care Organizations must offer and provide language assistance services including bilingual staff and interpreter services at no cost to each patient/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.
- 2 Health Care Organizations must provide patients/consumers (in their preferred language) both verbal offers and written notices informing them of their right to receive language services.
- 3 Health Care Organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)
- 4 Health Care Organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- 5 Health Care Organizations should ensure that patients/consumers receive from all staff members, effective understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- 6 Health Care Organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- 7 Health Care Organizations should ensure that staff at all levels and across disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.
- 8 Health Care Organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

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- 9 Health Care Organizations should conduct initial and ongoing organization self-assessments of CLAS related activities and are encouraged to integrate cultural and linguistic competency-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcome-based valuations.
- 10 Health Care Organizations should ensure that data on the individual patient/consumer's race, ethnicity, spoken and written language are collected in health records, integrated into the organization's information systems and are periodically updated.
- 11 Health Care Organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- 12 Health Care Organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- 13 Health Care Organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.
- 14 Health Care Organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the viability of this information.

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SECTION ONE

INTRODUCTION

This guide is intended to help Providers and their staff meet the challenge of caring for an increasingly diverse patient population, whose culture - which includes language, lifestyle, values, beliefs and attitudes may, differ from those of the dominant society.

Since these and other elements of culture influence the experience of illness, access to care, and the process of getting well, Providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan.

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations.

Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

Benefits of a culturally competent approach to care:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

SECTION TWO

HEALTH BELIEFS, ATTITUDES, AND BEHAVIORS: IMPLICATIONS FOR CLINICAL CARE

Culturally competent healthcare

An understanding of value systems and their influence on health is essential to providing culturally competent healthcare. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one's own values as well as the values of other groups. There is a natural tendency for people to be culture bound, that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right.

The following list, comparing dominant Anglo–American values with those of more traditional cultures demonstrates their differing views.

| <u>Anglo-American</u> | <u>More traditional cultures</u> |
|--|----------------------------------|
| Personal control over environment | Fate |
| Change | Tradition |
| Time dominates | Human interaction dominates |
| Human equality | Hierarchy/rank/status |
| Individualism/privacy | Group welfare |
| Self-help | Birthright inheritance |
| Competition | Cooperation |
| Future Orientation | Past orientation |
| Action/goal/work Orientation/informality | “Being” orientation |
| Directness/openness/honesty | Formality |
| Practicality/efficiency | Idealism/Spiritualism |

Source:

Cross-Cultural Counseling: A guide for Nutrition and Health Counselors, U.S. Department of Agriculture/US Department of Health and Human Services, Nutrition Education Committee for Maternal and Child Nutrition Publications, 1986.

General beliefs

- Beliefs about the cause, prevention, and treatment of illness vary among cultures. These beliefs dictate the practices used to maintain health. Health practices can be classified as folk, spiritual or psychic healing practices, and conventional medical practices. Patients may follow a specific process in seeking health care. Cultural healers may be used in addition to conventional medical care.

Understanding your values and beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.
- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing your patient

- The difference between a Provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent Provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Appreciate the heterogeneity that exists within cultural groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.
- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The role of economics

- The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

The role of religious beliefs

- Religious beliefs can often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, Providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, Providers and their staff may want to incorporate traditional healing into the general treatment plan.

The role of the family

- Traditional cultures place a greater emphasis on the role of the family. Decision-making about health issues may be a family affair. It can be helpful for Providers and their staff to take this into account as medical decision-making takes place.

Questions to consider:

1. How many family members can accompany the patient into the room?
2. Should friends be allowed in the room?
3. Who can or should be told about the patient's condition?

SECTION THREE

STRATEGIES AND APPROACHES IN ASSESSING PATIENT'S BELIEFS ABOUT HEALTH AND ILLNESS

Cultural assessment

Cultural assessment of the patient is an important step in identifying the patient's views and beliefs related to health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health. Studies have classified Health Practices into several categories: **folk practices, spiritual or psychic healing practices, and conventional medical practices.**

In addition to the general data collected from a patient, the following checklist may be helpful in gaining culturally specific information.

- Where were you born?
- If you were born outside the USA, how long have you lived in this country?
- Who are the people you depend upon the most for help? (Family members, friends, community services, church etc.)
- Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- What languages do you speak?
- Can you read and write in those languages?
- What is the first thing you do when you feel ill?
- Do you ever see a native healer or other type of practitioner when you don't feel well?
- What does that person do for you?
- Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- What are they, and what do you take them for?
- What foods do you generally eat? How many times a day do you eat?
- How do you spend your day?
- How did you get here today?
- Do you generally have to arrange for transportation when you have appointments?

Cultural assessment (continued)

To help Providers and their staff conduct cultural assessments, the questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

- Do individuals in this culture feel comfortable answering questions?
- When the Provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
- Who should be told about the illness?
- Does the family need a consensus or can one person make decisions.
- Does the patient feel uncomfortable due to the gender of the Provider?
- Does more medicine mean more illness to the patient?
- Does no medication mean healthy?
- Does the patient prefer to feel the symptoms, or mask them?
- Does the patient prefer ONE solution or choices of treatment?
- Does the patient want to hear about risks?

(Source: Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for Providers and patients alike. Since effective communication between patients and Providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like “diet” have different meanings to professionals than they have in the general public.

Other Factors Influencing Communication:

Conversational style:
indirect.

It may be blunt, loud and to the point – or quiet and

Personal space:

People react to others based on their cultural conceptions of personal space. For example, standing “too close” may be seen as rude in one culture and appropriate in another.

Eye contact:

In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person’s privacy.

Touch:

A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful.

Greeting with an embrace or a kiss on the cheek is common among some cultures.

Response to pain:

People in pain do not always express the degree of their suffering. Cultural differences exist in patient’s response to pain. In an effort to “be a good patient” some individuals may suffer unnecessarily.

Time orientation:

Time is of the essence in today's medical practice. Some cultural groups are less oriented to "being on time" than others.

Other Factors Influencing Communication (Continued):

What's in a name:

Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.

Nonverbal communication:

Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.

When English is a second language:

According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant.

Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.

Translators:

Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution.

Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

- Communicate effectively: Allow more time for cross-cultural communication, use translators who are not family members and ask questions about cultural beliefs.
- Understand differences: Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.
- Identify areas of potential conflict: Determine who is the appropriate person to make decisions and clarify and discuss important ethical disagreements with them.
- Compromise: Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide interpretation/translation services to Providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact the patient's AHCCCS Health Plan or Program Contractor to make the necessary arrangements.

AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of non-professional interpretation/translation services such as by bilingual staff and/or a patient's family member may jeopardize patient outcomes.

INTERNET RESOURCES

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

- National Center for Cultural Competence: <http://nccc.georgetown.edu/foundations/need.html>
- Ethnomed: <http://ethnomed.org/culture/>
- http://bearspace.baylor.edu/Charles_Kemp/www/hispanic_health.htm Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).
- Society of Teachers of Family Medicine: Multicultural Health Care and Education General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage <http://www.stfm.org/>

General Reference sites (continued):

- AMSA (American Medical Student Association):
<http://www.amsa.org/AMSA/Homepage/About/Committees/REACH/CSSP.aspx>
- Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. <http://www.xculture.org/>
- Communicating with your doctor - things you can do to help build an effective partnership
http://www.ucsfhealth.org/education/communicating_with_your_doctor/
- CCCH develops cultural competency programs, organization assessment tools, and education and training resources. <http://www.crosshealth.com/>
- The Office of Minority Health (OMH) was created in 1986 and is one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. The Office is dedicated to improving the health status of racial and ethnic minorities, eliminating health disparities, and achieving health equity in the United States. OMH was reauthorized by the Patient Protection and Affordable Care Act of 2010
<http://minorityhealth.hhs.gov/>
- U.S Department of Health and Human Services - Health Resources and Service Administration: clinical resources <http://www.hrsa.gov/publichealth/index.html>
- The Health Center Program – What is a health center <http://bphc.hrsa.gov/about/>
- Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)
- Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)
- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: <http://www.diversityrx.org/>
- National Urban League (Phone: 212-310-9000) or <http://www.nul.org/>
- African Community Health and Social League <http://www.progway.org/ACHSS.html>
- Association of Asian Pacific Community Health Organizations <http://www.aapcho.org>
- National Coalition of Hispanic Health and Human Services Organizations <http://www.hispanichealth.org/>
- Center for American Indian and Alaskan Native Health Phone:
<http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/CAIANH.aspx>
- www.culturalorientation.net
- The Provider's Guide to Quality and Culture
<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>