Provider Health Equity Toolkit

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PROVIDER HEALTH EQUITY TOOLKIT

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HEALTH EQUITY

Our Commitment

Iowa Total Care is committed to transforming the health of the communities we serve, one person at a time. Our goal is to improve the access and availability of care regardless of age, ethnicity, gender, race, national origin, religion, disability, sexual orientation, gender identity or socioeconomic background. We are committed to embracing diversity, equity, and inclusion in all the work we do. Iowa Total Care continues to work diligently to dismantle systemic and interpersonal racism, bias, discrimination and the social and structural inequities that threaten the health of our community.

Introduction

Health inequity remains a critical issue in Iowa, affecting marginalized groups, such as racial and ethnic minorities, low-income individuals and rural populations. These groups face significant barriers to accessing quality healthcare, leading to higher rates of chronic diseases like diabetes, heart disease and cancer. Cultural differences, including language barriers and varying health beliefs, further complicate the delivery of effective and culturally sensitive care.

According to a 2023 report by the Iowa Department of Public Health, Black Iowans have a diabetes prevalence rate of 14%, compared to 8% for white Iowans, and Hispanic Iowans are 1.5 times more likely to be uninsured than their non-Hispanic counterparts. Additionally, rural Iowans experience higher rates of obesity and a 20% higher mortality rate from heart disease compared to urban residents.

Social determinants of health, such as limited access to nutritious food, safe housing and educational opportunities, exacerbate these disparities. Implicit bias and systemic racism within the healthcare system can undermine trust and hinder effective member-provider communication. Addressing these inequities is crucial to improving health outcomes for all Iowans.

The Iowa Total Care Health Equity toolkit is designed to help providers with their diverse members, backgrounds and cultures which can impact their health. It includes resources to understand and navigate language and cultural differences among Iowa residents, fostering a more inclusive and effective healthcare environment for everyone.

Changing The Narrative

To address health equity in a meaningful way, we must change the lens through which we view healthcare.

Conventional Question	Asked Through a Health Equity Perspective
"How can we promote healthy behaviors?"	"How can we target dangerous conditions and ensure healthy spaces and places?"
"Which populations have the worst health?"	"What causes the unequal production and distribution of the conditions that promote and harm health?"
"What interventions can address health disparities?"	"What generates health inequity in the first place?"

Office of Management and Budget OMB Definitions:

The Office of Management and Budget (OMB) provides definitions and demographic data to inform various aspects of public policy and social research. Understanding these definitions is crucial for addressing the unique challenges and disparities faced by different racial and ethnic groups in Iowa.

African Americans/Black: Individuals with origins in any of the Black racial groups of Africa, including African American, Jamaican, Haitian, Nigerian, Ethiopian and Somali.

- Iowa's Black population has the highest cancer incidence rates of all racial/ethnic groups for those ages 50-79. Contributing to high cancer incidence rates, African Americans face increased barriers to cancer prevention resources than other groups[1]. Barriers to cancer prevention include lack of access to healthcare services, health insurance and higher rates of poverty[14].
- Iowa's Black maternal mortality rate is six times higher than the rate for White birthing individuals. Complications like excessive bleeding, cardiac arrest and extreme high blood pressure are experienced at higher rates by Black Iowans regardless of whether they have public or private health insurance or live in poverty.[2]
- In 2019, 83% of African Americans aged 25 and over in Iowa have at least a high school education. Iowa's average is 92.6%.[3]

Asian/Pacific Islander: Individuals with origins in any of the original groups of Central or East Asia, Southeast Asia or South Asia, including Chinese, Asian Indian, Filipino, Vietnamese, Korean and Japanese.

- 77 is the percentage of Asians in 2021, age 25 and over, who are high school graduates. The corresponding rate for all Iowans is 93.3%.
- Native Hawaiian and other Pacific Islander people have a 75% higher mortality rate for liver cancer and are two to three times more likely to die from cervical, stomach and endometrial cancers compared to White people.[1]
- Diabetes is a serious health concern, with Native Hawaiian and Pacific Islander populations especially at risk. There is a startling 47% diabetes prevalence in American Samoans, 20% diabetes prevalence in Native Hawaiians and 10% among Asian Americans, compared with 8% of the US general population.[6]
- In 2019, Native Hawaiian/Pacific Islander mothers were 4.6 times more likely to receive late or no prenatal care as compared to non-Hispanic white mothers disparities in diabetes.[7]

Alaska Native or American Indian (AI/AN): Individuals with origins in any of the original peoples of North, Central and South America, including, for example, prominent American Indian groups within Iowa, such as the Meskwaki, Omaha, Ponca and Winnebago.[8]

The Indigenous community includes American Indian (AI) and Alaskan Native (AN) populations. They have borne generations of policy that have been harmful to the health of their communities, including:

- Educational systems that forcefully removed children from homes for integration into white culture.
- Removal from and devastation of tribal lands.
- Lack of access and underfunding of healthcare.
- Indian Health Service per capita expenditures for personal healthcare is approximately $4,078 per user, compared to an average of $9,726 per person nationally.
- Where Indigenous people are eligible to receive healthcare is complex; they have federal protections to ensure they have access to culturally appropriate care, including providers who may not be in our network.

- 34% decrease in Iowa's Native American enrollment between the 1999-2000 school year and 2021-2022[13].
- 51.3% of the growth in Iowa's Native American population from 2000-2022 occurred in ten counties: Black Hawk, Crawford, Dallas, Johnson, Marshall, Polk, Pottawattamie, Tama, Wapello and Woodbury.[13]
- Heart disease rates are about 50% higher among the 5.2 million people in the United States who self-identify as American Indian and Alaska Native compared to their white counterparts. More than one-third of their deaths attributed to cardiovascular disease occur before age 65[11]. Type 2 diabetes affects American Indians and Alaska Natives at three times the rate of their white peers and is linked to high rates of heart attacks and strokes.[12]

White: Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish and Scottish.

- Average White Iowan graduation rate, 93%, state overall is 90% according to the Iowa Health and Human Services Healthy Iowans (hhs.iowa.gov/performance-and-reports/healthy-iowans).
- 72% of Iowan unemployment benefits recipients are White (as of January 2024).

Rural vs. Urban

Rural	Urban
An open swath of land that has few homes or other buildings and not very many people and where density is very low.	Areas that are very developed, meaning there is a density of human structures, such as houses, commercial buildings, roads, bridges and railways.
Typically quieter and less developed, whereas urban areas offer more educational and job opportunities and have rapidly developing infrastructure. Rural areas usually have small communities with less than 2,500 people, and urban areas have bigger towns and more crowded places.	"Urban area" can refer to towns, cities and suburbs. An urban area includes the city itself, as well as the surrounding areas.

Towns and cities appeal to people for a lot of reasons: Improved public transport, a mix of cultures, job opportunities and easy access to shops and amenities.

- Iowa is a predominately rural state (37%) with approximately 3.2 million people, 71 counties qualify as rural. 90% of rural Iowa is White.
- 67 of Iowa's 99 counties — most of them rural — lost population due to a smaller labor force and a declining economy[9].
- Rural Americans tend to have higher rates of cigarette smoking, high blood pressure and obesity. Rural residents report less leisure-time physical activity and lower seatbelt use than their urban counterparts. The shortage of healthcare providers in rural areas exacerbates rural health disparities. Only 12% of physicians practice in rural communities, and most areas deemed "health professional shortage areas" by the federal government—61%—are in rural areas[10].

Cultural Thinking

Cultural health encompasses a broad spectrum of factors that influence an individual's health beliefs, behaviors and outcomes. It goes beyond language barriers and ethnic stereotypes to encompass elements such as religious practices, family dynamics, socioeconomic status and acculturation experiences. Understanding and embracing cultural health allows us to bridge the gap between healthcare providers and members, fostering trust, communication and mutual respect. Cultural thinking should be member-centric.

Cross Cultural Health Beliefs and Differences in Iowa

Cross Cultural Health Beliefs:

- Mind, body and spirit are an integrated whole.
- Cause of illness may include imbalances between the mind, body and spirit.
- Preference for use of natural elements, such as plant-based remedies.
- Beliefs that treatment works when one feels better.
- Use or consultation with spiritual or faith-based healers.

Cross Cultural Encounters	
There are multiple cultures interacting in every clinical encounter, including: • Physician's culture. • Member's culture. • Culture of each person that interacts with the member, from the office staff to nurses. • Culture of the healthcare delivery institution.	**Cultural humility may improve member care by:** • Increasing confidence, satisfaction and follow-up. • Increasing member and health plan retention. • Improving health outcomes of the member when healthcare concepts and practices are taken into consideration.

Tips for Providers and Office Staff To Enhance Communication With Diverse Members:

- Recognize that member from diverse backgrounds may have different communication needs.
- Build rapport with the member. Address member by their last names. If the member preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on members when addressing them.
- Learn basic words in the member's primary language like hello and thank you.
- Recognize that members from diverse backgrounds may have different communication needs.
- Explain to the member the different roles performed by people who work in the office.
- Make sure members know what you do.
- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider arranges for care (when the provider is the first point of contact and then refers to specialists).
- Have instructions translated by a professional translator and available in the common language(s) spoken by the member base.
- Keep members' expectations realistic.

- Inform members of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the member to make a list of questions for the provider, review health materials or view waiting room videos.
- Work to build member's trust in you.
- Inform members of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times.
- Determine if the member needs an interpreter for the visit.
- Document the member's preferred language in their chart.
- Have a plan for interpreter access. An interpreter with a medical background is preferred, rather than family or friends of the member.
- Assess your bilingual staff for interpreter abilities.
- Resources for interpreter services are available from health plans, the state health department and the internet.
- Give members the information they need.
- Have topic-specific health education materials in languages that reflect the member base.
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss.
- Make sure members know what to do.
- Review any follow-up procedures with the and family before they leave your office.

Verify call-back numbers, the locations for follow-up services such as labs, X-ray or screening tests and whether or not a follow-up appointment is necessary. Develop preprinted simple handouts of frequently used instructions and translate the handouts into the common language(s) spoken by your member base. **Note:** See commonly used sentences and signs provided in this toolkit.

Additional Resources: Think Cultural Health

- Addressing Framework (PDF) (thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/addressing-framework.pdf)
- CLAS, Cultural Competency, and Cultural Humility (PDF) (thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/clas-clc-ch.pdf)
- Combating Implicit Bias and Stereotypes (PDF) (thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/combating-implicit-bias-stereotypes.pdf)
- How to Better Understand Different Social Identities (PDF) (thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/how-to-better-understand-different-social-identities.pdf)
- Communication Styles (PDF) (thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/communication-styles.pdf)

Language and Communication Best Practices & Tips

Iowa Total Care is committed to providing culturally and linguistically appropriate health services competently. This means all reasonable accommodations are provided to ensure equal access to communications resources for limited English proficient (LEP) members.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English, may be considered LEP.

How to identify a LEP member over the phone:

- Member is quiet or does not respond to questions.
- Member simply says yes or no or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.

Signs that a member may need interpretation services:

- Member is quiet or does not respond to questions.
- Member simply says yes or no or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member self identifies as LEP by requesting language assistance.
- Member speaks no English and you are unable to discern the language.

If the member speaks some English: Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

Communication Tips:

- Speak slow, not loudly with member.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.
- Use open-ended questions to assess understanding.
- If the member initially refused interpreter services and is not demonstrating full understanding, offer interpreter services again.
- Monitor non-verbal cues, such as facial expressions, positioning and body language. These may indicate understanding or confusion.

Best Practices for Providers:

- Document the member's preferred spoken and written language in their medical record.
- Document the communication aid used for the visit (example, the person who provided interpretation services); any use or refusal of a professional interpreter.
- Post free interpretation service sign at key point(s) of contact.
- Refrain from assuming sexual orientation and gender identity.
- Use gender-neutral language such as: friends, folks, everyone, all and you.

NOTE: If there's an accidental slip up, or if mistake is made, such as using the wrong name pronoun, or term, a straightforward apology is appropriate. For example,

"I apologize for using the wrong pronoun. I did not mean to disrespect you. I'll do my best to not let it happen again."

After letting the member respond, everyone can proceed with increased awareness of their word choice. Iowa Total Care values the provision of inclusive language services to members, to accommodate their needs. Members who do not speak English may be vulnerable to healthcare challenges.

Non-English Speaking Members

- Delays in preventable healthcare.
- Increased medical errors.
- Lower treatment adherence.

Providing quality language service for our members is the law. This includes in-person interpreters (including sign language) for clinical visits and telephonic interpreter services.

Professional interpreters must always be offered. It is against the law for children under the age of 18 to provide interpreter services (except in cases of imminent death).

Older Adult Communication Needs From Members' Perspective

Understanding the communication needs of older adults is essential for providing respectful and effective care. Our members have shared valuable insights about their experiences and preferences that can enhance our interactions. They express a desire to be treated with dignity, emphasized by the importance of formal address and empathetic communication.

Members want to be engaged in conversations about their health, included in decision-making and spoken to directly, regardless of the presence of caregivers. It's crucial to create a supportive environment, free from background noise, where clear and straightforward language prevails over medical jargon and acronyms.

Additionally, recognizing the potential barriers posed by cultural beliefs, language differences and varying literacy levels is key to fostering understanding. Our members appreciate when we take the time to encourage questions, provide written instructions and allow for thoughtful dialogue. Sensitive topics like advance directives or terminal prognoses require particular care, as cultural perspectives can shape their understanding and comfort level.

By integrating these insights into our practice, we can build stronger relationships, enhance member compliance and ultimately improve health outcomes for the older adult population we serve.

- I wish you knew/I wish you would do.
- I want to be respected and addressed formally.
- I appreciate empathy. Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as honey, dear and baby talk. Be empathetic and try to see through my lens.
- I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions. Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding decisions.
- I can't hear well with lots of background noise.
- To see with glaring or reflecting light. When possible, try to find a quiet place when speaking to hard of hearing members. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible.
- I may have a language barrier and cultural beliefs that may affect adherence to the treatment plan. Offer language assistance to help us better understand each other.
- Medical jargon and acronyms confuse me. Use layperson language, not acronyms or popular slang terms.
- I respect my doctor and am not always comfortable asking questions. I don't like to be rushed. Encourage questions. Avoid interrupting me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
- Nodding my head doesn't always mean I understand. Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using the teach-back method.
- I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you. Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
- Some topics, such as advance directives or a terminal prognosis, are very sensitive for me. Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner.

Health Literacy

Low health literacy can prevent members from understanding their healthcare services.

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

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, providers' directions, consent forms and the ability to negotiate complex healthcare 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 healthcare environment.

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.

Examples of barriers to health literacy are:

- A member's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of an accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a member 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.
- If an adult is learning a second language, it takes an average of 6 to 12 years to develop.

Sign of Low Health Literacy:

Members 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.

Members 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.

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 member's logic may be different from yours.
- Ask members 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.

Top Languages for Iowa Total Care Membership After English

1. Spanish
2. Arabic
3. Swahili
4. Karen
5. French

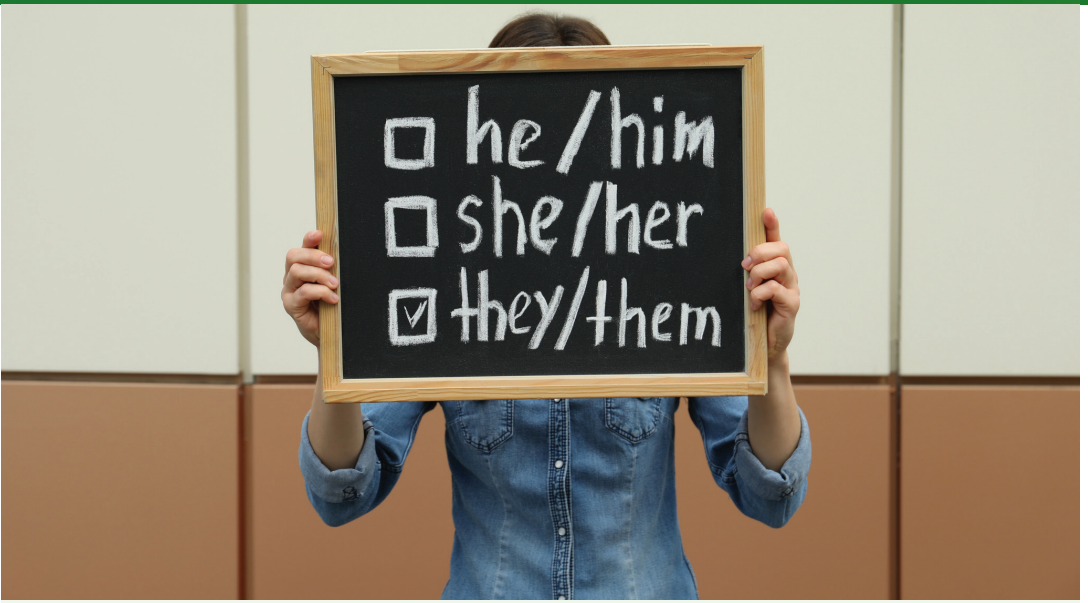
Iowa Total Care has the following member materials available in our current top 5 languages.

- My Health Pays® Rewards
- Health Risk Screening (HRS) Letter
- Value-Added Benefits
- iowatotalcare.findhelp.com information
- Disease Management/Health Coaching
- Stakeholder Advisory Board Flyer

Iowa Total Care aims to equip its providers with the knowledge and readiness to treat our members that may identify as LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, and gender-diverse) with respectful and equitable care.

The Importance of Inclusive Healthcare

Most individuals within the LGBTQIA+ community experience stigma from an early age, facing discriminatory laws, policies and marginalization for more than 100 years. A long history of differential treatment results in significant health and behavioral health implications for the LGBTQIA+ community. Recurring disparities persist in the availability of safe and consistent healthcare, often leading to delays in care that are rooted in the fear of unsupportive healthcare services and providers.



Guidelines to Navigating Pronouns and Chosen Names

- Pronoun is a linguistic tool used to refer to oneself and others.
- Chosen name is the name an individual (who typically identifies as transgender) chooses to be called by, which may or may not match their given or legal name.
- If you're unsure about how a member identifies, use thoughtful questions for clarity.
  - "Is the information on your insurance card current and accurate, including your name and gender?"

Health Equity Concerns and Barriers to Care

Vulnerability to Poverty

LGBTQIA+ communities experience disproportionate instances of economic insecurity and poverty, often leading to social determinants of health (SDOH) such as food insecurity, housing instability and other barriers that influence health outcomes. Various interconnected challenges often occur simultaneously exacerbating SDOH such as:

- Underemployment due to workplace stigma.
- Homelessness due to anti-LGBTQIA+ bias within families.
- Behavioral health and substance use issues.
- Becoming a parent without adequate family and community support.
- Increased risk of long-term health issues resulting from chronic stress.
- In the LGBTQIA+ community, historically overlooked are the intimate partner violence (IPV) and intimate partner sexual assault (IPSA).
- 26% of LGBTQ Iowans have incomes less than $24,000 annually.
- LGBTQ Iowans experience unemployment at 6% compared to Iowa's total unemployment rate of 2.4%.
- LGBTQ Iowans are also twice as likely to be food insecure (22%) when compared to non-LGBTQ Iowans (11%)[4].
- 44% of LGBTQ youth in Iowa seriously considered suicide in the past year.
- Addressing these vulnerabilities using Z Codes can better assist us in identifying resources and support for our members.

Considerations for Specific Demographics

When working with members who identify as LGBTQIA+, it's crucial to recognize and address the diverse health experiences that may be present such as:

- Caring for LGBTQIA+ youth members.
  - Greater risk for behavioral health issues.
  - Suicidal ideation.
  - Substance use.
  - More negative sexual health outcomes such as higher STI transmission rates[15].
- Caring for aging LGBTQIA+ adult members.
  - Healthcare mistrust.
  - Limited social and family support.
  - Increased likelihood to poverty.
- Caring for LGBTQIA+ members who are also Black, Indigenous, and people of color (BIPOC).
  - Lack of healthcare access.
  - Bias and prejudice in healthcare treatment.
  - Lack of adequate housing.
- Caring for transgender and gender non-conforming members.
  - May have mental health concerns or challenges.
  - Lack of preventative care.
  - Low health literacy.
- Caring for LGBTQIA+ members who have a disability.
  - Low health literacy.
  - Mental health concerns or challenges.
  - Mobility and social constraints.

Disabilities[1]

Disabilities, visible and invisible can vary in severity and affect individuals from all backgrounds and cultural groups.

Members with disabilities are more likely to have other serious health issues and may have challenges accessing and receiving quality care due to environmental barriers.

The Americans with Disabilities Act (ADA) became law in 1990. The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in many areas of public life, including jobs, schools, transportation and many public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else. The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services and telecommunications. The ADA divides into five titles (or sections) that relate to different areas of public life.

IOWAN DISABILITIES STATS:

1. The **unemployment rate for Iowans with a disability** in 2022 was **7.4%**. The overall unemployment rate for Iowa in 2022 was 3.5%.
2. The **poverty rate for Iowans with disabilities** in **2022** was **26.2%**. The overall poverty rate for Iowans without disabilities was 10.9%.
3. **402,615 Iowans lived with a disability** in 2022 and they represent 12.8% of the civilian, noninstitutionalized population.
4. **29.9% of people 65 and older, lived with a disability** in 2022, the highest of any age group.[16]

Disabilities: Qualifying Members

Section 504 of the Rehabilitation Act of 1973 defines an individual with a disability as a person with a physical or mental impairment that substantially limits one or more major life activities.

Breathing	Manual Tasks	Speaking
Hearing	Seeing	Walking
Learning	Self-Care	Working

Tips for Communicating With Members Who Live With the Following Disabilities

Blind, vision loss or deaf-blind:

- Provide a qualified reader.
- Use Braille.
- Provide information in large print.
- Use an audio recording of printed information.
- Use a computer screen-reading program.
  - Provider may request talking books.
    - Visit the National Library Service for the Blind and Print Disabled and complete their online form (loc.gov/nls/how-to-enroll/sign-up-for-bard-and-bard-mobile/)
  - Provider may request vision-enabled telephone.

Deaf, hearing loss or deaf-blind:

- Providing a qualified note taker.
- A qualified sign language interpreter.
- An oral interpreter.
- A cued-speech interpreter.
- A tactile interpreter.
- Real-time captioning.
- Written materials.
- Printed script of a stock speech.

Speech:

- Provide a qualified speech-to-speech transliterator (an individual trained to recognize unclear speech and repeats it clearly).
- Allow more time to communicate for those who use a communication board or device.
- Listen attentively and don't be afraid or embarrassed to ask the person to repeat a word or phrase.

In addition, aids and services include a wide variety of technologies, such as:

- Assistive listening systems and devices.
- Open captioning, closed captioning, real-time captioning and closed caption decoders and devices.
- Telephone handset amplifiers, hearing-aid compatible telephones, text telephones (TTYs), videophones, captioned telephones and other voice, text and video-based telecommunications products.
- Videotext displays.
- Screen reader software, magnification software and optical readers.
- Video description and secondary auditory programming devices that pick-up video-described audio feeds for television programs.
- Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

Federal Guidelines for Providers

Federal law prohibits providers and staff from recommending or requiring the use of family or friends to interpret or requesting them to provide their own interpreter. Interpretation services must be available at the time of the appointment. Minors should never be used as interpreters except in the case of an emergency involving imminent danger or threat to the safety and welfare of an individual or the public where there is no qualified interpreter available. If you use a minor, document the reason a minor was used.

Similarly, an adult may be used to interpret or aid in communication in an emergency involving imminent danger and there is no qualified interpreter available or; when the limited English proficient (LEP) individual specifically requests that an accompanying adult interpret, the adult agrees and reliance on that adult is appropriate.

Bilingual providers and staff are considered qualified to provide language services if they have a demonstrated proficiency in speaking and understanding both English and at least one other language, including any necessary specialized vocabulary, terminology and phraseology; are able to effectively, accurately and impartially communicate directly with individuals with limited English proficiency in their primary language. Iowa Total Care verifies language capability of health plan staff through bilingual assessments in target languages and through the hiring, training and evaluation process for staff in English. Members should always be advised of the risks of using an untrained interpreter could result in miscommunication of medical information and compromise quality of care. It may also cause embarrassment when discussing sensitive topics.

If a member declines interpretation services, it is best practice that providers document such in the medical record at the time of service. It is also recommended that an interpreter be offered for every encounter regardless of whether the member has refused the service in the past and that each offer be documented in the members chart.

Cultural Competency Opportunities

Iowa Total Care provides resources and toolkits on how to work effectively with an interpreter, communicate across language barriers, identify and address health literacy issues, trainings and much more!

- Visit the Iowa Total Care's provider Language Services webpage (iowatotalcare.com/providers/resources/language-services.html) for the following toolkits:
  - The Industry Collaboration Effort's Better Communication, Better Care: Provider Tools to Care for Diverse Populations (ICE Toolkit).
  - U.S. Department of Health and Human Services' A Physician's Practical Guide to Culturally Competent Care.

For additional resources, visit Iowa Total Care's Providing Quality Care webpage (iowatotalcare.com/providers/quality-improvement/quality-care.html).

For any question about how to provide cultural and linguistic appropriate service (CLAS), please contact our health equity specialist at C&L@IowaTotalCare.com.

Provider Education Opportunities

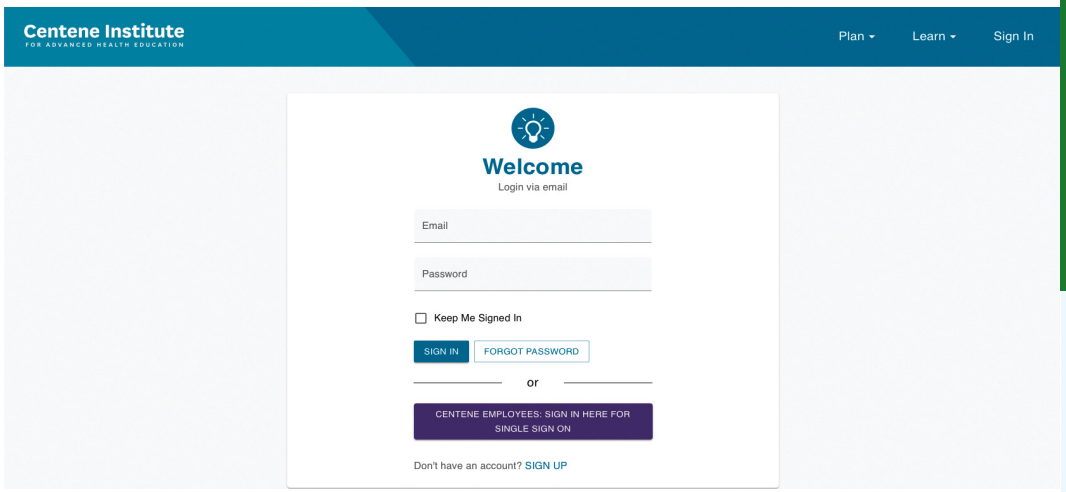
- **Iowa Total Care Trainings and Resources:**
  - To review the resources listed below, visit Iowa Total Care's Manuals, Forms and Resources webpage (iowatotalcare.com/providers/resources/forms-resources.html):
    - SDOH Z Codes Quick Reference Guide.
    - Social Determinants of Health (SDOH) Fact Sheet.
    - Language Access Services & Guidelines Quick Reference Guide.
    - Health Literacy & Cultural Competency Flyer.
  - For quick access to provider portals, links and alerts, visit Iowa Total Care's For Providers webpage (iowatotalcare.com/providers.html).
  - Keep up with the latest announcements with our Provider Newsletters webpage (iowatotalcare.com/providers/provider-newsletters.html).
- **Additional Resources, Trainings and Websites:**
  - Think Cultural Health (thinkculturalhealth.hhs.gov)
    - This is an Office of Minority Health (OMH) initiative that provides health and healthcare professionals with information, continuing education opportunities and resources to learn about and implement CLAS and the National CLAS Standards.
  - Office of Minority Health (minorityhealth.hhs.gov)
    - Offers a comprehensive source of information on eliminating health disparities and improving the health of people from all minority populations like people from racial and ethnic minorities, people with disabilities, members of the LBTGQ, individuals with limited English proficiency and rural communities.
  - Projectimplicit.net (projectimplicit.net)
    - Try taking one of the Harvard Implicit Bias tests to reveal where your implicit bias might exist.

Centene Institute

What is the Centene Institute for Advanced Health Education® (Centene Institute)?

The Centene Institute provides empowering interprofessional continuing education to external providers and clinical employees at no cost through leading-edge and research-informed educational activities, equipping them to deliver current therapies and better health outcomes.

The mission of the Centene Institute is to educate teams of healthcare professionals through empowering, research-informed content that aims to improve the skills, strategy and performance of the healthcare team, member quality of care and health outcomes of the community.



Create An Account

As a new user to the Centene Institute website, you will first go to the sign-in page (centeneinstitute.com/login). Please select the "Sign Up" button, complete all required fields and submit. After creating an account, you will receive an email with a validation code.

After entering this validation code, your profile will be ready to use. Setting up a profile with the Centene Institute allows you to house all your information in one location. You can easily access your transcript and certificates to confirm the continuing education credits obtained to date. In short, you can:

Register for a Course

If you are interested in attending an activity (a course), you can search for activities under Activity Catalog (centeneinstitute.com/catalog). To select an activity, click on "Enroll Activity."

- Search for activities under Activity Catalog.
- Click on "Activity Detail". Then click on "Enroll Now."

Courses Available

- Cultural Humility and Unconscious Bias in Healthcare,
- Health Equity Essentials: Fundamentals for Transforming Health,
- Person-Centered Thinking for Providers Podcast Series and
- Facilitating Treatment Adherence for Patients and their Families.

For additional information, visit Centene Institute website (centeneinstitute.com).

Additional Resources (Iowa and National)

- Iowa Department of Health and Human Services (HHS)
  - Health Equity Resources (hhs.iowa.gov/initiatives/health-equity)
- Iowa Hospital Associations (ihaonline.org)
- American Public Health Association (APHA)
  - Health Equity Resources (apha.org/topics-and-issues/health-equity)
- Centers for Disease Control (CDC)
  - Health Equity Resources (cdc.gov/dnpao-state-local-programs/php/data-research/health-equity-resources.html)

Glossary

Definitions are important concepts to learn. However, it is crucial to remember that language is continuously evolving and that not every member of the LGBTQIA+ community will identify with the terms listed below.

It is always best practice to ask before making an assumption.

Ally - An individual who supports and advocates for LGBTQIA+ communities.

Asexual - A sexual orientation in which an individual is partially or fully not sexually attracted to others.

Bias - An inclination or predisposition for or against someone or something.

BIPOC - An acronym for Black, Indigenous and People of Color. Members who are both LGBTQIA+ and BIPOC often face increased stigma and barriers to healthcare.

Bisexual - A sexual orientation in which an individual is attracted to multiple gender identities.

Chosen name - The name selected by an individual, who is (typically) transgender, that they choose to be called by, which may or may not match their given or legal name.

Cisgender - An individual who has a gender identity that corresponds with the gender they were assigned at birth by a healthcare professional.

Coming out - The process in which an individual first shares their sexual orientation or gender identity with others.

Deadnaming - The process of referring to an individual who is transgender as the name they were assigned at birth instead of their chosen name. This is usually considered disrespectful and can cause emotional distress for a member.

Disability - A physical or intellectual condition that impairs the body or mind, making certain activities or daily functions more challenging or impossible.

Gay - A sexual orientation in which an individual is attracted to individuals of the same gender identity. Most frequently used to describe men.

Gender expression - The external appearance of gender identity, usually expressed through behavior, clothing, body characteristics or voice. These characteristics may or may not conform to socially defined behaviors and traits that are typically associated with being either masculine or feminine.

Gender fluid - A gender identity that is not fixed to a single, conventional category, allowing individuals to experience and express a range of gender identities that typically shift over time.

Gender identity - An individual's internal sense of being a man, woman, both, neither or another gender.

Gender non-conforming - An all-inclusive term for a gender identity that does not fit neatly into a single category within traditional societal norms. While many also identify as transgender, not all do. (Sometimes referred to as third gender.)

Health equity - The action of ensuring that everyone has a fair and just opportunity to be as healthy as possible. This requires the removal of obstacles — which are often systemic — to health, such as poverty, discrimination and their consequences (e.g., lack of representation, powerlessness and decreased access to good jobs with fair pay, quality education and housing, safe environments and healthcare).

Heterosexual (straight) - A sexual orientation in which an individual feels attracted to people of a gender other than their own (typically used for a man who is attracted to an individual who identifies as a woman, and vice versa).

Homosexual - A sexual orientation in which an individual is attracted to individuals of the same gender identity. This term should typically be avoided due to its history of being used in a derogatory manner. Instead, many prefer the term gay.

Intersectionality - The interplay of social constructs (such as race, class, sexual orientation and gender) that apply to an individual or group and is regarded as creating overlapping and interdependent systems of discrimination or disadvantage. Intersectionality shapes the exponential inequality and oppression that individuals face and how it impacts their lives.

Intergenerational trauma - The psychological, physiological and social effects that trauma can have on subsequent generations. Trauma can originate from historical events (e.g., not being allowed to speak a native language, slavery, indigenous children dying in boarding schools) or may be more familial (e.g., abuse, alcoholism, surviving war). The transmission of trauma influences future generations and affects each individual in diverse ways.

Intersex - A gender identity sometimes used by individuals who have both male and female sex characteristics.

LGBTQIA+ - An acronym for "Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual and Gender-diverse

Intersex, Asexual - The plus sign represents the limitless and diverse identities used by members of this community.

Lesbian - A sexual orientation in which an individual identifies as a woman and is solely attracted to women.

Non-binary - A gender identity term used by an individual who either does not identify with any gender label or who identifies with all gender labels. This individual may use all pronouns or might not use any pronouns.

Outing - The act of disclosing a person's sexual orientation or gender identity without that person's consent. This is usually considered disrespectful and can cause emotional distress for a member.

Pansexual - A sexual orientation by an individual who is attracted to all gender identities, though not necessarily simultaneously, in the same way, or to the same degree for each gender.

Pronoun - A linguistic tool that is used to refer to oneself and others. Common examples include she/her/hers, he/him/his and they/them/theirs. Some individuals may use a combination of these pronouns or none at all.

Prejudice - A negative attitude toward another person or group. This can manifest in many forms, such as anger, pity, hatred, assumptions and verbal and physical harm.

Privilege - Unearned power that is afforded to specific individuals based on status or physical appearance. This power may come in the form of rights, benefits, social comfort, opportunities or the ability to define what is normative or valued.

Queer - An all-inclusive term used to describe any gender identity or sexual orientation that contrasts traditional societal norms. Younger generations are more likely to identify with this term.

Questioning - An individual who is discovering their sexual orientation or gender identity.

Sexual orientation - A self-chosen term used to label sexual and emotional attraction.

Traditional societal norms - Historically ingrained cultural values, behaviors, attitudes and expectations.

Transgender - An individual who has a gender identity that differs from the sex they were assigned at birth by a healthcare professional. These individuals can have a diverse range of sexual orientations and gender identities. See below definitions.

Transgender man - An individual who was assigned female at birth, but presently identifies as male (Common terms include: female-to-male, FTM, transmasculine).

Transgender woman - An individual who was assigned male at birth, but presently identifies as female (Common terms include: male-to-female, MTF, transfeminine).

Transitioning - The time during which a person begins to live according to their gender identity, rather than the gender they were assigned at birth. Not every transgender person will make physical changes to their appearance.

Two-Spirit - An all-inclusive term used by individuals in Indigenous communities who identify as having both a masculine and a feminine spirit or gender identity.

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