Massachusetts Department of Public Health

Literature Review
to inform *Making CLAS Happen* updates

July 2, 2013

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BACKGROUND

In light of new (2013) guidelines from the U.S. Department of Health and Human Services (http://thinkculturalhealth.hhs.gov) for the provision of culturally and linguistically appropriate services, the Office of Health Equity at the Massachusetts Department of Public Health updated *Making CLAS Happen: A Guide to Culturally and Linguistically Appropriate Services*. A review of current literature was conducted to inform and enhance current content of the guide and broaden usability for diverse populations beyond ethnic and linguistic needs.

RESEARCH

The purpose of the literature review was to identify best practices, applicable laws and research-based recommendations for providing culturally competent care to individuals from a variety of backgrounds. Articles reviewed focused on the unique health needs of individuals with low health literacy, disabilities, the gay, lesbian, bisexual and transgender (LGBT) community, and military veterans and their families. Special attention was paid to recommendations and best practices for serving these communities. Twenty-six (26) articles, 53 publications (including books toolkits, reports, manuals and guidance materials) and 7 online training modules and fact sheets were reviewed. Relevant findings are summarized in this report.

RESEARCH OBJECTIVES

- Identify best practices in offering health care to individuals with low health literacy, disabilities, diverse sexual orientation and gender identity, military veterans and their families

- Identify existing health disparities for individuals with low health literacy, disabilities, diverse sexual orientation and gender identity, and military veterans and their families

- Detail best practices in:

    o Improving communication with individuals with low health literacy or other communication barriers

    o Collecting sensitive data (sexual orientation and gender identity, disability status) in health care settings

    o Meeting new data collection requirements from the Affordable Care Act, Office of Minority Health regulations and others

    o Improving access for individuals with low health literacy, LGBT patients and patients with disabilities

o   Training staff to increase awareness and cultural competency in serving individuals with low literacy, disabilities, diverse sexual orientation or gender identity

- Identify laws that mandate or apply to culturally competent care and services for diverse individuals (including LGBT community, clients with disabilities and limited health literacy)
- Examine existing tools, articles, links and resources to be included in the *Making CLAS Happen* tools section

METHODOLOGY

The literature review was conducted through searches on the following research databases:

- Google Scholar
- PubMed

Additionally, articles and publications were identified through reviews of the bibliographies of relevant guidance materials, articles and publications.

The following web sites were also used as starting points to identify relevant articles, tools and publications:

- CLAS Clearinghouse, Office of Minority Health, U.S. Department of Health and Human Services (www.thinkculturalhealth.hhs.gov)
- The Gay and Lesbian Medical Association (http://www.glma.org)
- The Joint Commission (http://www.jointcommission.org)
- National Association of the Deaf (http://www.nad.org)
- National Council on Disability (http://www.ncd.gov)
- U.S. Defense Centers of Excellence, (http://www.dcoe.health.mil)
- U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, (http://www.ahrq.gov)
- U.S. Department of Justice, Civil Rights Division, American with Disabilities Act (http://www.ada.gov)
- U.S. Department of Veterans Affairs, Veterans Health Administration (http://www.va.gov/health)

RESEARCH FINDINGS

Relevant themes emerging from the literature reviewed are noted below, ***in bold italics***, with supporting research detailed below each theme.

Health equity and cultural competence go beyond racial, ethnic and linguistic diversity

In May of 2013, the Office of Health and Human Services issued revised Culturally and Linguistically Appropriate Services (CLAS) Standards broadening the definition

of cultural competence to include the ability to serve diverse populations beyond their racial, ethnic and linguistic characteristics (http://www.thinkculturalhealth.hhs.gov/content/CLAS).

The "enhanced" CLAS standards underscore *cultural identity* as a key characteristic of diversity that certainly includes but goes beyond race, ethnicity or languages spoken. The enhanced CLAS Standards Blueprint document goes on to indicate: "equitable care and services apply to all individuals regardless of cultural identity." [i]

Health equity is influenced by many factors, including race, education, health literacy, age, sexual orientation, ethnicity, religion, physical or mental disability, language, gender, gender expression, identity, income, class and access to care (National Partnership for Action to End Health Disparities, 2011).[ii] All individuals have the right to be free of discrimination while accessing care or services, whether that is included in specific state laws and regulations or not (Joint Commission, 2010).[iii]

Respectful care and services are require a welcoming environment, non-discrimination and proper communication

The enhanced CLAS standards (HHS, 2013) indicate that respectful care and services are offered when providers foster an environment where diverse individuals feel comfortable discussing their needs with any member of an organization's staff; offer assurances that disrespect and discrimination are intolerable; and offer clients reasonable assistance to overcome communication, language, physical and cultural barriers.

Health disparities still pervade the U.S. health care system

The 2009 National Healthcare Disparities Report revealed that disparities related to race, ethnicity and socioeconomic status still pervade the U.S. health care system and can be observed in all aspects of health care including quality, access to care, types of care, clinical conditions, settings and subpopulations.[iv]

Much has been done to address health disparities in the past ten years. Still, many disparities are not decreasing. Areas where disparities continue include care for cancer, heart disease and pneumonia for black, Asian and Hispanic persons.

While the causes of health disparities are varied, the American College of Physicians (ACP, 2010) identified *social determinants of health* as a significant source of health disparities among racial and ethnic minorities. ACP recommends that inequities in education, housing, job security and environmental health be erased to effectively address health disparities.

"All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high-quality health care."[v]

Significant health disparities were observed for Hispanics in Massachusetts

In its National Healthcare Quality and Disparities Report, the Agency for Healthcare Research and Quality offers an annual report detailing health disparities in the United States. In the health disparities "report card" section, information is broken down by state, race, ethnicity and income.

In 2010, compared to the United States, the performance for Massachusetts in quality of care compared to Whites (Non-Hispanic) was in the very weak range for Hispanics (All Races), in the strong range for Blacks (Non-Hispanic), and in the very strong range for Asians and Pacific Islanders (Non-Hispanic).

Measures with the greatest disparities observed included asthma admissions for persons aged 65 and over, admissions for diabetes with long-term complications, and admissions for hypertension for adults 18 and over.[vi]

While disparities have been tracked by race and ethnicity and income level, more data is needed to identify disparities for LGBT individuals and those with disabilities

The National Council on Disabilities (2009) rates past health disparities research around disabilities as inconsistent and lacking focus on disability as a demographic characteristic.[vii]

In light of the limited health information available about the LGBT population, and recognizing the need for more data to identify and address health disparities in the community, the Institute of Medicine recommends that sexual orientation and gender identity data be collected in national and state health demographic surveys. In 2011, the U.S. Department of Health and Human Services began to incorporate sexual orientation and gender identity in the National Health Interview Survey, the primary source of health information on the U.S. population.[viii]

General principles of cultural competence can be applied to meet the needs of individuals from diverse cultural, REL backgrounds

The Joint Commission (2010) offers the following general principles of cultural sensitivity for staff[ix]:

- Ask open-ended questions, create a respectful partnership
- Use inclusive language to collect patient information
- Train staff in the concept of cultural humility to develop self-awareness and a respectful attitude
- Use resources and tools to meet the cultural and religious needs of the most frequently encountered populations
- Have information materials in the most frequently encountered languages, to meet diverse health literacy needs
- Offer mobility assistance and specialized equipment
- Enlist professional chaplains in care

To gain support of leadership, the Joint Commission recommends using data as a way to galvanize action within a hospital. In *Leading Change,* John P. Kotter states,

"seeing even a small amount of data showing an area for concern can incline hospital leadership to take action."[x]

Communication and language assistance are essential for patients with limited English Proficiency (LEP) as well as for those with physical and learning disabilities and low health literacy

The 2013 CLAS standards extend the need for communication and language assistance to those with physical and learning disabilities, "individuals may have communication not related to a [spoken] language barrier, such as those who are deaf or hard of hearing, visually impaired, or disabled, or those with low health literacy."[xi]

Health Literacy

Definition of health literacy:

According to the Institute of Medicine, 90 million U.S. adults (47 percent) have limited health literacy, [xii] which is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[xiii]"

Low health literacy disproportionately affects racial and ethnic minorities, low-income persons, individuals with learning disabilities, and the elderly.

While health literacy can affect individuals from all backgrounds and income levels, low health literacy disproportionately affects racial and ethnic minorities, with 50 percent of Hispanics, 40 percent of Blacks and 33 percent of Asians estimated to have lower literacy skills.[xiv]

Health literacy tends to be lower for those with limited English proficiency (LEP), cognitive impairments, learning disabilities, low educational attainment, and among the poor, elderly, and minorities.[xv]

Elderly persons also tend to have lower literacy skills. In *The Literacy Problem*, Doak et al (1996) report that more than 66 percent of U.S. adults aged 60 and over have either inadequate or marginal literacy skills.[xvi]

Literacy skills significantly affect health outcomes, costs.

Weiss (2003) found that literacy skills are a stronger predictor of an individual's health status than age, income, employment status, education level, or their racial, ethnic group.[xvii]

More than five articles included in this review indicate that patients with low literacy skills are at higher risk for hospitalization than people with adequate literacy skills, [xviii] make more medication or treatment errors and are less able to comply with treatments[xix]; lack the skills needed to successfully negotiate the health care system.[xx] ; and are more likely to use emergency services and incur higher Emergency Department costs.[xxi]

Low levels of health literacy negatively affect patients' ability to become drivers of their health.

Parker (2000) and Lavelle-Jones et al (1993) found that most patients do not understand or read the information contained in informed consent forms, despite signing them.[xxii] [xxiii]

There is a discrepancy between patient literacy levels and the level of available health information

Articles reviewed underscored the discrepancy between patient reading levels and reading levels of health information they receive.

Doak (1996) found that one in five American adults reads at the 5th grade level or below, and the average American reads at the 8th to 9th grade level, yet most health care materials are written above the 10th grade level.[xxiv]

A 2011 review of health literacy and emergency department outcomes (Herndon et al, 2011) found that 40 percent of emergency department patients had literacy levels at or below the eighth-grade level while emergency department patient materials were typically assessed at or above the 9th grade reading level.[xxv]

Further, Bass et al (2002) found that clinicians tend to overestimate their patients' reading abilities.[xxvi]

Policies to improve health literacy include Healthy People 2010, IOM Priority Areas for National Action, and National Action Plan to Improve Health Literacy

Addressing low health literacy has been identified as a top priority at the federal level.

The Affordable Care Act of 2010 includes several provisions that address the need for greater attention to health literacy. Among these, there are provisions to clearly communicate health information, promote prevention, be patient-centered, assure equity and cultural competencies and deliver high quality care.[xxvii]

The U.S. Department of Health and Human Services, in Healthy People 2010, designated health literacy as one of its primary goals. Health literacy is also one of the Institute of Medicine's top 20 priority areas for national action.[xxviii] [xxix]

The National Action Plan to Improve Health Literacy (HHS, 2010)[xxx] is a multi-sector effort that seeks to engage organizations, professionals, policymakers, communities, families and individuals in improving health literacy. The plan is based on the principles that (1) everyone has the right to health information that allows them to make informed decisions and (2) health services should be delivered in ways that are understandable to health, longevity and quality of life.

Based on these principles, the National Action Plan to Improve Health Literacy (HHS, 2010) issued the following seven goals to improve health literacy, based on recommendations from Nielsen-Bohlman (2004).[xxxi]

1. Develop and disseminate health and safety information that is accurate, accessible and actionable.
2. Promote changes in the health care system that improve health information, communication, informed decision making and access to health services.
3. Accurate, standards-based, health and science information and curricula in childcare and education through the university level.
4. Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health info services in the community.
5. Build partnerships, develop guidance, and change policies.
6. Increase basic research and development, implementation, evaluation of practices and interventions to improve health literacy.
7. Increase dissemination and use of evidence-based health literacy practices/interventions.

The Plain Writing Act of 2010 requires all new publications, forms and publicly distributed documents from the federal government to be written in a "clear, concise, well-organized" manner.[xxxii]

Assessments for identifying health literacy should go hand-in-hand with assessments of language and culture

Two brief, valid assessments of health literacy identified in this review include the Rapid Estimate of Adult Literacy in Medicine, Revised (REALM-R), and the Short Test of Functional Health Literacy in Adults (S-TOFHLA).

The **Rapid Estimate of Adult Literacy in Medicine (REALM)** is a brief screening instrument used to assess an adult patient's ability to read common medical words. It is a word recognition test--not a reading comprehension instrument and takes less than 2 minutes to administer and score. [xxxiii] A study conducted by the Journal of the American Medical Association found that the REALM-R might offer a practical approach to identify patients at risk for health literacy problems in a clinical setting.[xxxiv]

The **Short Test of Functional Health Literacy in Adults (S-TOFHLA)** is a practical measure of functional health literacy with good reliability and validity that can be used by health educators to identify individuals who require special assistance to achieve learning goals.[xxxv]

Additional health literacy assessments include the Adult Basic Literacy Examination (ABLE), Literacy Assessment for Diabetes (LAD), Newest Vital Sign (NVS), Nutritional Literacy Scale (NLS), Rapid Assessment of Adult Literacy in Dentistry (REALD), Short Assessment of Health Literacy for Spanish-speaking Adults (SAHLSA), Single Item Literacy Screener (SILS), Slosson Oral Reading Test, Test of Adult Basic Education (TABE), and the Wide Range Achievement Test (WRAT).[xxxvi]

Andrulis et al (2007) indicate that though these tests offer a baseline for identifying patients at risk for health literacy problems, low scores on assessments don't

pinpoint the nature of health literacy problems, and should therefore go hand-in-hand with assessments of culture and language.[xxxvii]

Strategies for addressing the needs of patients with limited health literacy (LHL)

Create a welcoming environment through improved facility navigation

For limited literacy, LEP and culturally diverse persons, facility navigation can pose difficulties. Rudd (2004) found that culturally diverse, limited literacy and/or LEP individuals can face significant challenges in finding their way to and around health care facilities.[xxxviii]

To address this challenge Andrulis et al (2007) recommend hiring patient navigators or health educators, ensuring signs are easily understandable by using translated signage, graphics, color-coding and pictograms. [xxxix]

Improve communication by keeping messages concise, jargon-free and using proven methods to assess patient understanding.

To improve communication, Andrulis et al (2007) propose the following strategies:
- Limit the number of messages delivered at one time.
- Use simplified, jargon-free language.
- Use teach-back or teach-to-goal methods.

Teach back

Doak et al (1996), Andrulis, and the National Quality Forum identify teach back as a widely recommended practice for effectively communicating with patients with low health literacy levels. Asking patients to "teach back" information increases patient retention, gives providers a gauge of how well patients understand information, and actively involves patients in their own healthcare.[xl]

Beyond safety and outcome improvements, teach back has been shown to benefit health care organizations' bottom line. A hospital participating in the National Quality Forum (NQF, 2005) informed consent study[xli] found that **more than 95 percent** of surgery appointments that were canceled or delayed were attributed to patient misunderstanding of pre-surgical preparation instructions. The cost of surgical delays was estimated at $70 per minute. With 8 percent of surgical visits resulting in delays or cancellations, the costs multiplied. Four months after adopting "teach back" in pre-surgical instructions, the surgery cancellation and delay rate dropped from 8 percent to 0.8 percent.

Barriers to implementation of teach back included provider time in using a script, physician buy-in, perception that all patients understand, discomfort in asking for teach back based on a fear of being condescending and patient attitudes (reluctance to ask questions out of deference to physician authority or as a result of feeling intimidated by physicians).

To address barriers to adoption of teach back, the National Quality Forum (NQF, 2005) recommends:
- Underscoring the potential improvements in efficiency that can result after adopting teach back.

- Educating all staff about the extent of low health literacy.
- Countering negative physician attitudes toward patient involvement with education.
- Enlisting leadership support and involving a clinical champion for teach back.
- Training staff and physicians on how to ask for teach back.
- Defining who is responsible for asking for teach back.

Benefits of teach back identified in the NQF study (2005) included ensuring medication safety, correcting misperceptions and promoting informed decision-making, avoiding surgical errors, promoting a culture of quality, safety and patient-centeredness, and cost savings.

Empower patients to be drivers of their own care through an improved informed consent process.

Informed consent, the process in which a patient consents to undergo a medical or surgical treatment or to participate in an experiment after understanding the risks involved,[xlii] was identified as a key area for intervention in improving safety and patient communication.

In its *Safe Practices for Better Healthcare* (2010) the National Quality Forum proposes targeting the informed consent process as a means of improving patient safety and empowerment.[xliii]

The U.S. Agency for Healthcare Research and Quality (AHRQ, 2001) found that strategies that involve active engagement of patients in the process of informed consent can improve patients' recall and understanding of what they consented to receive.[xliv]

The National Quality Forum's Safe Practice 10 calls for health care practitioners to use a form of teach back in the informed consent process, or to "ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion."[xlv]

Safe Practice 10 entails:

- Using informed consent forms written in simple sentences and in the patient's primary language.
- Engaging the patient in a dialogue about the nature and scope of the procedure covered by the consent form.
- Providing an interpreter or reader to assist non-English-speaking patients, visually or hearing-impaired patients, and patients with limited literacy.

The National Quality Forum (NQF, 2005) recommends using a script like the following in an informed consent encounter.

> *"For patient safety, could you please tell us in your own words what are you here for today?"*

> *"I know I've just given you lots of information. For me to know if I did my job properly, could you please repeat back to me the information you just received, mentioning what, why, where, when, who and how the procedure will be done?"*

In 2005, the National Quality Forum pilot tested Safe Practice 10 in a variety of hospital settings, and published the results in the report "Improving patient safety through informed consent for patients with limited health literacy."

Key recommendations to ensuring informed consent stemming from this study include:

- Achieving greater buy-in of informed consent through leadership support and improvement of organizational awareness.
- Educating health care practitioners of the extent of low health literacy and promoting practices such as "teach back" for all patients.
- Developing a standardized approach to educating providers about the informed-consent process.
- Improving consent forms to be more reader-friendly, simple and useful.
- Having verbal discussions of forms with patients.
- Involving interpreters in the informed-consent process.
- Broadening patient understanding through the informed-consent process (going beyond simple verification).
- Clarifying the role of individuals participating in the informed-consent process. (According to NQF, informed consent is ultimately responsibility of the physician, though others play a role).
- Assessing the level of patient understanding through performance measures.[xlvi]

Empower patients with low literacy levels through adequate patient education materials

Simplify written materials

To meet the needs of low literacy individuals, written materials must be easy to read and culturally and linguistically appropriate.

The reading level and clarity of all written materials, including prescription labels, informed consent forms, brochures and posters should be considered (Andrulis, 2007).

Recommended reading levels varied among materials included in this review.

The Plain Writing Act of 2010 has issued guidelines for developing materials that allow users to "find what they need; understand what they find; and use what they find to meet their needs."[xlvii] Plain Writing Act Guidelines do not specify a reading

level, but recommend "writing for your audience," or considering the reading level of the end user.

The National Work Group on Literacy and Health recommends simplifying written materials, such as informed consent forms, to the fifth grade reading level or lower.[xlviii]

The reading level of translated materials should also be considered. Andrulis et al (2007) recommends testing translated materials for cultural appropriateness and literacy and going beyond simple translations to transcreation, the process of creating materials in tandem with their English counterparts.

Efforts to simplify written materials require broad-level support from the health care system, including pharmacists, health plans and departments of health, and accreditation organizations to ensure that everything from forms to prescription labels are clear, in culturally acceptable terms and translated when necessary.

Involving the community, especially adult education programs, in developing and testing written communications is also recommended (Andrulis, 2007).

Use of technology and visuals can improve patient understanding.

Audiovisual aids such as DVDs and interactive multimedia are recommended to improve understanding among patients with limited literacy and limited English proficiency (LEP) (Andrulis, 2007).

Enlist and train all staff in the provision of a culturally appropriate, literacy sensitive approach.

Addressing literacy requires awareness and participation of all staff, according to the Institute of Medicine (2004). "It is nearly impossible to deal with literacy, language, and cultural issues within the context of a 10-15 minute patient visit."[xlix]

Karliner (2004) recommends that clinicians, adjunct staff, and interpreters regularly participate in training that addresses both the delivery of culturally and linguistically appropriate services as well as the recognition of and effective responses to limited health literacy.[l]

Reach out to community organizations, enlist community health workers and invite participation of community organizations in advisory boards.

A 2004 study from the California Health Initiative underscores the key role that community health workers can play in helping patients with limited health literacy feel at ease in health care settings.[li]

Patients with limited literacy, the study cites, may avoid health care settings for fear of being embarrassed. Working with trusted community health workers who are familiar can help patients overcome trepidation.

Andrulis et al (2007) recommend inviting members of key community organizations, such as local adult education programs, to serve on community advisory boards; and in turn, participating in outreach with local community programs.[lii]

Address health literacy needs in tandem with cultural competence efforts.

While addressing health literacy needs involves specific challenges and strategies, these must be addressed in tandem with broader cultural competence efforts. In *Health Literacy: A Prescription to End Confusion*, Nielsen-Bohlman et al indicates, "health literacy must be understood and addressed in the context of culture and language."[liii]

Andrulis et al (2007) found that strategies to improve health literacy for low-literacy individuals are distinct from strategies for REL individuals or those with limited English proficiency (LEP). The lack of integration between strategies to meet the needs of each of these populations often results in "health care that is unresponsive to some vulnerable groups' needs."

An effective approach to integrating cultural competency and health literacy efforts may include the following recommendations (Nielsen-Bohlman, 2004 and Andrulis, 2007):

- Collecting and including detailed information on patient preferences and needs (language, health literacy) in medical records
- Asking clients about environmental, lifestyle, family values, cultural health beliefs, folk medicines, and health practices affecting treatment choices
- Using the principles of clear communication:
  - Confirm understanding
  - Probe to make sure culture or language are not causing miscommunication
- Developing easy-to-read, culturally relevant and translated written materials
- Training staff and interpreters in health literacy, cultural and linguistic competence
- Enlisting the assistance of family members or friends in note taking, questions, and recall of instructions (not as interpreters)
- Engaging consumers in the development of written materials and testing written materials and pharmacy labels with diverse audiences to ensure appropriateness across literacy, culture and language
- Developing united performance standards and using cultural and linguistic competence as an essential measure of the quality of care
- Offering help lines or other methods to help those with difficulty reading or understanding written materials
- Creating a welcoming environment by offering clear directions, accessible posters, and offering receptionist assistance reading or filling out forms
- Consolidating health literacy, cultural and language strategies (For example, having one individual serve in multiple roles: community health worker, patient navigator, cultural broker, health educator, and interpreter)
- Participating in local adult education and literacy programs, and K-12 health programs to improve overall health education levels in the community
- Inviting representatives from various cultural and linguistic groups and the adult learner community to participate in advisory councils

The following Joint Commission (2010) checklist for improving communication offers a similarly integrated approach to identify and address the communication needs of a variety of populations, including REL and LGBT populations, those with low health literacy levels, LEP, and disabilities.[liv]

The Joint Commission (2010) outlines a process during intake, assessment, treatment and discharge, which is summarized in the key points below:

- Inform patients of their rights
- Identify patient's preferred language for discussing health care
- Identify and address sensory, mobility or communication needs (interpreter, sensory or communication, auxiliary aids and services, assistive devices, augmentative and alternative communication (AAC) resources, mobility aids, room modifications for access to switches/fall prevention)
- Identify and accommodate cultural, religious, or spiritual beliefs or practices that influence care (modesty needs, appropriate gender providers, privacy in toileting and washing, space and scheduling to accommodate the need to pray, and dietary needs)
- Supporting the patient's ability to understand and act on health information (assistance completing forms, provide patient education that meets patient needs)
- Ask the patient if there are any additional needs that may affect his or her care
- Ask patient to identify a support person
- Tailor the informed consent process to meet patient needs
- Involve patients and family in the care process (not as interpreters)
- Communicate information about unique patient needs to the care team

Data Collection

Federal data collection requirements include new standards for the collection of disability status

Section 4302 of the Affordable Care Act contains provisions to strengthen federal data collection by requiring that all national federal data collection efforts collect information on race, ethnicity, sex, primary language and disability status.[lv]

Unique to these provisions is the inclusion of disability status in data collection requirements.

The most recent data collection standards from the Office of Minority Health at the U.S. Department of Health and Human Services (OMH, 2011) have added standards for the collection of disability status, as follows:

Data standards for disability status:

- Are you deaf or do you have serious difficulty hearing?
- Are you blind?
- Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
- Do you have serious difficulty walking or climbing stairs?
- Do you have difficulty dressing or bathing?
- Do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

New national data collection efforts integrate questions on sexual orientation and gender identity

In 2011, the U.S. Department of Health and Human Services began collecting data in its population surveys to facilitate identification of health issues and reduction of health disparities among LGBT populations. Additionally, HHS recommends integrating questions on sexual orientation and gender identity into national data collection efforts and began testing questions on sexual orientation for potential incorporation into the National Health Interview Survey by 2013.[lvi]

HHS-recommended optional data fields include religion, mobility needs, sexual orientation, and gender identity or gender expression.

In addition to using the OMB data categories, the Joint Commission (2010) recommends collecting the following optional data fields: religion, mobility needs, sexual orientation, and gender identity or gender expression.[lvii]

Resources identified for the collection of literacy data include the national and state literacy and health literacy levels from the 2003 National Assessment of Adult Literacy (NAAL) Survey (http://nces.ed.gov/naal/). The NAAL is a representative assessment of English literacy among American adults age 16 and older nationwide, sponsored by the National Center for Education Statistics, and most recently conducted in 2003.[lviii]

For LGBT data, identified sources include national and state-level data on sexual orientation from Web sites such as http:///www.census.gov and http://www.lgbtdata.com.

In 2012, the National Committee on Vital Health Statistics (NCVHS) recommended that HHS take additional measures in collecting data on socioeconomic status across all racial/ethnic populations and socio-economic groups. Specifically, NCVHS recommended including the following measures:

- Education
- Income
- Occupation
- Family size and relationships[lix]

Development of Standards for the Collection of Socioeconomic Status in Health Surveys Conducted by the Department of Health and Human Services

Cultural Competence for the Lesbian Gay Bisexual and Transgender (LGBT) population

Health disparities exist among the LGBT population and improved data collection efforts are needed.

There is a need for culturally competent medical care and prevention services that are specific to the LGBT population. The Centers for Disease Control (CDC, 2010) report that members of the LGBT community are at increased risk for a number of health threats when compared with their heterosexual peers.[lx]

"The experiences of LGBT individuals are not uniform and are shaped by factors of race, ethnicity, socioeconomic status, geographical location, and age, any of which can have an effect o health-related concerns and needs."[lxi] (IOM, 2011)

Studies (Mayer, 2008; Meyer, 2007) have found that while sexual behaviors account for some of these disparities, others are associated with social and structural inequities, such as the stigma and discrimination that LGBT populations experience.[lxii] [lxiii]

Health Disparities Affecting LGBT Youth

LGBTQ youth (as a group) may experience higher rates of smoking, alcohol use, substance abuse, HIV and other sexually transmitted infections, anxiety, depression, suicidal ideation and attempts, and eating disorders.[lxiv] Harrison (1996) reports that LGBT youth are particularly vulnerable to internal and external pressures, resulting in higher rates of homelessness.[lxv]

Additionally, LGBT youth report experiencing higher levels of violence, victimization, and harassment compared with heterosexual youth (IOM, 2011).

Health Disparities Affecting LGBT Adults

Lesbian, gay and bisexual adults appear to experience more mood and anxiety disorders, depression, and are at higher risk for suicide than heterosexual adults (IOM, 2011).

Lesbian and bisexual women may use preventive health services less frequently, may be at greater risk of obesity and have higher rates of breast cancer than heterosexual women (IOM, 2011).

Lesbian, gay and bisexual adults are also more frequently the targets of stigma, discrimination, and violence, and may have higher rates of smoking, alcohol use, and substance abuse than heterosexual adults (IOM, 2011).

Health Disparities Affecting LGBT Seniors

Discrimination, fear of discrimination, stigma and victimization within the health care system remain a problem for LGBT elders.[lxvi]

Lesbian, gay, bisexual and transgender elders are less likely to have children than heterosexual elders and less likely to receive care from adult children. They may have higher rates of isolation, and the disability or death of one partner may threaten the economic security of the surviving partner.[lxvii]

Senior LGBT adults also experience higher rates of HIV, while few HIV prevention programs target older adults.

New data collection recommendations recognize the need for more data to identify and address health disparities in the LGBT community.

Researchers face a number of challenges in understanding the health needs of LGBT populations, including a lack of data.[lxviii]

In light of the limited health information available about the LGBT population and recognizing the need for more data to identify and address health disparities in the community, the Institute of Medicine recommends that sexual orientation and gender identity data be collected in national and state health demographic surveys. In 2011, the U.S. Department of Health and Human Services began to incorporate sexual orientation and gender identity in the National Health Interview Survey, the primary source of health information on the U.S. population.[lxix]

Section 4302 of the Affordable Care Act includes provisions to strengthen federal data collection efforts by requiring that all national federal data collection efforts collect information on race, ethnicity, sex, primary language, and disability status. This also includes provisions to improve data collection on populations susceptible to health disparities, including the LGBT community.[lxx]

Experiences with health providers have a significant impact on future health behaviors of LGBT persons.

The American College of Physicians (ACP, 2008) found that "the degree of safety, comfort, openness and respect that LGBTQ youth patients feel often has an impact on their future access to health care, risk reduction, and help-seeking behaviors."[lxxi]

The Joint Commission (2011) cited studies showing LGBT patients and their families survey their surroundings to determine if the environment is one in which they feel welcome and accepted.[lxxii]

Laws and ethical rules prohibit discrimination of LGBT people

Almost every major American medical association has ethical rules that prohibit discrimination of LGBT people in the practice of medicine, recognizing that such discrimination is harmful to patients' health. In July 2011, the Joint Commission released their *Comprehensive Accreditation Manual for Hospitals*. The Centers for Medicare and Medicaid Services updated their Conditions of Participation in January 2011 for hospitals and critical access hospitals to require equal visitation for partners. The Code of Federal Regulations for hospitals includes similar non-discrimination rules (The Joint Commission, 2011).

HHS has issued guidance to state Medicaid agencies on financial protections for same-sex couples. New rules require hospitals to protect patients' rights to choose their own visitors during a hospital stay, including a visitor who is a same-sex domestic partner.[lxxiii]

Strategies for equitable care of LGBTQ population

Strategies recommended by the Joint Commission (2011) in *Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community* are comprehensive and pertain to all branches of health care organizations.[lxxiv]

A summary of strategies recommended in the literature reviewed (Joint Commission, 2011; IOM, 2011; and GLMA, 2006) are summarized below:

> *Ensure leadership responsibility*, as a key to making sure that the needs of LGBT populations are taken into account in providing patient-centered and equitable care.
>
> *Adopt policy-level actions* to meet the needs of LGBT community. These should include non-discrimination policies protecting patients from discrimination based on sexual orientation and gender identity; equal visitation rights[1]; broadening the definition of family to include same sex partners; and ensuring grievance procedures include mechanisms to report discrimination or disrespectful treatment.
>
> *Obtain a better understanding of patient identity and behaviors*, which can lead to more appropriate care, targeted risk-reduction counseling and

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[1] On April 15, 2010, President Obama released a presidential memorandum for the secretary of the Department of Health and Human Services respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members.[1]

screenings, and targeted treatments and referrals. It is important to avoid assumptions and ask open-ended questions.

Develop a sensitive and inclusive intake procedure. Information about sexual orientation or identity should come only from the patient. It is important to ask gender-neutral questions, such as "How would you like to be addressed?" or "What name would you like to be called?"

Create a welcoming environment by prominently posting the nondiscrimination policy; displaying LGBT friendly symbols such as the rainbow flag, or safe zone sign in waiting areas; reflecting and being inclusive of LGBT patients in brochures, magazines, and images depicted in waiting areas; providing resources, information and guidance on specific concerns facing the LGBT community, offering unisex or single stall restrooms; and offering nondiscriminatory visitation policies.

Become aware of and avoid misconceptions, bias and stereotypes, understanding that self-identification and behaviors don't always align.

Offer cultural competence training in LGBT culture and health needs. Recommended topics for LGBT training (Joint Commission, 2011) include:

- LGBT terminology and demographics
- History and background
- State and local laws affecting LGBT people in health care settings
- LGBT health disparities and inequities
- Clinical concerns, mental and behavioral health concerns
- Health promotion and disease prevention
- Communication and other interactions
- Resources for follow-up learning
- Training for LGBT patient care
- Mandatory presentations on HIPPA, sexual harassment

Collect and document self-reported data on sexual orientation and gender identity. The Joint Commission recommends collecting voluntary and self-reported data at admission or registration, and documenting this data in medical records.

Use inclusive, gender-neutral language. When talking with patients, staff should use inclusive, neutral language (for example: "Who are the important people in your life?" vs. "Are you married?"). Forms should also be written in gender-neutral language and include a designation of relationship status, gender identity and registration admitting forms that allow for patient support persons, visitors, indication of preferred name and gender pronouns.

Assure confidentiality and show sensitivity in data collection. According to the Institute of Medicine: "information on sexual orientation and gender identity could be perceived as more sensitive than other information." Providers should be aware that some patients may be hesitant to disclose this information. Staff should ensure the confidentiality of information collected

and disclosed. Best practices in data collection include "the respectful involvement of individuals who represent the (disability, LGBT, veteran, etc.) population in the research process, from design to data collection to dissemination." (IOM, 2011)

Train staff in the collection of data, so they are prepared to explain why data are important, how they will be used, and emphasize this information will not be used to facilitate discrimination.

Collect data to identify and address health disparities. Add information about sexual orientation and gender identity into patient surveys and use aggregated patient-level sexual orientation and gender identity data to develop or modify services.

Develop policies that attract and retain LGBT employees. Offer equitable treatment and inclusion of LGBT employees through discrimination protection, equalization of health coverage for partners and other hospital benefits. Demonstrate commitment in recruitment and hiring through LGBT-inclusive language in job notices, attendance to LGBT job fairs, publications, and outreach with LGBT groups. Train Human Resources staff on general LGBT workplace concerns and nondiscrimination, benefits and policies.

Include the LGBT community in planning, communications and outreach. Survey satisfaction of LGBT patients and their families; include representatives from the LGBT community in advisory boards; seek feedback on communications materials from LGBT community; share resources and participate in education opportunities addressing LGBT health issues (i.e. cultural competency programs, local colleges and high schools).

Culturally Competent Services for Persons with Disabilities

Disability is a common characteristic that should be defined broadly.

About 30 percent of people living in the U.S. experience some difficulty with "basic" movement, or cognitive, sensory or emotional limitations--with 20 percent reporting physical difficulties; 13 percent with vision or hearing and three percent with emotional or cognitive difficulties.[lxxv]

Disability should be thought about broadly (Kailes, 2011), beyond wheelchair users and people who are deaf or blind to include those with activity limitations such as a reduced ability to see, read, walk, speak, hear, learn, remember, understand, manipulate or reach controls, or respond quickly.

Challenges in the health of persons with disabilities include the need for services, slow progress at the federal level and lack of proper disparities research.

In *The Current State of Health Care for People with Disabilities*, the National Council on Disability (2009) describes slow progress in meeting the needs of clients with

disabilities, citing that most federally funded health disparities research does not recognize or include people with disabilities as a disparities population.

The study highlights the following facts and challenges, underscoring the urgency of better serving the population with disabilities:

- In 2005, 18.7 percent of people in the U.S. had a severe disability. As the population ages, that number will only increase.
- People with disabilities comprise the largest and most important health care consumer group in the United States.
- People with disabilities tend to be in poorer health than people who do not have disabilities.
- Paradoxically, people with disabilities use preventive services at a lower rate than those who do not have disabilities.
- Some barriers to care facing persons with disabilities include health care provider stereotypes, lack of appropriate training among providers, lack of accessible medical facilities, examination equipment, sign language interpreters and individualized accommodations.

In 2009, The National Council on Disabilities (NCD) rated past health disparities research around disabilities as inconsistent and lacking focus on disability as a demographic characteristic.

Deaf and hard-of-hearing patients face unique health challenges.

Nine to 10 percent of Americans (Collins, 2007) have hearing loss,[lxxvi] making hearing loss the second most common disability in the United States.

Meador et al (2005) indicate persons who are deaf or hard of hearing show altered health utilization patterns and significant communication difficulties with physicians, often experiencing misunderstandings about their disease or treatment recommendations.[lxxvii]

Low health literacy is a challenge in the deaf and hard-of-hearing community. Lass et al (1978) note that many deaf individuals have low English proficiency and have problems with common English words, as American Sign Language (ASL) is their primary language.

Because American Sign Language has no written form, *An Introduction to the Deaf World for Behavioral Health Practitioners* (MDPH, 2013) notes that a person can be fluent in ASL and not be able to read, understand or write English.[lxxviii] In light of this, the deaf community is a non-English-speaking minority at great risk for physician-patient miscommunication.[lxxix]

Tamaskar (2000) noted that many deaf persons have poorer health care knowledge including inferior understanding about current preventive medicine interventions, when compared with hearing persons.[lxxx]

One study (Witte et al, 2000) found that deaf persons tend to visit physicians less frequently and expressed a belief that physicians and nurses seemed unprepared to accommodate their communication needs.[lxxxi]

The deaf community has its own culture and social mores, which affect their experience in the health care system.

Meador and Zazove (2005) describe the deaf and hard-of-hearing community as a heterogeneous group made up of diverse cultures and levels of hearing loss. Solutions for one group do not necessarily apply to other groups.

Some individuals with hearing loss do not consider themselves members of the culturally Deaf Community (capital "D" refers to culturally deaf), and may prefer English as their means of communication.

The Deaf Community (Dolnick, 1993) is a minority population with its own culture and social mores.[lxxxii]

After conducting multiple research studies in the deaf community over a period of 15 years, Meador and Zazove (2005) identified the following clinical issues affecting deaf persons.

- The need for linguistic accommodations (literacy levels, consent forms, need for explanation of processes)
- Lack of trust of the "hearing world"
- The need for confidentiality
- The need for respect for intelligence. Many deaf persons reported being treated as having inferior intelligence. Meador and Zazove note it is important to remember the intelligence of many deaf persons is not reflected in their written English, because English is their second language.
- The need for transparency and sharing of information.[lxxxiii]

NCD recommends improving research, trainings, monitoring, accountability and access to health care.

Recommendations from the NCD study include (1) improving research, using disabilities as a demographic characteristic to identify and address disparities; (2) improving trainings by including disability cultural competence in professional education programs; (3) improving monitoring, oversight and accountability; and (4) improving access to health care services and programs (NCD, 2009).

Topics recommended for disability cultural competence training include disability knowledge, cultural competency, the basic capacity to work effectively with people with disabilities, transitions for young people with intellectual and developmental disabilities, awareness of linguistic and cultural issues related to the deaf community, health care issues and concerns of blind and visually impaired persons, and issues for women with disabilities.[lxxxiv]

Federal disability discrimination laws mandate equal access to and equal opportunity to participate in health care services, and effective communication with individuals who are deaf or hard of hearing.

Laws mandating equal access for persons with disabilities include:

- Section 504 of the Rehabilitation Act of 1973, which applies to federal health care services and facilities, and recipients of federal financial assistance (including those receiving Medicaid funds or federal research grants).
- Title II of the Americans with Disabilities Act, which applies to all public (state and local) health care providers.
- Title III of the Americans with Disabilities Act, which applies to all private health care providers.[lxxxv]

Principles of universal design, inclusive resources and imagery, and removal of common barriers can contribute to a welcoming environment.

As a means to improve access in health care spaces, the Joint Commission (2010) recommends incorporating principles of universal design in physical spaces[lxxxvi]:

- Equitable use
- Flexibility in use
- Simple and intuitive use
- Perceptible information
- Tolerance for error
- Low physical effort
- Size and space for approach and use (regardless of body size, posture or mobility)

Further, a welcoming environment can be created by displaying diverse magazines and brochures in the waiting area, reflecting persons with disabilities in marketing materials, décor and photography and navigational signage that is easily understood (i.e. pictures, symbols, bilingual materials).

To create a more accessible and welcoming environment, Kailes (2011) recommends watching for and removing common barriers, such as, vehicles blocking ramps; housekeeping and cleaning carts blocking hallways and restrooms; potted plants, benches, ashtrays, trash cans and other items blocking access to ramps, railings and elevator call buttons; parking personnel using an accessible parking space as waiting areas; and snow and ice on walkways, ramps and parking areas.[lxxxvii]

The American Disabilities Act mandates effective communication assistance for persons with disabilities in health care settings.

All hospital programs and services are required by the Americans with Disabilities Act (ADA) to provide effective means of communication for patients, family members and hospital visitors who have a disability.

Providing effective communication, according to the ADA, is particularly critical in health care settings where miscommunication may lead to misdiagnosis and improper or delayed medical treatment.[lxxxviii]

In its *Checklist for Effective Communication* (The Joint Commission, 2010) recommendations include offering auxiliary aids and services for patients with sensory impairments such as American Sign Language (ASL) interpreters,

telecommunication devices for the deaf (TDD) in public areas, volume control and hearing aid adaptable telephones, closed captioning services, and Braille materials.

Also recommended is using augmentative and alternative communication (AAC) resources--such as writing pads, communication boards, visual pain scales, speech generating devices and adaptive nurse call systems--into care delivery.

Such resources should be made known to clients and addressed in policies and procedures.[lxxxix]

To ensure communication for persons who are deaf or hard of hearing, sign language interpreters, oral interpreters, cued speech interpreters or computer assisted real-time transcription (CART) may be necessary (DOJ, 2003).

An interpreter may be required for effective communication in the following situations:

- Discussing a patient's symptoms and medical condition, medications, and medical history
- Explaining and describing medical conditions, tests, treatment options, medications, and surgery or other procedures
- Providing a diagnosis, prognosis, and recommendation for treatment.
- Obtaining informed consent for treatment
- Communicating with a patient during treatment, testing procedures, and during physician's rounds
- Providing instructions for medications, post-treatment activities, and follow-up treatments
- Providing mental health services, including group or individual therapy, or counseling for patients and family members
- Providing information about blood or organ donations
- Explaining living wills and powers of attorney
- Discussing complex billing or insurance matters
- Making educational presentations, such as birthing and new parent classes, nutrition and weight management counseling, and CPR and first aid training (DOJ, 2003)

Avoiding assumptions, using sensitive language and making small accommodations can contribute to respectful communication.

When addressing individuals with disabilities and their families, Kailes (2011) recommends choosing disability terms that describe diversity in accurate and respectful ways. For example, a "person with epilepsy" instead of "epileptic" or "wheelchair user" instead of "wheelchair bound." Disability-specific language, according to Kailes, should be precise, objective and neutral, and avoid reinforcing negative values, biases and stereotypes.

It is important to avoid assumptions when offering assistance to persons with disabilities. Kailes recommends "asking before acting" and, if offering assistance, waiting until the offer is accepted.

Small accommodations, such as stepping around counters to provide service to persons using wheelchairs and speaking directly to the person with a disability rather than through family members, can be helpful (Kailes, 2001).

When communicating with deaf persons, it is important to note certain social mores that can affect communication (Meador and Zazove, 2005), such as the need to inform deaf people of the content of any conversation including personal asides and environmental sounds. Also important is to remember that ASL sentence structure differs from English. ASL communication starts with the main point and winds down, and has been described as having "abrupt beginnings and long goodbyes."[xc]

Recommendations for improving communication with deaf persons (MDPH, 2013 include:

- Asking the person "What is the best way to communicate with/for you?"
- Inquiring about family history or education background to understand personal support systems, identity and communication needs
- Addressing the Deaf consumer directly and not the interpreter
- Avoiding comments that infer deafness is a condition in need of curing
- Making and keeping eye contact
- Using plain language
- Explaining audio interruptions such as the phone ringing or knocks at the door
- Using visual aids when necessary

Culturally Competent Care for Veterans

A search for literature specific to the health of veterans began at the Defense Centers of Excellence website (http://www.dcoe, health.mil).

Articles and materials reviewed highlighted the special health concerns facing military veterans, namely post-traumatic stress disorder (PTSD), acute stress disorder (ASD), depression, substance abuse, suicide and Gulf War illness. The following themes emerged from the research.

Veterans are a growing population, facing unique health repercussions after deployment.

According to the National Institutes of Health (NIH), there are more than two million active and reserve members of the U.S. Military and more than 23 million U.S. veterans[xci]

Families of veterans cope with deployment and separation, illnesses and injuries, the mental health effects of war on military family members, stresses related to disruptions in parenting and caregivers, among other issues.

Medical conditions particularly affecting Veterans include:

- o Agent-Orange-Exposure-related diseases (certain cancers, chloracne, diabetes type 2, ischemic heart disease, birth defects in biological children of exposed Veterans)

- o Gulf War Syndrome
- o Traumatic Brain Injury
- o Radiation Exposure [xcii]

Higher prevalence of psychosocial problems are observed among deployed forces.

There is a high prevalence of psychosocial problems among deployed forces (VA, 2001). These include post-traumatic stress disorder, mental health injuries, depression, suicide, substance abuse, and domestic violence.[xciii]

Richardson et al (2012) found that military personnel who show symptoms of post traumatic stress disorder (PTSD), major depressive disorder, alcohol use disorder, and generalized anxiety show higher levels of suicidal ideation.[xciv]

Deployment presents unique challenges and health repercussions, including medically unexplained symptoms.

Although symptoms and health concerns after a deployment may be indistinguishable from those reported in routine primary health care settings, deployment presents unique and often difficult challenges for military members, veterans and their families.

Deployed veterans experience physical or psychological trauma resulting from factors such as combat, environmental extremes, illness or infectious disease, injury, weapons of mass destruction, and potential environmental threats

Deployment can create or exacerbate existing family problems and strain already fragile family relationships and coping mechanisms.[xcv]

Certain war veterans also exhibit medically unexplained symptoms, or symptoms that remain relatively unexplained after an appropriate medical assessment that includes focused diagnostic testing.[xcvi]

The Kaiser Foundation reports that 20 percent of Veterans who participated in Operation Enduring Freedom and Operation Iraqi Freedom have experienced symptoms of psychological problems. Many of them do not seek treatment because there is often stigma associated with disclosing mental health symptoms and asking for help within military culture.[xcvii]

Higher prevalence of homelessness and criminal behavior has been observed in Veterans.

According to the Institute of Medicine (2000), Veterans are disproportionately represented among the U.S. homeless population and Veteran unemployment figures are significantly higher than their peers.

There is a growing prevalence of veterans entering jails, state and federal prisons with criminal behavior stemming from service-related mental health and cognitive injuries.

A priority system within the Veterans Health Administration poses coverage challenges, many Veterans report having no insurance.

The Veterans Health Administration (VHA) is the branch of the U.S. Department of Veterans Affairs (VA) that purchases coverage for and delivers health care to veterans and their families.

Eligibility for care depends on active military services. Veterans are assigned coverage based on a priority system that has been challenging for veterans rated with disabilities that are on the lower end of the severity scale yet have not been eligible to receive services through the VA.

This system also poses a challenge when selecting how to pay for services, as Veterans enrolled in both Medicare and VA health must choose either Medicare or VA to pay for services every time they need care.

One in 10 nonelderly veterans report neither having health insurance nor using VA Health Care (The Kaiser Family Foundation, 2011).

Particular challenges for women in service include changing roles, prevention and treatment of sexual assault, a better understanding of the effects of PTSD.

One growing area of attention has been the rising number of women in the armed forces as well as their changing roles and the military's capacity to meet women's health needs.

An urgent area of need is the prevention and treatment of sexual assault or military sexual trauma among active duty and veteran women. Other areas requiring particular attention for active or veteran women include ending prohibition of abortions in military facilities, improving primary reproductive health care for women in the military, and a better understanding of the differential gender effects of PTSD (The Kaiser Family Foundation, 2011).

Understanding rank and structure, core values, and key demographics of military veterans is important in competent care.

The competency-training course *Military Cultural Competence* (Essential Learning, 2011) underscores the importance of understanding rank and structure, core values and key demographics of members of the military in order to gain a better understanding of unique environmental factors affecting health and behaviors. For example, it helps to understand that members of the military often have an elevated sense of duty resulting from having responsibilities well above their educational level and age group peers.[xcviii]

VA training guidelines for providers highlight the importance of training for civilian and new military providers.

A number of training guidelines for care providers are available on the Defense Centers of Excellence web site, including guides for providers treating specific conditions such as PTSD, traumatic brain injury and medically unexplained illnesses.

These guidelines highlight the importance of training for civilian and new military providers in military culture and terminology to ensure that care is targeted to the unique needs of active-duty service members and their families.[xcix]

The recommended training objectives, while unique to each condition, share the following common elements:

- Formal training in evidence-based treatments of each condition
- Training in clinical decision-making for deviating from clinical practice standards for circumstances in which patients may not be ready for certain evidence-based treatments
- Receiving case consultation from a trained senior provider
- Ensuring providers have training and experience in military culture and terminology to deliver context-sensitive care for treatment of conditions related to war trauma

The *Guidance for Training* (DCOE, 2011) also includes toolkits, resources, webcasts and computer-based training for treatment of Major Depressive Disorder (MDD), Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD); post-deployment health evaluation and management; and resources for treatment of substance abuse in military and their families.[c]

Putting Clinical Practice Guidelines to Work in VHA explores a process for implementing Veteran's Health (VHA, 2001) clinical practice guidelines, as well as recommendations, an action plan and a guide for leaders.[ci]

In *Clinical Practice Guidelines for the Management of Medically Unexplained Symptoms* (VHA, 2001), a thorough and early review of all information sources (including medical records, history, psychosocial assessments, screenings, physical examinations, mental health status, test results and standard health assessments) is recommended as a way to help validate patient concerns.

Of note among the guidelines included is the BATHE technique for patient symptom review, in which the acronym BATHE stands for the following:

- Background: What is going on?
- Affect: How do you feel about it?
- Trouble: What troubles you the most?
- Handle: What helps you handle that?
- Empathy (shown by the care provider)[cii]

Clinical Practice Guidelines for Post-Deployment Health Evaluation and Management includes key steps in evaluating post-deployed veterans.[ciii]

The VHA developed Clinical Practice guidelines in response to recommendations in the Institute of Medicine report, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces*.

The Institute of Medicine (IOM, 2000) recommends that standardized guidelines address the need for screening, assessing, evaluating and treating deployed forces. Based on the experiences encountered after the Vietnam and Gulf Wars, the IOM emphasized that the post-deployment period is a crucial time for carrying out medical evaluations and providing appropriate care for returning service members.[civ]

Six strategies identified in the report to address and better track special health concerns of deployed persons include:

- Using a systematic process to evaluate non-battle related risks associated with deployments, such as chemical and biological warfare agents
- Collecting environmental data and personnel location to analyze deployment exposures
- Developing risk management, communication and risk assessment skills of leaders at all levels
- Using a health surveillance system that spans the service life cycle
- Developing strategies to address medically unexplained symptoms in populations that have deployed
- Using joint computerized patient records and automated record keeping to meet the information needs of those involved with individual care and military public health

Tools and resources identified in this review will be incorporated into *Making CLAS Happen*.

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