SECTION III: Provider Roles and Responsibilities

GENERAL AND INFORMED CONSENT TO TREATMENT

General Requirements
As per AHCCCS AMPM 320-Q General and Informed Consent, each member has the right to participate in decisions regarding his or her physical and/or behavioral health care, including the right to refuse treatment. It is important for members seeking physical or behavioral health services to be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services in order to be able to agree to these services.

There are two primary types of consent for physical and behavioral health services:

General Consent and Informed Consent.

1. Unless otherwise provided by law, General Consent shall be obtained before any services and/or treatment are provided. Verification of member's enrollment does not require consent.

2. Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order shall obtain consent, as specified in A.R.S. Title 36, Chapter 5.

General Consent
Administrative functions associated with a behavioral health member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a member's, or if under the age of 18, the member's parent, legal guardian or lawfully authorized custodial agency representative's written agreement to participate in and to receive non-specified (general) behavioral health services.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

Informed Consent
Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/guardian's signature when required.

Universal requirements for informed consent
A higher level of consent may be required for provision of specific behavioral or physical health services or for services provided to vulnerable members. This is not an exhaustive list of those instances but a guide of some situations in which informed consent may be necessary.

1. Providers of behavioral health services shall gain Informed Consent in a variety of specific circumstances for members with an SMI designation. These requirements can be found in A.A.C. R9-21-206.01.
2. At times, involuntary treatment, including medications, can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give Informed Consent is situational, not global, as a member may be willing and able to give Informed Consent for aspects of treatment even when not able to give General Consent. Members should be assessed for capacity to give Informed Consent for specific treatment and such consent obtained if the member is willing and able, even though the member remains under court order.
3. At a minimum, the following treatments and services require Informed Consent:
    a. Surgical or other procedures requiring anesthesia services,
    b. Sterilization as specified in all requirements in 42 CFR 441, Subpart F and AMPM Policy 420,
    c. Procedures or services with known substantial risks or side effects (psychotropic medications, electroconvulsive therapy). Informed consent is required for each psychotropic medication prescribed. Essential elements for obtaining informed consent for medication are contained within AMPM 310-V, Prescription Medications – Pharmacy Services: Attachment A – Informed Consent – Assent For Psychotropic Medication Treatment. The use of AMPM Exhibit 320-Q-A, Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
    d. As required by Arizona or Federal law.
4. Telehealth‒In addition to the requirements set forth in section of Universal Requirements for Informed Consent of this Policy, before a provider delivers health care via telehealth, verbal or written Informed Consent from the member, or when applicable, the member's Health Care Decision Maker, shall be obtained as specified in AMPM Policy 320-I, A.R.S. §36-3602, and A.A.C. R9-21-206.01. Exceptions to this Consent requirement include:
    a. If the telehealth interaction does not take place in the physical presence of the member,

b. In an emergency situation in which the member, or when applicable, the member's Health Care Decision Maker is unable to give Informed Consent, or
c. Transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

General consent for adults

Adults are considered individuals ages 18 years and older or emancipated minors as specified in A.R.S. §12-2451 et seq.

1. The following specifications apply to both general and informed consent. Unless otherwise provided by law:
    a. Any member in need of physical or behavioral health services shall give voluntary General Consent to treatment and/or services, as demonstrated by the member, or when applicable, the member's Health Care Decision Maker's signature on a General Consent form, before receiving treatment and/or services,
    b. Any member, or when applicable, the member's Health Care Decision Maker after being fully informed of the consequences, benefits and risks of treatment, has the right to not consent to receive physical or behavioral health services,
    c. Any member or, when applicable, the member's Health Care Decision Maker has the right to refuse medications unless specifically required by a court order or in an emergency situation, and
    d. A member, or when applicable, the member's Health Care Decision Maker, may revoke Informed Consent or General Consent at any time orally or by submitting a written statement withdrawing the consent.

General and informed consent for children

Unless otherwise provided by law:

1. To the extent legally authorized to do so, the member's Health Care Decision Maker, shall give General Consent to treatment, demonstrated by the authorized Health Care Decision Maker's signature on a General Consent form prior to the delivery of physical or behavioral health services, or refuse treatment.
    a. Under A.R.S. §8-514.05, in situations where the Department of Child Safety (DCS) and/or Foster Caregiver are temporarily operating as the Health Care Decision Maker of a child member, consent may only be granted for some services.
    b. In cases where the member's Health Care Decision Maker is unavailable to provide General or Informed Consent and the child is being supervised by a caregiver who is not the child's Health Care Decision Maker (e.g. grandparent), a Health Care Power of Attorney (or a document with similar provisions) is necessary to provide General and Informed Consent.

SECTION III: Provider Roles and Responsibilities

Emergency Situations

1. In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, Informed Consent to treatment is not required, and
2. Any child, 12 years of age or older, who is determined upon diagnosis by a licensed physician, to be under the influence of a dangerous drug or narcotic, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and when applicable, Informed Consent to treat.

Emancipated Minor

1. In the event the child is an emancipated minor, evidence of an emancipation shall be required, except in emergency situations under A.R.S. §12-2453, and
2. Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide General and, when applicable, Informed Consent to treatment without parental consent (A.R.S. §44-132).

Foster Children

1. For any child who has been removed from the home by DCS, the Foster Caregiver may give General Consent for the following:
    a. Routine physical, behavioral health, and dental treatment and procedures, including but not limited to, early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications) (A.R.S. §8-514.05(C-D), and
        i. Evaluation and treatment for emergency conditions that are not life threatening.
2. A Foster Caregiver (except for a DCS case manager) shall not consent to:
    a. General Anesthesia,
    b. Surgery,
    c. Testing for the presence of the Human Immunodeficiency Virus (HIV),
    d. Termination of behavioral health treatment,
    e. Blood transfusions, or
    f. Abortions.

Documentation

1. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record as per AMPM Policy 940 Medical Records and Communication of Clinical Information.

2. If the member, or when applicable, the member's Health Care Decision Maker, refuses to sign a written acknowledgment and gives verbal Informed Consent or General Consent instead, the provider shall document in the member's medical record that the information was given, the member or the member's Health Care Decision Maker refused to sign an acknowledgment, and that the member, or when applicable, the member's Health Care Decision Maker, gives consent.
3. Informed Consent shall be correctly documented in the member's medical record and the form shall include relevant information about the service provided, the providers name and certification to provide the service and the signature of the member of their Health Care Decision Maker, when applicable, and for the requirements of documenting consent for mobile dental services, refer to A.R.S. §32-1299.25.
4. For the requirements of documenting consent for mobile dental services, refer to A.R.S. §32-1299.25.

Revocation of Informed Consent
If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

Special Requirements For Children
In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

Non-emergency Situations
In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster parent, group home staff or other person with whom the Department of Economic Security/Department of Child Safety (DES/DCS)
- Government agency authorized by the court.

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal Guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other member/agency	Copy of court order assigning custody
DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child.	Copy of Notice to Provider-Educational and Medical (DCS Form FC-069)

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other member or agency in whose care the child is currently placed may give consent for the following behavioral health services: Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

Consent for behavioral health survey or evaluation for school-based prevention programs

1. Written consent shall be obtained from a child's Health Care Decision Maker for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS. A.R.S. §15-104 requires written consent from a child's Health Care Decision Maker for any behavioral health survey.

2. Attachment B shall be used to gain the Health Care Decision Maker's consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent shall satisfy all of the following requirements:
a. Contain language that clearly explains the nature of the screening program and when and where the screening will take place,

b. Be signed by the child's Health Care Decision Maker, and Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by Health Care Decision Maker.
3. Completion of Attachment B applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.
4. Analysis, or evaluation conducted in reference to a school based prevention program.

PCP GATEKEEPER ROLE

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

Additional responsibilities include:

- Coordinating care except for children's dental services when provided without a PCP referral.

- Ensuring behavioral health information is included in the member's medical record.

- Utilizing the AHCCCS approved EPSDT tracking forms or approved electronic versions.

- Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.

- Enrolling as a Vaccines for Children (VFC) provider if serving children.

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

SECTION III: Provider Roles and Responsibilities

PCP ASSIGNMENTAND PANEL RESTRICTIONS

Members are assigned to a provider based on geographic location, provider availability, the member's age, and any special medical needs of the member. All members can request to change their PCP at any time.

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

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

MEMBERS WITH SPECIAL HEALTH CARE NEEDS

Members with SHCN are those members who have serious and chronic physical, developmental, and/or behavioral conditions requiring medically necessary services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a PCP The following populations that meet this definition but are not limited to:

1. Members with qualifying Children's Rehabilitative Services (CRS) conditions.
2. Members diagnosed with HIV/AIDS.
3. Members diagnosed with opioid use disorder, separately tracking pregnant members and members with co-occurring pain and opioid use disorder.
4. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant.
5. Members enrolled in the Arizona Long Term Care System (ALTCS):
    a. Members enrolled in the ALTCS program serving individuals who are elderly and/or have a physical disability, and
    b. Members enrolled in the ALTCS program serving individuals who have a developmental and/or intellectual disability.
6. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).
7. Members who are enrolled in Comprehensive Health Plan (CHP).
8. Members who transition out of CHP up to one year post transition.
9. Members with an SMI designation.

10. Any child that has a Child and Adolescent Level of Care Utilization System (CALOCUS) level of 4+.
11. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system.
12. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS).
13. Members diagnosed with Severe Combined Immunodeficiency (SCID).
14. Members with a diagnosis of autism or at risk for autism.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, Care1st allows members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

SPECIALIST RESPONSIBILITY

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

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

COVERING PHYSICIANS

If for any reason a physician is unable to provide Covered Health Care Services to a member, the provider may secure the services of a Covering Physician. The Covering Physician must be a qualified Care1st provider before delivering Covered Health Care Services to the member.

SERVICE DELIVERY RESPONSIBILITIES

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

SECTION III: Provider Roles and Responsibilities

Excluded Participation in Federal Health Care Programs

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

CARE COORDINATION

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

- Arizona Long Term Care System (ALTCS)
- Department of Developmental Disabilities (DDD)
- Regional Behavioral Health Authority (RBHA) and/or Behavioral Health Home Providers

APPOINTMENT AND WAIT TIME STANDARDS

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

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

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

APPOINTMENT AVAILABILITY STANDARDS

PCP	SPECIALTY / DENTAL SPECIALTY	DENTAL	MATERNITY
***Urgent** As expeditiously as the member's health condition requires, but no later than 2 business days of request **Routine** Within 21 calendar days of request	***Urgent** As expeditiously as the member's health condition requires, but no later than 2 business days of referral **Routine** Within 45 calendar days of referral	***Urgent** As expeditiously as the member's health condition requires, but no later than 3 business days of referral **Routine** Within 45 calendar days of referral	**First Trimester** Within 14 calendar days of request **Second Trimester** Within 7 calendar days of request **Third Trimester** Within 3 business days of request **High Risk Pregnancies** As expeditiously as the member's health condition requires, but no later than 3 business days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists

BEHAVIORAL HEALTH

1. ***<u>Provider Appointments</u>***
   a. ***Urgent Need**
      i. As expeditiously as the member's health condition requires, but no later than 24 hours from identification of need
   b. **Routine Care**
      i. Initial assessment within 7 calendar days of referral or request for service
      ii. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but:
         a. For members age 18 years or older, no later than 23 calendar days after the initial assessment
         b. For members under the age of 18 years old, no later than 21 days after the initial assessment and
      iii. All subsequent services, as expeditiously as the member's health condition requires but no later than 45 calendar days from the identification of need

2. ***<u>Referrals for Psychotropic Medications</u>***
   a. Assess the urgency of the need immediately
   b. If clinically indicated, provide an appointment with a Behavioral Health Medical Professional (BHMP) within the timeframe that ensures the member
      i. Does not run out of needed medications; or
      ii. Does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

*Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.

WAIT TIME STANDARDS

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

NON-EMERGENCY TRANSPORTATION STANDARDS

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

PROVIDER NETWORK CHANGES

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

PCP TERMINATIONS/MEMBER REASSIGNMENT

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

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

PROVIDER LEAVE OF ABSENCE OR VACATION

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

NURSING FACILITY AND ALTERNATIVE RESIDENTIAL SETTING TERMINATIONS

To the extent applicable, Care1st follows the procedures set forth in ACOM Policy 421 Contract Termination: Nursing Facilities and Alternative Residential Settings to provide for the needs of the members residing in the facility at the time of contract termination.

AHCCCS PROVIDER ENROLLMENT PORTAL (APEP)

As of August 31, 2020, all new providers, as well as existing providers who need to update their accounts, will use the APEP. This online system, available 24/7, streamlines the provider enrollment process and eliminates the need for paper-based applications.
Providers must register for a Single-Sign-On (SSO) to access APEP by visiting, https://www.azahcccs.gov/PlansProviders/APEP/Access.html.

SECTION III: Provider Roles and Responsibilities

RIGHT TO REVIEW AND CORRECT INFORMATION

All practitioners participating within the Care1st Health Plan Arizona, Inc network have the right to review information obtained by the Care1st Health Plan Arizona to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a practitioner to review peer review-protected information such as references, personal recommendations, or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, the practitioner has the right to correct any erroneous information submitted by another party. To request release of such information, a practitioner must submit a written request to Care1st Credentialing Department. Upon receipt of this information, the practitioner has 14 days to provide a written explanation detailing the error or the difference in information to the Care1st Health Plan. . The Care1st Health Plan Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

REMOVAL OF MEMBER FROM PANEL

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

PROVIDER INQUIRIES, COMPLAINTS/GRIEVANCES AND REQUESTS FOR INFORMATION

Providers are instructed to contact Network Management regarding an inquiry, complaint/grievance and requests for information. Acknowledgement of provider inquiries, complaints/grievances and requests for information occurs within three business days of receipt.

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

PROVIDER SELECTION AND NON-DISCRIMINATION

Care1st must comply with all provider selection requirements established by the state [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(e)].

PROVIDER DIRECTORY

The Care1st Provider Directory is updated on a regular basis. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their assigned NMR. The Provider Directory is available on our website - www.care1staz.com, or you may contact Network Management for a printed version.

PROVIDER LOCATIONS WITH ACCOMMODATIONS

New providers complete the AzAHP Practitioner Data Form to initiate the credentialing and contracting process. The data form contains questions related to populations the provider is able to service/accommodate. This information is then loaded to the provider record in the Care1st claims payment system and used to populate the "Accommodates Accessibility needs for Members with Disabilities" data element of our Provider Search Tool.

ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to rendering medical services. To verify eligibility providers can visit our website www.care1staz.com or contact Customer Service.

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

CANCELLED AND MISSED APPOINTMENTS

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

AHCCCS COST SHARING & COPAYMENTS

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

MANDATORY (REQUIRED) COPAYMENTS

AHCCCS members who have *mandatory* copayments for certain services are:

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

TMA Copays (Copay Level 50)

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

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

These copayments do not apply to:

- People under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- An individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to Title 9, Chapter 22, Article 13
- ACC, CMDP, and RBHA members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year
- People who are enrolled in the Arizona Long Term Care System (ALTCS)

- People who are Qualified Medicare Beneficiaries
- People who receive hospice care
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
- People in the Breast & Cervical Cancer Treatment Program (BCCTP)
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age
- People who are pregnant and throughout the postpartum period following the pregnancy
- Individuals in the Adult Group (for a limited time*)

* NOTE: For a limited time, persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

Services that do not require a co-pay include:

- Hospitalizations and services received while in a hospital
- Emergency services
- Services received in the emergency department
- Family Planning services and supplies
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
- Preventative services, such as well visits, pap smears, colonoscopies, mammograms and immunizations
- Provider preventable services

OPTIONAL (NON-MANDATORY) COPAYMENTS

Optional (also known as non-mandatory) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment.

5% LIMIT ON ALL COPAYS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January-March, April-June, July-September, and October-December). The 5% limit applies to both optional and required copays.

HOW TO DETERMINE IF A MEMBER HAS A MANDATORY COPAYMENT

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

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

COPAYMENT TRACKING

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

Ongoing updates from AHCCCS regarding copayment requirements can be found at:
https://azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

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

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

ASIIS

The State of Arizona (ARS 36-135 and AAC R9-6-706 and R9-6-707) requires that immunizations administered to children covered by AHCCCS be reported to the Arizona State Health Department ASIIS system. ASIIS - which stands for the Arizona State Immunization Information System - requires that all immunizations are reported at least monthly, and it is recommended that high volume immunization providers report more frequently. Your office can report to ASIIS electronically or by paper, and ASIIS can also accept data exports from a patient management/billing system. Training by ADHS is provided free of charge. While the law does not require reporting of adult immunizations, ASIIS recommends doing so.

Contact Information:

- ASIIS website https://asiis.azdhs.gov/
- Training - contact ASIIS Hotline at 877.491.5741
- For Technical Support call 602.364.3899 or 877.491.5741
- For free ASIIS web-based application call 602.364.3899 or 877.491.5741
- For paper forms call 602.364.3899 or 1.877.491.5741
- For assistance with other methods of electronic data transfer call 602.364.3619

REFERRALS AND PRIOR AUTHORIZATION

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

Specialty providers, including Behavioral Health providers, may be identified using the **Find a Doctor** function on the Care1st Provider website. Select “Behavioral Health” as the Category and “Professionals” as the Provider Type. Once the specialist has been identified, follow the “Referral/Prior Authorization Process from PCP to Specialist” steps found in Section IX: Medical Operations, page 4.

Behavioral Health Hospitals and Outpatient Centers will be found under the **”Behavioral Health” Category and “Facilities” as the Provider Type**, also under the **Find a Doctor** link. Provider Manual Section VII: Behavioral Health Services provides details for the Behavioral Health Referral process.

SUBMITTING CLAIMS AND ENCOUNTERS

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

INAPPROPRIATE USE OF THE EMERGENCY ROOM

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

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

MEDICAL RECORDS

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

Members are guaranteed the right to request and receive one copy of their medical record at no cost to them. The member also has the right to request that the medical record be amended or corrected [45 CFR Part 160, 164, 42 CFR 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi)].

Providers are required to create a medical record when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request or more quickly if necessary.

RECORD RETENTION

Providers must retain medical records in accordance with all federal and state regulations. This includes, but not is limited to compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the provider shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

In accordance with Arizona Administrative Code R9-22-512 (E) all providers shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge. If the provider uses a vendor to store medical records, it is the provider's responsibility to work with the vendor and facilitate receipt of the requested records at no charge to Care1st.

QUALITY IMPROVEMENT

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Care1st's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Care1st the use of their performance data for quality improvement activities.

As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow Care1st to use their performance data.

END OF LIFE CARE/ ADVANCE CARE PLANNING

End of Life care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and practical supports. The goals of End of Life care focuses on providing treatment, comfort, and quality of life for the duration of the member's life.

SECTION III: Provider Roles and Responsibilities

Advance Care Planning is a billable face-to-face discussion between a qualified health care professional and the member/guardian/designated representative. A qualified health care professional is a Medical Doctor (MD), Doctor of Osteopath (DO), Physician Assistant (PA), or Nurse Practitioner (NP). This face-to-face discussion should consist of the following:

- Educate the member/guardian/designated representative about the member's illness and the health care options that are available to the member to enable them to make educated decisions
- Identify the member's healthcare, social, psychological and spiritual needs
- Develop a written member centered plan of care that identifies the member's choices for care and treatment, as well as life goals
- Share the member's wishes with family, friends, and his or her physicians
- Complete Advance Directives. An advance directive is a document (such as living wills and health care/medical powers of attorney) by which a person makes provisions for health care decisions in the event that, in the future, he/she becomes unable to make those decisions
- Refer to community resources based on member's needs
- Assist the member/guardian/designated representative in identifying practical supports to meet the member's needs

Advance Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The provider may bill for providing Advance Care Planning separately during a well or sick visit.

Providers and their staff will complete annual training in the concepts of EOL care, Advance Care Planning and Advance Directives as offered by Care1st.

NON-DISCRIMINATION POLICY

Care1st members have the right to receive courteous, considerate care regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, or source of payment. Providers must be compliant with the Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability.

CULTURALLY COMPETENT CARE

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds. Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location. Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction. Refer to our website for additional resources: https://www.care1staz.com/az/providers/compliance.asp, then click on "Cultural Competency"

LANGUAGE SERVICES

Care1st believes that effective health communication is as important to health care as clinical skill. Health care providers must recognize and address the unique cultural, language, and health literacy of diverse members and communities to improve individual and community health.. Moreover, Care1st members have a right to interpretation services. To assist in meeting this challenge, Care1st offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All Care1st contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to Care1st so that you can focus on ensuring effective communication with your Care1st non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

AMERICAN SIGN LANGUAGE INTERPRETATION

Care1st contracts with Valley Center of the Deaf to provide American Sign Language Interpreters at no cost to members or providers. Services are available and arranged through Member Service. Valley Center of the Deaf recommends setting up services seven business days in advance of the appointment and Community Outreach Program for the Deaf recommends setting up services 10 business days in advance of appointment.

CLAS Standards

1 Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

2 Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3 Recruit, promote and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

5 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

9 Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10 Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12 Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13 Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts of interest.

15 Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Institute for Health Professions Education

Georgia G. Hall, Ph.D., MPH

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Phoenix Health Plan

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University Family Care

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TABLE OF CONTENTS

SECTION ONE

INTRODUCTION

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

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

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

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

Benefits of a culturally competent approach to care:

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

SECTION TWO

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

Culturally competent healthcare

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

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

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

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

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

General beliefs

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

Understanding your values and beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.

- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing your patient

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

Appreciate the heterogeneity that exists within cultural groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.

- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The role of economics

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

The role of religious beliefs

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

The role of the family

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

  Questions to consider:

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

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

Cultural assessment

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

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

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

Cultural assessment (continued)

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

Tools To Elicit Health Beliefs

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

Further Questions to Consider

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

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

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

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

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

Other Factors Influencing Communication:

Conversational style: It may be blunt, loud and to the point – or quiet and indirect.

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

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

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

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

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

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

Other Factors Influencing Communication (Continued):

What's in a name:	Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.
Nonverbal communication:	Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.
When English is a second language:	According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant. Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.
Translators:	Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution. Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

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

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

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

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

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

INTERNET RESOURCES

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

General Reference sites:

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

General Reference sites (continued):

- AMSA (American Medical Student Association): http://www.amsa.org/AMSA/Homepage/About/Committees/REACH/CSSP.aspx

- Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. http://www.xculture.org/

- Communicating with your doctor - things you can do to help build an effective partnership http://www.ucsfhealth.org/education/communicating_with_your_doctor/

- CCCH develops cultural competency programs, organization assessment tools, and education and training resources. http://www.crosshealth.com/

- The Office of Minority Health (OMH) was created in 1986 and is one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. The Office is dedicated to improving the health status of racial and ethnic minorities, eliminating health disparities, and achieving health equity in the United States. OMH was reauthorized by the Patient Protection and Affordable Care Act of 2010 http://minorityhealth.hhs.gov/

- U.S Department of Health and Human Services - Health Resources and Service Administration: clinical resources http://www.hrsa.gov/publichealth/index.html

- The Health Center Program – What is a health center http://bphc.hrsa.gov/about/

- Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)

- Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)

- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: http://www.diversityrx.org/

- National Urban League (Phone: 212-310-9000) or http://www.nul.org/

- African Community Health and Social League http://www.progway.org/ACHSS.html

- Association of Asian Pacific Community Health Organizations http://www.aapcho.org

- National Coalition of Hispanic Health and Human Services Organizations http://www.hispanichealth.org/

- Center for American Indian and Alaskan Native Health Phone: http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/CAIANH.aspx

- www.culturalorientation.net

- The Provider's Guide to Quality and Culture http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English