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**Service Category Definition - DSHS State Services Grant
September 1, 2011 - August 31, 2012**

| | |
|---|--|
| Local Service Category | Linguistics Services |
| Amount Available: | To be determined |
| Unit Cost: | |
| Budget Requirements or Restrictions: | Maximum of 10% of budget for Administrative Cost. |
| Local Service Category Definition: | To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual HIV positive clients. |
| Target Population (age, gender, geographic, race, ethnicity, etc.): | HIV/AIDS-infected individuals living within the Houston HIV Service Delivery Area (HSDA). |
| Services to be Provided: | Services include language translation and signing for deaf and/or hearing impaired HIV+ persons. Services exclude Spanish Translation Services. |
| Service Unit Definition(s): | A unit of service is defined as one hour of interpreter services to an eligible client. |
| Financial Eligibility: | Income at or below 300% Federal Poverty Guidelines. |
| Client Eligibility: | HIV positive resident of Houston HSDA |
| Agency Requirements: | Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies. |
| Staff Requirements: | ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS. |
| Special Requirements: | Must comply with the State Services Standards of Care. |

Service Category Definition - DSHS State Services Grant
September 1, 2010 - August 31, 2011

FY 2012 RWPC “How to Best Meet the Need” Decision Process

| | | |
|---|---|--|
| Step in Process: Council | | Date: 06-09-11 |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: Steering Committee | | Date: 06-02-11 |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: Quality Assurance Committee | | Date: 05-19-11 |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: HTBMTN Workgroup #3 | | Date: 04-27-11 |
| Recommendations: | Financial Eligibility: | |
| 1. | | |
| 2. | | |
| 3. | | |

DSHS STATE SERVICES
1112 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

| # | STANDARD | MEASURE |
|------------|--|--|
| 9.0 | Services are part of the coordinated continuum of HIV/AIDS and social services | |
| 9.1 | <u>Scope of Service</u> The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual HIV positive clients. Services exclude Spanish Translation Services. | <ul style="list-style-type: none"> • Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files. |
| 9.2 | <u>Program Policies</u> Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service. | <ul style="list-style-type: none"> • Review of Program Policies. |
| 9.3 | <u>Timeliness of Scheduling</u> Agency will schedule service within one (1) business day of the request. | <ul style="list-style-type: none"> • Review of client files indicates compliance. |
| 9.4 | <u>Interpreter Certifications</u> All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation. | <ul style="list-style-type: none"> • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency requests denote appropriate levels of interpreters are requested. |
| 9.5 | <u>Subcontractor Exclusion:</u> Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters. | <ul style="list-style-type: none"> • No Measure |



Monday, April 11, 2011

Need for Medical Interpreters Growing

As immigrant population ages, health care providers must overcome language and cultural barriers
By: Paul Kleyman, New America Media

Language interpretation will be increasingly important in providing health and social services to the growing number of seniors — many of them immigrants. Federal law, especially Title VI of the Civil Rights Act, and statutes and regulations in many states, including as California, require agencies and many health care providers to have adequate translations services.

Among the challenges the Garcias of Mountain View have encountered in caring for their father Felipe, 79, who has Alzheimer's disease, and his wife Manuela, 65, who has diabetes and heart disease, is the need for adequate language interpretation, particularly for medical appointments. (Read their [full story here](#).)

California's new Alzheimer's plan, developed with the Alzheimer's Association, calls for providers to "identify the patient's and family's culture, values, primary language, literacy level and decision-making process."

Marco Garcia said he attends medical appointments with his parents to translate linguistic as well as cultural differences.

"It's just as important to have the cultural comprehension," said Marco, "because if you learn a foreign language but don't understand the nuances inherent in that culture, you'll miss a big part. It's important to translate, but also you need to understand how is Alzheimer's viewed in the Latino culture."

Marco's wife Elena said that Latinos often find American doctors "very cold, very harsh, the way they just say, This is what's wrong with you."

Even when a doctor does speak more sensitively, she said, she has seen bad interpreters miss important nuances because "a lot of times emotions are lost in translation."

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Your Money / Your Health

Medical interpreters are a patient's right

Federal and state law requires assistance for patients with limited English. New national competency standards begin in 2011.

December 27, 2010 | By Francesca Lunzer Kritz, Special to The Los Angeles Times

Even people who speak English fluently often find that conversations with healthcare professionals sound like Greek to them. So imagine if you speak only Greek or Spanish or Farsi and want to have, say, an in-depth conversation with an oncologist about the risks and benefits of an aggressive form of chemotherapy.

Until recently, the most likely interpreter in such an encounter would be a family member, often a poor choice because he or she might be reluctant to share bad news or be unfamiliar with medical terminology. But new developments are helping patients with limited English communicate better with their healthcare providers — including a 2-year-old California law that requires health insurers to provide interpreting (oral) and translating (written) services to patients with limited English proficiency, draft standards on how medical interpreting should be conducted in hospitals, two new certification bodies for medical interpreters and the rapidly increasing use of remote interpretation service by phone or video conference.

"Getting competent interpreting services to everyone who needs them is not all the way there, but we've come a long way," says Mara Youdelman, managing attorney of the Washington, D.C. office of the National Health Law Program, an advocacy group for the underserved that has studied the need and effect of medical interpretation services.

The need is certainly there. According to the federal Department of Health & Human Services' Office of Minority Health, at least 25 million Americans speak English less than "very well." Census data show that at least 40% of California residents speak a language other than English at home. (In Los Angeles, that number rises to more than 50%.)

And a 2002 report from the Institute of Medicine on health disparities found that language barriers between patients and the professionals who care for them can result in poor, shortened or wrong communication, poor decision-making and below-optimal outcomes for members of minorities.

Kathy English, now the director of healthcare marketing solutions for Internet networking firm Cisco Systems, which develops technology for remote video medical interpretation, says she got a firsthand lesson a few years back on the need for medical interpreting. She worked as a hospital floor nurse and was caring for a patient just out of surgery who spoke only Spanish. Soon after the operation, the patient began moaning in pain and pointing to his stomach. Unable to speak Spanish, English says she couldn't ask about the source of the pain, so she gave an approved dose of pain relief drugs but didn't call the doctor.

When, an hour later, the patient was still moaning and clearly in excruciating pain, English says she did call the doctor, who, on arrival, took the patient back to surgery. "If I had been able to understand the precise pain location, I would have called the doctor sooner, and speeded up his second surgery, pain relief and recovery," English says.

The right to medical interpreting falls under the Civil Rights Act of 1964. That right was further emphasized by a 2000 presidential executive order stating that healthcare organizations receiving federal funds must make medical interpretation available to patients with limited English proficiency.

According to a 2009 report by the federal Agency for Healthcare Research and Quality, California has the most comprehensive medical interpretation laws of any state. Two years ago, a law took effect in the state requiring commercial health plans to provide medical interpretation to plan members during doctor and hospital visits. The provisions also included translation of key documents, such as a plan's explanation of benefits, into very commonly used languages. And new efforts at improving the quality of medical interpretation across the country should refine the services patients can expect.

One of these changes is voluntary certification for interpreters. To be certified, interpreters must show competency in the language they will be interpreting, including medical terminology, as well as an understanding of ethics issues such as maintaining a patient's privacy. That level of competency has been long awaited. A 2002 study funded by the Commonwealth Fund found, on average, 31 mistakes in each encounter of medical interpreting in 13 sessions reviewed. Mistakes were most likely to occur when an ad hoc interpreter was used, such as a family member or hospital employee with limited medical background.

For now, healthcare organizations vary in how they test the competency of their interpreters; some groups have even developed their own courses and exams. Competency tests will be even more important next year when new national standards kick in. The standards include putting patients' language of choice into their medical records and determining that interpreters are doing a competent job. In 2012, the standards become one of the factors in a hospital's accreditation evaluation.

The two certifying organizations call for interpreters to be recertified every four or five years. This is crucial, says Hala Fam, head of the interpreter program at Ronald Reagan UCLA Medical Center. Fam, who started her career as a hospital interpreter speaking Farsi, says keeping up with drug names, new technology and changing terminology is challenging — but it's a skill she expects of the interpreters she works with.

Next month, Fam will add quite a few interpreters to her five-person team when UCLA joins the Health Care Interpreter Network, a cooperative of at least 17 California hospitals that share trained healthcare interpreters through a video/voice call center. The network requires its interpreters to take a 40-hour course and pass a competency test. When a patient requests an interpreter, hospital staff can access the network if no hospital-based interpreter is available via video- or telephone-conferencing. "Even a hospital which has a dozen full-time interpreters could often find it impossible to be available for every patient who needs interpreting," says Frank Puglisi, the network's executive director.

The network also includes clinics and health plans that serve Medi-Cal patients, and languages include Spanish, Cantonese, Mandarin, Thai, Russian, Farsi, Tongan and Hindi as well as American Sign Language.

Puglisi says many patients prefer the phone or video conferencing system to an in-person interpreter because they feel it affords them greater privacy — though respecting the patient's privacy and modesty is part of the training all interpreters seeking certification are taught. (Hospitals in the network include Harbor-UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center and Riverside County Regional Medical Center.)

Numbers show the service is needed. Melinda Paras, of Paras and Associates in Emeryville, which manages the video network, estimates that Los Angeles County USC Healthcare Network, which became part of the network three years ago, now averages 30 to 50 calls/video conferences each day.

Youdelman of the National Health Law Program says patients should not hesitate to ask for translation services out of cost concerns. "Hospitals are not allowed to charge patients for the service," she says.

health@latimes.com

[Print This Article](#)[<< Return to Medical interpreters can increase patient satisfaction with ED experience](#)

Medical interpreters can increase patient satisfaction with ED experience

Ann W. Latner, JD
August 17 2010

A recent study, published in the *Annals of Emergency Medicine*, has revealed that non-English speaking patients who are provided with a professional interpreter in the Emergency Department (ED) of a hospital are far more likely to be satisfied with the experience and to understand information from health care professionals. The increase in patients who do not speak English has led hospitals to use a variety of interpretation methods, including having a friend or family member translate for the patient, using a hospital staff member as an informal interpreter, or finding a physician who speaks the patient's language. These methods are often hit or miss, leading to confusion about what was said, and the potential for errors.

For the study, researchers used professionally trained medical interpreters. The study took place in two New Jersey hospital EDs. During some blocks of time, professional interpreters were provided to Spanish-speaking patients. During control blocks of time, interpretation methods took place as usual. The study took place over a seven-month time period. Results indicated that 96% of the patients provided with the professional interpreter were “very satisfied” with their ability to communicate with health-care professionals during their time in the ED, as compared with only 24% of the control group patients. Similarly, almost 95% of physicians reported being “very satisfied” when an interpreter was used, compared with 17% when the interpreter was not used. The same was true with both triage and discharge nurses who had over 94% satisfaction rates when an interpreter was used.

Most important, perhaps, was the percentage of patients reporting an ability to understand what was happening in the ED. Ninety-three percent of patients who were provided with an interpreter reported that it was “very easy” to understand what was transpiring during their ED visit. Less than 18% of the control group reported that level of understanding.

The study authors speculated that beyond increased satisfaction levels, improved communication from in-person interpreter services may yield additional benefits, including:

- More accurate patient assessment on arrival in the ED;
- Assistance in explaining procedures necessary for diagnosis and treatment;
- Anxiety relief for patients unfamiliar with ED tests and procedures;
- Improvement in patient safety and reduction in potential errors by improved communication and understanding of the patient's individual needs; and,
- Improved compliance because patients can understand the discharge plan.

Research

Health literacy and harm: Who is at risk? What is the fix?

Allan Frankel MD

∞ See related article page 1555

The study by Bartlett and colleagues¹ on the risk of preventable adverse events among patients with communication problems admitted to acute care hospitals in this issue of *CMAJ* highlights major known flaws in how health care is delivered. It also reminds us of 2 types of needed improvements in health care: those that are simple but hard to do, and those that are complex and disruptive.

The authors chose to focus on patients with communication problems, but they also have shone a broader light on the risks to all patients. The results of this study revealed that some patients' communication problems predisposed them to a 3-fold increased risk of a preventable adverse event and identified a segment of the patient population worthy of extra scrutiny and effort. The results also revealed the ubiquity of error and the universality of risk, whether inpatient or outpatient, preadmission or postadmission. It comes as little surprise that elderly women, those who were admitted to hospital because of an emergency and those whose ability to communicate with health care providers was limited because of a foreign language, deafness or a psychiatric disorder were the patients most likely to receive inadequate care. This constellation of characteristics requires a health care system whose very fabric has woven into it patience and cultural sensitivity, which is not exactly a picture of current general-care or emergency-response systems in most health care systems worldwide.²

Deafness adds an extraordinary level of complexity to the care process. In addition to data suggesting that less than 20% of deaf individuals are fluent in reading English, nuanced differences exist between English and American Sign Language and may lead to substantial misunderstanding.³

The 2 main factors associated with preventable adverse events in the study by Bartlett and colleagues were communication problems and poor clinical management. If we start with communication, a national study in the United States indicated that one-third of individuals have below basic or basic reading skills.⁴ Individuals with such reading skills are unlikely to understand more than the simplest written documents or verbal explanations. Health care providers, who tend to write and speak at a graduate level, get little training or organizational support about how to bridge this comprehension chasm. As a result, medical documents are often written at a 10th-grade level or higher, and verbal communications are fraught with opportunities for misunderstanding.⁵

In a video produced by the American Medical Association to highlight issues of patient health literacy, one segment

Key points

- All patients are at risk of preventable adverse events, regardless of disabilities or communication limitations.
- Common factors that lead to harm are communication and poor clinical management.
- Simple mechanisms to enhance patient comprehension are well known, but must be vigorously applied.
- Decreasing the risk of preventable adverse events will also require effective standardization and simplification of care.

shows a female physician discussing the word “hypertension” with a gentle and calm elderly male patient. The physician asks the patient what he understands when she says hypertension. The elderly man, sitting quietly in his chair, replies that he thinks the physician perceives him as hyperactive and unable to sit still in his chair. The physician then replies that she has not done an effective job of explaining his medical problem and that his problem is not hyperactivity but high blood pressure.⁶

A solution is to implement a framework of communication that ensures patients know the steps needed to take care of themselves. Work promulgated through the Partnership for Clear Health Communication, and built on the stellar efforts from Iowa Health in the United States, has simplified the questions patients or family members should be able to answer before leaving their care providers (www.npsf.org/askme3). The 3 key questions are: What is my main problem? What do I need to do? Why is it important for me to do this? The devil in the details is that the patient must verbally relate this information back to the provider before leaving — a step that ensures the patient's comprehension of the issues.

The second common factor associated with preventable adverse events identified by Bartlett and colleagues is poor clinical management. This factor, unfortunately, is not simple to fix. The reliability of care improves when care is standardized and developed to manage the condition rather than when it is fashioned and limited according to payment methods or organizational structure. Health care in the United States has been abysmal in separating financial reimbursement from the care processes, but health care systems in other countries have fared only marginally better. Although,

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All editorial matter in *CMAJ* represents the opinions of the authors and not necessarily those of the Canadian Medical Association.

in the United States, misaligned payment incentive is the major issue, in Canada and the United Kingdom, physician myopia favouring practice autonomy over practice standardization continues to undermine the reliability and cost savings that accrue from the application of human factors to care delivery. Simplification, performance measurement and continuous refinement are at least understood today, but not well applied yet, in health care. There are some who are ahead of the curve: at Intermountain Health in the state of Utah, for example, standardization of practice has led to healthier patients at substantially lower costs than in the rest of the United States.⁷ France leads the European Union nations in value for money spent on the delivery of care. In England, the National Health System fares almost as well. The costs in both countries are a fraction of the US costs.⁸

Health care delivery is complicated, and health care providers universally try to do their best under difficult conditions. The study by Bartlett and colleagues identifies, once again, the extent to which the process is fraught with risk, and it adds to the literature by characterizing the increased risk in a subset of our patients. Some fixes seem simple, others wholly disruptive. But they are feasible where there is a will. Let's hope this study strengthens the will.

Competing interests: None declared.

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Healthcare and the Deaf:

Also see: [Unique Challenges Encountered by the Deaf in Accessing Healthcare Services](#)

Kathryn J. Little
4/28/2008

The Healthcare Experience from a Deaf Perspective

According to I. King Jordan, a past president of Gallaudet University, "Deaf people can do anything hearing people can do except hear" (King, 2005). Due to the fact that this truth is often forgotten or ignored, deaf people sometimes endure inferior or patronizing treatment from uninformed individuals. At best, this lesser treatment must be insulting, but at worst, it may be life-threatening. A person receiving healthcare treatments or preventions can not afford to be ignored or misunderstood. This paper will explore some of the most common causes for miscommunications between healthcare providers and their patients, and options for improved communication will be presented.

An estimated 9% of the US population is deaf or hard of hearing, and that percentage is increasing. Individuals who were born deaf or deafened before the age of three constitute the Deaf Culture. Many healthcare providers erroneously believe that members of the Deaf Culture simply have a disability, while members of the Deaf Culture are actually a culturally and linguistically distinct entity. Some features of the Deaf Culture that are important to understand include: individuals live by distinct norms, are often educated in specialized schools for the deaf, use a non-English language, and often socialize and marry within their own community (Ross & Feller, 2005).

There are many dangerous implications to consider when a healthcare provider cannot communicate effectively with a patient. According to a study by the Agency for Healthcare Research and Quality, "Inadequate communication with deaf or hard-of-hearing patients can lead to misdiagnosis and medication errors, as well as patient embarrassment, discomfort, and fear" (Agency for Healthcare Research and Quality, 2008). Unfortunately, the risk for miscommunications and misperceptions seem to be higher in healthcare settings. Among deaf individuals who regularly used ASL interpreters, interpreter utilization was lower in physicians' offices than in other settings. Also, at least one-fifth of deaf individuals report rarely or never communicating with hearing persons, and physicians report rarely communicating with deaf persons either inside or outside of the office. The deaf rarely receive healthcare from a deaf physician or nurse. It's thought that the cultural barrier that divides the patient from the provider is as important as the practical barrier between them. The provider and the patient often both have misconceptions about one another and the situation, and this may complicate the mounting feels of distrust. The results of poor communication between the patient and provider may include prejudice, avoidance of acute and preventative care, low healthcare literacy, and ultimately, poor quality care overall (Ross & Feller, 2005).

There are many considerations to be aware of as a healthcare provider, and one should be made aware of them long before their first deaf patient ever

steps into their office. Some key concepts to remember regarding the understanding of deaf patients will be reviewed. First, all deaf individuals will communicate differently. Their style and methods of communication will depend on their age when they became deaf, type of deafness, comprehension of spoken English, intelligence, speech-reading abilities, personality and educational background. Some deaf patients will identify strongly with the Deaf Culture and will use ASL as their language of choice. For some of these people, English will be a second language, if not a foreign language altogether. For this reason, they might have problems with written English, and this should in no way be taken as a reflection of their education or intelligence. The Department of Health and Human Services has recognized that there is a large distinction between ASL and English, and the use of unskilled interpreters or the use of written notes are not effective means of communicating with a deaf patient. Many deaf people are poor lip readers, since only a small percentage of words are visible on the lips (King, 2005).

There are many strategies that healthcare providers can implement to enhance their communication with a deaf individual. To get a patient's attention, the provider should tap the person on the shoulder or arm, or flicker the overhead lights. The provider should always face the patient while speaking, since this will enable the patient to observe crucial facial expressions. The provider should also maintain eye contact with the patient because deaf people are primarily visual learners and communicators. This is the reason that facial expressions and body language are critical to communication with a deaf patient. Also, maintaining eye contact promotes a feeling of enhanced communication. The provider should always speak slowly and clearly since overemphasizing or yelling distorts lip movements and can cause confusion. A good rule is to speak at a normal volume, as one would speak to a hearing patient. The provider should refrain from placing anything in their mouth while speaking since this may obscure the lips and make it difficult for the patient to understand. The provider should also always make sure that the patient knows what subject is being discussed so that they can pick up key words and understand more fully. As a provider, one should not assume that the patient understands simply because it appears that they are nodding in agreement; often, this is feigned understanding of what's being stated. The provider should take care to avoid standing in front of a light source because this may create glare and shadows and hinder comprehension and communication. If an interpreter is present, the provider should speak directly to the patient rather than addressing the interpreter at any point. A provider should be as proactive as possible in learning how to foster positive, effective communication with their deaf patients. One great way to do this is to research community outreach programs to refer deaf patients to if needed and to participate in ASL classes so as to communicate with deaf people in their first language (King, 2005).

As a deaf patient, there are several steps that can be taken to ensure effective communication occurs when seeing a healthcare provider. While in the waiting room, the patient should alert the receptionist if calling out their name is not the best way to tell them that their doctor is ready to see them. If the patient prefers to communicate with ASL, they should request an interpreter when they schedule their appointment. The interpreter should be certified by the Registry of Interpreters for the Deaf, and this certification ensures competency and confidentiality. It's not a good idea for a patient to use a friend or family member to serve as an interpreter, since the provider might need to ask personal questions. Some patients will want to read lips or use some spoken language. These patients should be assured that they need not feel awkward if they didn't understand something, and since it's critical to understand everything, the patient should be made to feel comfortable to ask for repeats as often as necessary. If the provider will be wearing a face mask for a procedure, the patient should be told what they need to know ahead of time.

The provider and patient may find that they need to repeat each other's sentences to one another, and this is one way to illustrate a comprehensive understanding of the other person. The patient should request that the provider writes down and clearly explains any word they don't understand. Additionally, the patient should request written information about their condition, medications, treatments choices, and wellness promotion (American Academy of Family Physicians, 2004).

The patient and the provider are a team in pursuit of the highest level of health and well-being, and clear, positive, effective communication is a cornerstone of this partnership. With these simple, considerate actions, the patient and the provider can feel confident that they are understanding one another and achieving their goals together.

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